Making a Difference: How Health Visitors Understand the Social Processes of Leadership

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Abstract

Leadership has become a pre-requisite for all health professionals working at every level in healthcare. The need to strengthen leadership in health visiting has been voiced in health care policy for the past eighteen years (Department of Health (DH), 1999 & 2006; National Health Service (NHS) England, 2016). Yet there is still a lack of research examining how health visitors understand leadership, with, much of the existing research on leadership focusing on leaders "per se" as opposed to leadership as a social process.

This study sought to understand how health visitors perceive their leadership role, and how leadership is demonstrated in the delivery of the health visiting service in the context of the NHS. The aim being to enable the researcher to examine how health visitors understand leadership as a social process.

The research focused on 17 participants, 16 of whom came from a health visiting background. The participants consisted of three groups: a focus group comprising health visitors in clinical practice taken from one NHS Trust, a further group consisted of team leaders, managers and practice teachers, drawn from the same NHS Trust. The third group comprised of national, strategic leaders in health visiting. The latter two groups were interviewed individually.

A constructivist grounded theory approach was used to ascertain the participants' main concerns in relation to leadership (Charmaz, 2014). A conceptual framework of making a difference: how health visitors understand the social processes of leadership has been constructed to explain how health visitors understand leadership through their professional ideology (Whittaker et al, 2013). The conceptual framework demonstrates how the categories, *context of leadership, the purpose of leadership and leadership behavior* emerged. These were constructed from the comparative analysis, of the data and encapsulate the participants' main concerns.

The findings support the construction of a conceptual leadership development framework for health visitors. This framework identifies the need to incorporate education based on the three categories and the core category "making a difference" and there is a need to focus on leadership development as a continuous process. In addition, the findings recognize the importance of establishing both a health visitor and leadership identity (Lord & Hall, 2005; Day & Harrison, 2007).

This study has provided a framework for leadership development that can be used as a structural framework in health visiting education in both academic and clinical practice settings, and as a way of articulating how health visitors understand leadership. This study sheds light on the importance of building not only health visiting identity but also leadership identity when delivering health visitor education. It provides an interpretive perspective instead of the more common positivist approach to leadership research reported in the literature.

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I thank Dr Oliver Couch, my supervisor for your constant support, you have helped me to consider how to be more reflexive and really question my data; you have provided immensely helpful feedback. You have both helped me think about things in a way that I wouldn't have imagined possible at the start of the programme. I have learnt so much from both of you and I am grateful to have experienced role modeling in action as well as recognizing it in my participants' experiences.

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aim of undertaking this work in the first place to “make a difference”.

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In conclusion, huge thanks goes to my husband Mark, who has provided me with the space to be able to undertake this substantial piece of work and to all my friends and family who have been so supportive, and who will like me be so pleased to see this thesis completed.

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Chapter One

1. Introduction

The purpose of this dissertation is to understand how health visitors perceive their leadership role; to explore how leadership is demonstrated in the delivery of the health visiting service and to examine how health visitors understand leadership as a social process.

This chapter examines why leadership in health visiting is a phenomenon worthy of exploration. In doing so it is important to contextualise leadership and health visiting to understand historical changes, including the change of title in 2004 to Specialist Community Public Health Nursing (SCPHN) (Health Visiting).[1]

The setting and the scope of the study are discussed using the outline of my journey in this field. The study's aims and objectives are made explicit, along with the contribution to academic knowledge and professional practice.

It is important to state right at the offset that my approach to this research has been subjective in that I see myself as part of the study and I am constructing subjective knowledge with the participants in the study in order to understand the meanings they attribute to leadership (Wainwright, 1997; Emmel, 2013). This is the "usual" approach when using constructivist grounded theory methodology (Charmaz, 2014).

As part of this methodology, I have used the Alvesson and Skoldberg (2009) model of reflexivity to inform my reflection on the decisions I have made throughout the study.

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[1] The removal from statute of the title 'Health Visitor' meant that the title was not protected and was no longer a feature of the regulatory body's title. The regulator's title changed from the United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting to the Nursing and Midwifery Council (NMC). From 2004 Health Visitors would be known as SCPHN (Health Visitor).

The rationale for using a constructivist grounded theory approach and how I have used reflexivity is discussed in Chapter 3.

1.1 Background to the study

When I commenced the Doctorate in Business Administration (DBA) I knew that I wanted to look at leadership and what it meant to health visitors. As it had been an area that I had found intriguing in both my clinical and educational practice. As an educationalist, I was constantly asked by education commissioners and service partners (NHS Trusts) to incorporate more leadership into the curriculum of the SCPHN (Health Visiting) programme. However, what they thought was required to develop leadership knowledge and skills in health visiting practice were not stipulated. I thought this was probably because they did not understand what was required in terms of specific leadership knowledge and skills. In addition, I observed that there exists much rhetoric around the term leadership (Hewison & Griffiths, 2004; Storey, 2011) and the public health leadership role of the health visitor (Smith, 2004; Carr, 2005; Poulton, 2009).

It was apparent to me that it was a widely held belief that health visitors didn't have sufficient leadership skills (DH, 2007 & 2010a), but why this was deficient was not clear. This is similar to the findings in nursing where several authors have highlighted that newly qualified nurses are not adequately prepared to undertake leadership (Heller et al, 2004; Cook & Leathard, 2004; Taylor, Irvine, Bradbury-Jones, & McKenna, 2010; Hendricks, Cope, & Harris, 2010).

The NMC regulate the nursing and midwifery professions by producing standards for education. All providers of nurse or midwife education throughout the United Kingdom (UK) have to adhere to these standards (NMC, 2004, 2009 & 2010). All pre- and post-registration programmes, leading to entry into nursing or midwifery, including health visiting, are specifically approved by the NMC and must include leadership in the curriculum.

Leadership must be evident in the taught component of the programme, and be applied in the practice-learning environment. The taught and applied components each contribute to half of the education programmes (NMC, 2004, 2009 & 2010). This is in line with government health care policies that dictate that nurses at all levels have to be leaders (DH, 2000 & 2006; NHS England, 2016) regardless of their role and healthcare setting (Paterson, Henderson & Trivella, 2010). [2]

The desire for more leadership in the SCPHN programme was not surprising because developing leaders and leadership has been seen by government as the key to developing high quality safe and compassionate healthcare (Ford, Wynne, Rice, & Grogan, 2008; NHS England, 2016) and modernising the NHS (DH, 2006; NHS England, 2014; West, et al, 2015) and continues to be high on the healthcare modernisation agenda (NHS Improvement, 2016). Health policy has repeatedly identified the need for nurses/health visitors to undertake and "strengthen leadership" in their role (DH, 1999, 2008 & 2011; NHS England, 2016).

What was surprising, however, was that other than the request for more leadership there was never a clear suggestion of what else should be included under this broad heading. In the literature, leadership has been described as an abstract concept that is ambiguous and difficult to define and continuously debated (Parry, 1998; Jackson & Parry, 2011; Northouse, 2016). This made me think after reviewing the literature on leadership that perhaps this is why it is so difficult to articulate just what specific elements are required by educational commissioners and others, as the concept appears to mean different things to different people.

Despite these challenges however, leadership is a concept that shows no sign of waning in the business environment or within health care policy (Hartley, Martin, & Benington, 2008) and is often portrayed in the literature as the panacea for curing all the issues

[2] In order to be a health visitor, you have to be a registered nurse or midwife with the professional body, (NMC, 2004, 2009 & 2010). Therefore, when nurses are referred to this includes health visitors.

prevalent in healthcare (Storey, 2011). Indeed, this could be because it has continually been found that effective leadership in nursing can improve patient outcomes and thus save lives (Germain & Cummings, 2010; Wong, Cummings, & Ducharme, 2013; Francis, 2013) by reducing mortality outcomes through *the "creation of practice environments, with appropriate staffing levels, that support nurses in preventing unnecessary deaths"* (Wong & Cummings, 2007, p. 518).

This further raised my interest in researching leadership as, if we know we can save lives and improve work environments for health professionals through leadership. Then, surely, we need to understand what health visitors require from leadership education, and how best that can be delivered in their pre-qualifying programme and through Continuous Professional Development (CPD).

When I commenced the DBA, health visiting as a profession was at a crisis point. The health visiting workforce was experiencing several issues in terms of problems with recruitment, retention and low morale (Craig & Adams, 2007; Ly, 2009). This was viewed by many as a result of the impact of several health policies changing the role of the health visitor (Lindley, Sayer & Thurtle, 2011) with a shift to health visitors only being able to focus on the most vulnerable in society, particularly around the safeguarding of children (Condon, 2011).

Laming, (2009, p. 6) had recently released a progress report as a follow up to the initial inquiry that he chaired into the death of Victoria Climbie from *non-accidental injuries* in 2003. This progress report highlighted the crisis in the health visiting service stating "...*of greater challenge still is the need to address the status, training and responsibilities carried by health visitors. Evidence to this progress report makes clear that there are a number of challenges to be addressed in this service. The work of health visitors requires immediate action to increase the numbers, confidence and competence of staff."*

At the same time the publication of the Francis report (2010) following the Mid Staffordshire Hospital crisis, and subsequent reports by The Kings Fund (2011) and the

National Advisory Group on the Safety of Patients in England (2013) has meant that there has been an increased interest in developing leadership for all health care professionals, in response to these failings and as part of a desire to modernise the NHS through leadership. NHS England has invested a substantial amount of money, through the NHS Leadership Academy, with the intention of increasing leadership capabilities of all NHS healthcare professionals (NHS Leadership Academy, 2011 & 2013).

It is still felt however, that this has not been fully achieved in both health visiting and nursing (DH, 2010a & 2010b) and that this area is under researched and there are few studies that identify what leadership means in health visiting or how this constant production of health policies has impacted on the health visiting leadership role (Haycock- Stuart, Baggaley, Kean & Carson, 2010; Cameron, Harbison, Lambert & Dickson, 2011).

This is what convinced me to look at leadership in health visiting to understand what leadership means to health visitors in order to be able to develop educational programmes for health visitors that would support their leadership requirements.

1.2 Health Visiting

1.2.1 A brief history of health visiting

Health visiting arose from the Victorian philanthropic public health movement and has always had a strong focus on the prevention of ill health (Brooks & Rafferty, 2010). Throughout its history health visiting has been described as a "*contested profession*" and there is continued debate as to its nature, form and purpose, and even which terms should be used to describe it (Cowley et al, 2013, p. 30). Historically health visiting identity has been embedded through the four Health Visiting Practice Principles (Council for the Education and Training of Health Visitors (CETHV), 1977; Machin, Machin & Pearson, 2011). These are discussed further in Chapters 7 and 8.

The most recent metamorphosis of the health visitor came with the change of title and introduction of the Standards for SCPHN (Health Visiting) (NMC, 2004).

In 2001 the NMC replaced the UKCC for Nursing, Midwifery and Health Visiting. As part of this new act it was decided to remove the title health visitor from statute. As a result, "*for the first time in 85 years, health visiting was no longer seen as a distinct profession in statute"* (Hoskins, 2009, p. 6). The change of title from Health Visitor to SCPHN led to some disagreement in the profession and contributed to confusion around professional and role identity (Machin et al, 2011). This disagreement was focused on those who wanted to retain the title health visitor in statute as a separate profession to nursing and those who believed health visiting was a specialist element of nursing practice (Cowley, 2007). In practice, the majority of employers and health visitors still use the title health visitor. However, all health visitors are registered on the third part of the NMC register as SCPHN (Health Visitor) and it this title with health visitor in parenthesis that government bodies use in health policy documents when referring to health visitors.[3]

This is discussed further in Chapter 2 in relation to the health policies that influence and direct the role of the health visitor and in Chapters 7 and 8 in relation to role identity.

1.2.2 The leadership role of the health visitor

Health visitors are registered nurses and/or midwives who have undertaken additional specialist training (Bunn and Kendall, 2011) "*to develop knowledge and skills that bring together individual, family and community interventions to improve health in populations by assessing and responding to local need" (*Public Health England (PHE), 2016a, p. 11). A key component of the role of the health visitor is leadership (Lindley et al, 2011), particularly in relation to the agenda around public health (Smith, 2004;

[3] In this study, the title health visitor not SCPHN will be used predominantly as this is the title that participants used when referring to health visitors in the interviews.

Brocklehurst, 2004) and health promotion and child health (DH, 2007; DH/Department for Children, Schools and Families (DfCSF), 2009a, b; DH, 2010c). However, health visitors working at band six Agenda for Change (AfC), (DH, 2004) which accounts for most clinical health visitors do not normally have any formal leadership role in the sense that they are not given the title leader.[4] Instead they are responsible for delivering and leading on the Healthy Child Programme (HCP) (DH/DfCSF, 2009a, b). This is a health promotion programme for children aged 0-5. Health Visitors (band 6) are also expected to lead health visiting teams that may consist of nursery nurses to whom health visitors delegate work (DH, 2011; Donetto et al, 2013). However, health visitors do not have any formal authority to lead as the HCP is delivered by an array of early years workers across different organisational structures (Cowley et al, 2013). This is discussed in more detail in Chapter 2 and 5.

At the commencement of the study health visitors received training on leadership as part of their pre-qualifying SCPHN (Health Visiting) programme. In terms of post qualifying leadership training however, it can be quite sporadic and unstructured and many health visitors do not undertake leadership training even when moving into formal appointed leadership roles.

The specificity of the health visiting context with respect to leadership demands has been confusing through successive health policies (DH, 2007 & 2011, Haycock-Stuart et al, 2010; Lindley et al, 2011). It has also been complicated through the structural redesign of how health and social care are commissioned and delivered by the Health and Social Care Act (2012) as a result of which health visitors have received contradictory direction on leadership. Health visitors are leaders of public health (DH/DfCSF, 2009a; PHE, 2016b; PHE, 2018) yet their leadership role is not clearly defined and can therefore be invisible as they work in the community mainly with families in the home setting as

[4] AfC (DH, 2004) is the NHS grade and pay scale for NHS staff, excluding doctors and dentists. There are 9 bands ranging from 1-9 in seniority and an accompanying Knowledge and Skills framework that identifies what is required in each band. Health visitors are normally employed on band 6.

oppose to the more visible acute setting (Cameron et al, 2011). The crux of the issue for health visiting leadership recognised in the literature for several years is that, whilst they are required to lead on reducing health inequalities, they have an overarching role to protect children at risk which often takes precedent over their wider public health leadership role (Carr, Procter & Davidson, 2003; DH, 2007; Thunhurst, 2009, Condon, 2011).

Thus, the nature of the health visiting role is that it is defined as a universal service requiring public health leadership. Yet it simultaneously requires that health visitors meet the complex needs of families. Historically this balancing act (DH, 2007; Laming, 2009; Thunhurst, 2009) has not always been managed successfully (Carr et al, 2003; Carr, 2005). Moreover, although professionally seen as leaders (DH, 2007 & 2011) health visitors have, over the years, been uprooted into different multi agency work settings. Hence, they are mandated to lead the HCP without authority and with the challenge of developing shared purpose across multiple agencies and the wider integrated children's workforce 0-19 to deliver collective leadership (NHS Confederation, 2010; West, Eckert, Steward & Pasmore, 2014; NHS Improvement, 2016). Many health visitors do not feel that they have had sufficient skills or training in being able to do this (Thunhurst, 2009). This is discussed further in chapter 2 and 5.

There are some similarities with the style of leadership required of other professional groups within the NHS i.e. transformational and collective/shared leadership (Kumar, 2013; NHS Leadership Academy, 2013; West et al, 2014; West et al, 2015; Kumar & Khiljee, 2015; NHS Improvement, 2016). All healthcare professionals are expected to demonstrate leadership in line with the NHS Leadership Academy Healthcare Leadership Model (2013) – nine behaviours.

There is however, perhaps a distinction between health visitors and other professional groups in that the impact of successive health policies on health visiting leadership has been contradictory, in a way that has not been experienced in the same way by other professional groups. Thus, investment was made to increase the number of health

visitors to allow health visitors to undertake both public health population level work and personalised care. One objective of this was to strengthen the leadership role of health visitors in these areas (DH, 2011). Yet when health visiting services were subsequently transferred from NHS to local authority commissioners in October 2015, this led to a reduction in numbers. The direct consequence of this was a return to a service focussed on personalised care rather than public health.

As a result of this the context of the leadership role remains confusing for health visitors (Bryar, Cowley, Adams, Kendall & Mathers, 2017) in a way that is not the same for other professional groups. For example, doctors have more power to influence health policies and the culture within an organisation (Gilmartin & D'Aunno, 2007; DH, 2008 & 2010b; Kumar, 2013; Kumar & Khiljee, 2015) and policy direction than health visitors.

1.3 The setting for this study

The 17 participants involved in the study all work in health visiting and undertake leadership at a strategic and/or operational level. They hold a variety of roles encompassing practising health visitors; health visiting managers/leaders; health visiting educators and nationally appointed strategic leaders in health visiting.

Participants were interviewed in their workplace or another convenient location. Participants in Group 1 and 2 were employed in one NHS Trust in the North of England. Participants in Group 3 all worked in regional and national roles associated with health visiting at a strategic level.

1.4 My research journey

I began reading for a DBA in February 2010. As discussed earlier, my interest in the subject arose from my intrigue in why leadership was seen as the answer to all of the existing issues in healthcare and if it was so important surely it was important to understand what leadership meant to health visitors (as discussed in section 1.1 and

1.2). This was driven fundamentally from my professional practice which is not unusual when choosing an area to research (Strauss & Corbin, 1990) and the recognition of how important it was to get leadership education right for health visitors. Without been overly dramatic, the literature reviews I had undertaken as part of the DBA programme had demonstrated that lives could be saved by improved leadership (Wong & Cummings, 2007; Germain & Cummings, 2010).

Whilst delivering the education programme for SCPHN and engaging with student health visitors I could see the leadership abilities of the students developing on the programme, but there didn't appear to be opportunities available to develop leadership skills after they qualified. Moreover, students also reported that it was difficult to lead or effect change in practice settings if the health visiting teams in which they worked were not receptive. Considering how many child protection serious case reviews request better communication and leadership I was professionally concerned about the impact on client safety if there was indeed a lack of leadership skills in health visiting (Laming, 2003; Brandon, Bailey & Belderson, 2010).

As part of the "taught" component of the DBA programme I undertook two broad literature reviews in line with the constructivist grounded theory approach (Charmaz, 2014). Chapter 2 provides an overview of the literature from these reviews to contextualise the study.

The more I read the more interested I was in the concept of 'post-heroic' leadership, particularly distributed leadership which I was not familiar with. I had struggled with some of the health policy directives (DH, 2008 & 2010a) stating that every nurse/health visitor must be a leader. I did not understand what that meant in practice, and it had been a topic for debate in many of the sessions when I taught nursing and health visiting students. It was apparent to me that the majority of students also struggled with this concept.

I was concerned that the notion of leadership might become worthless because it was discussed in the context of 'everyone being a leader' without any clear understanding of what that meant for practitioners.

After reading the literature, I recognised that leadership was defined in more ways than the leader/follower dyad (Northouse, 2016), that is as a specialised role (Yukl, 2013). I wished to consider leadership in this study as a shared process that happens between individuals in an organisation as opposed to an individual activity undertaken by leaders. The literature on leadership frequently defines it as a "social process"; however, what the term social process means is not always apparent (Parry, 1998).

Leadership has been defined in the literature by many authors as a process of influence (Yukl, 2013; Northouse, 2016). It is believed that using influence will change what individuals do within an organisation and the relationships between those individuals "*because leadership involves a transformation in the views, beliefs and attitudes and motivations of followers"* (Parry, 1998, p. 86) therefore, leadership must involve change.

Yukl (2013, p. 19) discussed this further, as leadership being a shared influence process between individuals that "*occurs naturally" within "a social system"* such as between members of an organisation. This views "*leadership as a social process or pattern of relationships rather than a specialised role."* As these social processes can be undertaken at any level of the organisation (Parry, 1998) this provides a way of viewing or understanding the concept put forward in health policies that leadership for nurses/health visitors should exist at every level (DH, 2006; NHS England, 2016). I was interested to explore the idea of leadership as a social process, as a means of refining the phenomenon under investigation and exploring if and how health visitors relate to each other through leadership relationships.

I refined my research question after undertaking the literature reviews and I developed some broad themes for questions for my upcoming interviews and focus groups.

Thus, these personal observations and my understanding of the literature resulted in me wanting to interview health visitors (Group 1) in focus groups. By this means I hoped to get a collective understanding of how they attributed meaning to leadership i.e. did they see themselves as emerging as leaders and if so in what context and for what purpose? Furthermore, I wanted to understand how health visitors related to each other through leadership as I felt this would give insight into the leader-follower dyad.

In addition to the focus groups, I decided to conduct individual interviews with middle managers, team leaders and practice teachers (Group 2). These practitioners should have the ability to formally influence the development of leadership within their organisation.

Finally, I elected to interview national, strategic leaders in health visiting (Group 3). These individuals have influence and formal responsibility to develop a strategic direction for education and health policy in the health visiting profession.

I chose to perform the study this way because I particularly wanted to understand how groups 2 and 3, in their senior roles, understood the social process of leadership. Moreover, I was especially intrigued to see if the view of these two groups differed significantly from how frontline health visitors (Group 1) engaged with leadership as a social process.

All interviews were conducted between September and November 2013.

An interpretive approach (Crotty, 1998) is proposed as an appropriate theoretical framework. This will allow me to search for meanings in actions to co-construct with participants in the study and create reality and develop understanding. Such an approach will aid understanding of the experiences of the participants. An appropriate methodology that will allow me to explore the phenomenon in this way is a constructivist grounded theory perspective (Charmaz, 2014). This will enable me to explore the health visitors' perceptions of their experience of leadership within their

role and to help uncover the social processes of leadership within the context of health visiting.

By using a constructivist grounded theory approach, I am using a "subjective" approach that places me within the research. I see myself as active in the research from the beginning and having a part in the construction of categories (concepts) along with shaping the process and the end result as advocated by Charmaz (1990). The implications of this are important and so this is discussed further in Chapter 3 where a rationale for the chosen methodology is discussed.

Reflexivity is an important activity for qualitative researchers and especially for those using constructivist grounded theory. Using memos ("*analytical notes"*) discussed further in Chapter 4 allowed me to be reflexive, i.e. to consider my own part in the study and the construction of social knowledge and consider my professional experiences, values and beliefs (Charmaz, 2014, p. 4). It also allowed me to make sense of what participants were telling me and the meaning they ascribed to their actions. Writing memos reminded me of my own sensitising theories (Charmaz, 2014) about health visiting. One example of this was considering the change in title from health visitor to SCPHN in 2004 (NMC). I did not see the importance attributed to this change until I wrote memos to understand what I was told about health visiting roles and health visitor identity.

As part of my DB2 oral presentation I was reminded of the need to be open about what professional sensitising views you bring to the research. I have substantial experience in the area this study examines and I have formed views about leadership and health visiting. I have included these here as a way of acknowledging my *a prior* thoughts on the phenomenon recognising that they may cause bias as part of data collection and analysis as they cannot totally be eliminated as discussed in Chapter 3 and 4. However, acknowledgement of these views is an important part of using a constructivist grounded theory methodology, which recognises the importance of my role in co-construction of the data, whilst still needing to bring rigour to the findings (Charmaz, 2014).

1.5 Research aims and objectives

By undertaking a broad review of the literature at the beginning of the study I identified a gap in specific studies that explored the concept of leadership in health visiting and their perceptions and experiences. The research question *how do health visitors understand "leadership" within the NHS?* Was developed as a general question to capture the phenomenon in line with the grounded theory approach and reviewed as the data was collected and analysed (Charmaz, 1990). The aim of the research and the objectives were devised from the literature and from my own sensitising concepts i.e. ideas that I had from professional practice about leadership. These changed as the study developed and I constructed the data through comparative analysis as is common in a grounded theory study (Charmaz, 2014).

1.5.1 Aims of the research

The purpose of the research was to gain an understanding of how health visitors perceive their leadership role. In addition, I sought to examine how leadership is demonstrated in the delivery of the health visiting service. I also wished to explore underlying assumptions about leadership, in the context of the workplace, to allow me to examine how health visitors understand leadership as a social process.

1.5.2 Research objectives

- To understand what the term leadership means to health visitors at every level.
- To identify what leadership activities health visitors, undertake within the organisations within which they work and to clarify what leadership identity they have.
- To explore how followers, make sense of leadership.

- To analyse how 'top-down' policies, different professional discourses, and cross boundary working affects leadership in health visiting.
- To understand the social processes operating within the health visiting service, to generate a conceptual framework to explain health visiting leadership within the NHS.
- To offer recommendations on how leadership education for health visitors might be improved.

1.6 Contribution of the research

This research contributes to academic knowledge and the professional practice of leadership in health care, by extending the body of knowledge. This will broaden the base for ideas around leadership development for health visitors.

This study builds on the work undertaken by Whittaker et al (2013) and Cowley et al, (2013) and the leadership literature on developing leader identity by Lord and Hall (2005) and Day and Harrison (2007). In addition, the frameworks of leadership devised by Hartley et al (2008) and Storey (2003 & 2011) are used to contextualise the findings.

By undertaking the study from a constructivist grounded theory approach, using in depth interviews and focus groups to explore the leadership experiences of health visitors as a social process, provides a different methodological approach to researching leadership, as the literature identifies that most leadership studies are undertaken from a positivist methodology (Parry, 1998; Parry, Mumford, Bower, & Watts, 2014). Previous studies have tended to be concerned with the paradigm of leadership conceptualised at an individual level and the notion that leadership can be understood purely by the leader-follower relationships (Gronn, 2002a; Parry et al, 2014).

This study demonstrates that, whilst leadership as a concept is important it is not a universal panacea for all the issues in healthcare. Moreover, it will not, on its own, deliver high quality healthcare (Hewison & Griffiths, 2004; Storey, 2011). Indeed,

leadership remains a contested concept without a universally accepted definition or theory (Parry, 1998; Jackson & Parry, 2011; Scully, 2015; Northouse, 2016). There exists scepticism of the benefits that leadership can bring to health care organisations. It is widely held that the successive focus of health policies on leadership is merely rhetoric. It is felt that what has really happened is a change in terminology from administration to management to the fashionable term leadership. The discourse that has developed through successive health policies sees leadership as the panacea. As it is felt that the term leadership is more popular with practitioners than the term management which has negative connotations (Martin & Learmonth, 2012).

The focus in health policy (DH, 2000 & 2008; NHS England, 2014) is upon the importance of the individual health professional being a leader and developing leadership behaviours (DH, 2008; NHS Leadership Academy, 2013). Whilst this is beneficial, it can mask the wider system issues in the NHS that are so important for effective leadership to flourish i.e. organisational culture and the removal of hierarchical structures (West et al, 2014; West et al, 2015). In addition, the NHS is facing financial constraints and workload pressures with more nursing staff choosing to leave than are being trained (Ham, Berwick & Dixon, 2016; Timmins, 2016; Health Education England, 2018). Simultaneously the direction of health policy is confusing. It asks for all to be leaders and to develop local leadership (DH, 2008) yet increases the amount of central control through regulation and inspection of service providers (Ham et al, 2016; Timmins, 2016).

The NHS is currently focused on building collective leadership (NHS Improvement, 2016). Without however, a change in culture (West et al, 2014) and the sharing of power it is difficult to see how collective leadership, the most sought-after style of leadership (NHS England, 2016; NHS Improvement, 2016) will be delivered. The success of this style of leadership rests on staff being engaged (West et al, 2014) and this is not currently the case (Dixon -Woods et al, 2013). Indeed, transactional leadership is still common within the NHS (Kumar, 2013). Paradoxically the NHS is a highly bureaucratic organisation that can hinder change and the development of leadership (Kumar, 2013; Kumar & Khiljee, 2015). It is widely recognised that whilst a compassionate style of leadership is required

(NHS Improvement, 2016), what exists in areas of the NHS is a fear and bullying culture (National Advisory Group on the Safety of Patients in England, 2013; Powell, 2016; Ham et al, 2016; Timmins, 2016). This is compounded by the fact that the NHS is not one organisation but instead a complex array of hundreds of organisations (Timmins, 2016).

The current focus of health policies is that all health professionals must undertake leadership as part of their role (DH, 2000, 2008 & 2010a). There is no discussion about the fact that not all health practitioners may be suited to leadership. Moreover, some staff may display negative leadership (Scully, 2013) and not want to change which is a central component of leadership (Kumar, 2013). Many health policies do not inform how such leadership will be undertaken in practice (Martin & Learmonth, 2012). Despite a call for more training and support for staff to lead improvements in care as part of the National Advisory Group on the Safety of Patients in England (2013) report, a survey of the outputs from this report by the Health Foundation, Monitor, NHS Trust Development Authority (2014) showed this had not happened sufficiently in all healthcare organisations one year later.

1.7 Structure of the thesis

The methods used in grounded theory are *applied in a cyclical process* as is discussed in Chapter 3 (Charmaz, 2014; Giles, De Lacey & Muir- Cochrane, 2016a, p. E32). However, for the purpose of presenting the research in a coherent way the grounded theory methods used will be presented in a linear structure within the nine chapters of the dissertation as follows:

Chapter Two – Literature Review - The literature review provides a broad overview of the research undertaken in this area together with a review of health policy pertinent to leadership in nursing and health visiting in the NHS. The review has been purposefully undertaken in this way in line with the grounded theory methodology which advises against an in-depth review at the beginning of the study (Strauss & Corbin, 1990;

Charmaz, 2014). Further literature is reviewed and used to support the emerging categories in Chapters 5, 6 and 7 to contextualise the emerging conceptual framework.

Chapter Three – Methodology - The methodology presents the research process, ontology and epistemology, theoretical perspective. It also contains a review of the chosen methodology that of grounded theory and a rationale for the use of constructivist grounded theory. It explains in detail the research methods, interview technique, focus groups, data collection technique, reflexivity and the ethical considerations in this research.

Chapter Four – Data Collection and Analysis - The data collection and analysis procedures are presented including selection of the participants, recruitment of participants, overview of the interview process, analysis of the data using coding, the constant comparative analysis and the use of memos. This chapter also outlines the emergence of the three main categories of this dissertation from the empirical data. It also explains the data reduction process.

This chapter goes on to propose a core category *making a difference* that brings together the three categories and supports the development of a conceptual framework. The discussion of the findings from the study in later chapters is supported both by the relevant literature and by participant's quotes. Thus, chapter 4 informs the discussion of findings in the three following chapters.

Chapter Five - Context of Leadership - This chapter outlines the findings that constitute the category and its properties. This includes: professionalism, which relates to professional background and professional boundaries; organisational change which incorporates governed by policies from above, health visiting model of practice and team leadership.

Chapter Six - Purpose of Leadership - This chapter outlines the findings that constitute the category and its properties. This includes: setting the direction, which includes

engagement in change and taking the vision forward; followership which constitutes influencing, safe to follow, two-way process and right to reply.

Chapter Seven - Leadership Behaviour - This chapter outlines the findings that constitute the category and its properties. This includes: role modelling which includes impact on staff and clients and attributes; identity which includes health visiting leadership identity and autonomy to make decisions; developing leadership which consists of leadership skills, and leadership training.

Chapter Eight - Discussion of the construction and use of the conceptual framework - This chapter begins with a discussion about the co-constructed conceptual framework that explains how health visitors understand leadership, and the core category *making a difference*. Leadership identity of health visitors is discussed in the context of the findings from the study. The chapter goes on to consider how this might relate to future leadership development for health visitors.

Chapter Nine - Conclusions and recommendations - This chapter draws conclusions and recommendations from the study. It discusses the value of the study and the contribution of this study to academic knowledge and professional practice and personal reflexions on professional practice. The aims and objectives of the study are reviewed to ensure they have been met. The study is evaluated in line with Charmaz's (2014) criteria for studies using grounded theory. Finally, recommendations are made for practice and further research.

1.8 Chapter summary

This chapter has identified the rationale for the study – Making a difference: how health visitors understand the social processes of leadership. The background surrounding why the phenomenon of leadership in health visiting is a relevant area to explore has been discussed. An overview of the different groups of participants taking part in the study and the setting has been identified. My own personal experiences are highlighted along

with the sensitising concepts I bring to the study. The constructivist grounded theory approach and the aim and objectives of the study are outlined. Finally, the chapter provides an overview of the structure of the subsequent chapters.

Chapter Two

2. Literature Review

2.1 Introduction

This chapter will review what is already known in the existing literature about leadership in health visiting. The use of the literature within a grounded theory approach, in terms of and how and when it should be used, is considered as this is a key part of the methodology and a frequently debated issue (Yarwood-Ross & Jack, 2015).

There is a relative scarcity of literature about leadership in health visiting so I have included a selection of the more extensive literature on leadership in nursing and healthcare. It is hoped that this will identify relevant gaps in the available literature and help to place the study in context. The literature review thus considers how theory and practices of leadership have traditionally been visualised in the NHS and nursing/health visiting. The review highlights what is currently being espoused about leadership, and reviews health policy that directs the role of the health visitor.

Reviewing the literature has informed the research design of the study, by contributing to the refinement of the research question and objectives and to the development of the themes utilized to explore leadership as a social process through the methods of in depth interviews and focus groups.

In line with the methodology of constructivist grounded theory (discussed in chapter 3) an initial broad overview of the literature was undertaken, this was purposefully not a detailed review of the literature. A further review of the literature was subsequently completed after data analysis and the development of the categories outlined in Chapters 5, 6 and 7 (Charmaz, 2014). This latter review was designed to explore how the categories developed from the data are situated in the literature and is discussed further in Chapter 8.

In 2015, the Kings Fund along with the Faculty of Medical Leadership and Management and the Centre for Creative Leadership undertook a review of the leadership evidence surrounding leadership and leadership development in health care (West et al, 2015). This review has been used to support the study findings (see Chapters 5, 6 & 7) and to enhance the initial literature review that was undertaken prior to commencing the fieldwork in 2013. In addition, selected papers from 2013 onwards have been added to this initial literature review as appropriate.

The literature review comprised two stages. The first stage is presented in this chapter. For this stage a literature review was performed prior to commencing the study. This thus represents my understanding before commencing the study. Subsequently, additional references were used to strengthen the review at the end of the study but not to change the structure of stage one of the review. The structure of stage one was developed after completing two separate literature reviews. These reviews were undertaken as part of the modular assessment of the DBA programme during the first two years of study. These reviews occurred before both data collection and analysis.

A flowchart has been constructed (appendix 1) to demonstrate how the literature review derived from stages one and two was used in this chapter and subsequently throughout the study. The literature review from stage one discusses the phenomenon of leadership and related concepts in terms of what is known about leadership theories that apply to a health context. In addition, how leadership is viewed from a health visiting, nursing and NHS perspective is considered and the relevant policy driving leadership for health professionals in the NHS is discussed.

This flowchart shows the second stage of the review. It aims to clarify how different bodies of literature and theories are used and integrated in the findings of chapters 5, 6 and 7. The output from stage two of the literature review was used to explore the materials from my interviews and focus groups and in the discussion chapter 8, it was used to support the development of the conceptual framework. This approach is in

keeping with how literature is used in a constructivist grounded theory study (Charmaz, 2014; Birks & Mills, 2015).

Using the literature in this way enables the comparison of extant literature with the emerging data and any aspects that are different or the same can be identified and discussed (Giles et al, 2016a). The constant comparative method of data analysis supports the ability to review literature with the emerging conceptual framework after the categories have been established. This shows how extant literature supports but does not influence the development of, nor impose preconceived ideas onto the framework (Charmaz, 2014). This shows how the conceptual framework is situated within the extant knowledge and what it adds in terms of contribution to new knowledge and practice in the field of leadership and health visiting.

In addition, Figure 4.1 in chapter 4 (p. 86) illustrates the processes and methods involved in this grounded theory including the initial and secondary literature review stages.

2.1 Use of literature in grounded theory

When and how to use literature within a grounded theory study is a contentious issue and one that is constantly debated by academics, although all agree that a literature review should be undertaken as part of the study (Parry, 1998; Yarwood-Ross & Jack, 2015). Glaser (1998) advocates starting the research without a prior literature review. He suggests that this avoids preconceptions about the data analysis. Strauss and Corbin (1990) similarly agree with Charmaz (2012) and others that one need not omit the literature review completely and they recognise that this may not be feasible due to the requirements of university programmes (Yarwood-Ross & Jack, 2015).

The controversy arises because a grounded theory study requires you to enter the study with an open mind. The concern that otherwise data might be ignored if it does not fit expectations of existing models has been raised (Cormack, 1991; Lansisalmi, Peiro & Kivimaki, 2006). It is also suggested that prior knowledge may impact on the

interpretation of results by the researcher and influence the direction of the study rather than allowing the data to emerge and develop (Strauss & Corbin, 1990; Hussein, Hirst, Salyers & Osuji, 2014).

By contrast, Bryman (2008) questions whether it is possible to ignore what is already known about a subject area or relevant theories until the late stages of the analysis. The researcher's innate knowledge might be seen as positive, because personal knowledge and insight might help us to see and understand the situation (Alvesson & Skoldberg, 2009).

As several authors (Parry, 1998; Charmaz 2006 & 2014) have acknowledged, researchers have preconceived ideas about the subject of their research. The notion that researchers can start with a completely blank canvas is not sustainable. Similarly, it is impossible to discount the researcher's own cultural position and traditions (Simmons, 1995). The essence is however that the researcher keeps an open mind, and must not disregard what emerges if it does not concur with what is expected.

These issues can be addressed by taking Henwood and Pidgeon's (2003) "*stance of theoretical agnosticism. They argue that grounded theorists should subject prior theories* identified in the literature to *rigorous critical analysis rather than ignoring or denying them"* (Charmaz, 2012, p. 4). They suggest, that by this means, one can view things theoretically and know a range of theories and be aware of what might resonate with the data from your study (Charmaz, 2006). This idea is supported by Charmaz (2012, p. 4) who advocates acknowledging "*our starting points and standpoints and the shifting positions we make and take as our studies proceed".* This includes theoretical knowledge, hunches and hypotheses when planning the study (Emmel, 2013). Thus, a constructivist grounded theory approach supports the early review of the literature at the start of the study (Charmaz, 2012 & 2014).

As I am an expert health visitor it would have been impossible to ignore my professional expertise and knowledge in this area, however, by adopting a theoretical agnostic

approach I have seen literature and data which has both supported and challenged my existing understanding. This is discussed throughout the study.

Before I reviewed the literature, I had not heard of distributed/collective/shared leadership. When I discovered these leadership theories, I thought this approach to leadership, as a social process, might offer an opportunity to view leadership in a different way from the traditional dyad of leader-follower (Northouse, 2016). Therefore, I was keen to look at leadership as a social process (as discussed in Chapter 1) and not through the lens of a specialised role, e.g. leader (Yukl, 2013), as I believed that this view might shine a light on how health policies that required all health visitors to be leaders could be implemented in practice when health visitors were not in a formal leadership position.

I reflected on this and wrote early memos (discussed in chapter 4) in order to critically analyse these leadership theories using the concept of theoretical agnosticism (Henwood & Pidgeon, 2003) along with identifying my own hunches and theoretical sensitivity about what I thought was going on in the phenomenon, to ensure that I did not force the data and analysis (Charmaz, 2014). In addition, I amended the objectives for the study to reflect what I had established from the literature review, which also informed the questions formulated for the interviews and focus groups. Modification of my objectives and using the literature in this way is endorsed by the methodology of grounded theory, an approach advocated by Parry, (1998) to explore leadership.

2.2 Policy directing the development of health visiting

The evidence base surrounding early year's development and supporting families has increased significantly since the 1990's (Whittaker et al, 2013). This has led to a greater understanding of neurophysiology, how this is impacted on by inheritance and environment and pregnancy and the significance of the early years on the future life direction of the child and health inequalities (Marmot et al, 2010). As a result, the health promotion and preventative activities that are effective in addressing these issues is

more apparent (DH, 2007; Cowley et al, 2013; PHE, 2014). This focus, on what is effective and what is required to improve early years, has been reflected in health policy with the introduction and investment in Sure Start in 1998; a government initiative to give children the best start in life (Lewis, 2011) by targeting the most disadvantaged communities (Whittaker et al, 2013).

The Sure Start initiative was transferred to Local Authority (LA) control from the DfCSF as a result of Every Child Matters (Department for Education & Skills (DfES), 2004) report developed as a result of the death of Victoria Climbie and the subsequent inquiry (Laming, 2003) in 2005 to bring Sure Start into Children's Centres in every community. This entailed a large investment in the early year's workforce to improve the transfer of evidence into practice (Cowley et al, 2013). One of the key ways in which this was achieved was through the HCP, an evidence based (Hall & Elliman, 2006; Barlow et al, 2008) government programme that focuses on the most effective approaches and "*health-led* "*parenting interventions in pregnancy and the early years"* (Cowley et al, 2013, p. 28; PHE, 2016a). "*The HCP is a universal programme available to all pregnant women and children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life" (*PHE, 2016a, p. 5), by focusing on prevention and support.

The HCP (DH/DfCSF, 2009a, b) provides guidance to all who work with children across the health and children sectors and "*refers to pre-school children and name health visitors as the lead professionals in implementing the policy"* (Cowley et al, 2013, p. 32). Yet interestingly the same investment was not reflected in health visiting services which in fact had a reduction in investment and therefore in the numbers of health visitors in the same period (Cowley et al, 2013) thus reducing their ability to "*deliver public health initiatives and family focused care"* (Whittaker et al, 2013, p. 4) and ultimately the HCP effectively.

It has been suggested that health visitors are the lead professionals of the HCP because they have the skills to deliver and implement the programme for children aged 0-5

(DH/DfCFS, 2009a, b; DH, 2011; Cowley et al, 2013, PHE, 2016a). In addition, it was believed that by making the health visitor the lead of the HCP it would ensure a consistent approach to how the HCP was commissioned and delivered something that was lacking from the previous child health promotion programme (DH, 2007; Cowley et al, 2013).

At the same time as the development of the early years workforce and a focus on the HCP, changes occurred in the health visiting role (Hogg & Hanley, 2008) as a result of differing health policies (Lindley et al, 2011) that resulted in a workforce where "*morale and job satisfaction"* were low (Whittaker et al, 2013, p. 6) retention of staff had been an issue, and some NHS Trusts experienced high levels of sickness and stress. All of these changes affected service delivery. In the period from 2000 - 2010 health visiting had struggled with a loss of confidence in the profession caused by a shrinking work force and a less than clear health policy (DH, 2007; Craig & Adams, 2007; Ly, 2009; Laming, 2009; Wallbank & Preece, 2010; Lindley et al, 2011).

In response to the challenges within health visiting and the issues raised by Laming (2009) (discussed in chapter 1) A Programme of Action on Health Visiting was undertaken this aimed to review the profession and the way forward to reverse the trend (DH/Unite the Union/Community Practitioners' & Health Visitors' Association (CPHVA), 2009c). This work was radically affected by the formation of the coalition government in 2010. This led to an unprecedented focus on health visitors in health policy with a commitment to substantial investment to increase by fifty percent the number of health visitors in England to 4200 over a four-year period. This was articulated through the Health Visitor Implementation Plan (HVIP) 2011-2015: A Call to Action (DH, 2011) which was introduced with the intention of strengthening the delivery and implementation of the HCP (DH/DfCSF, 2009a, b; Donetto et al, 2013; Whittaker et al, 2013) by increasing the number of health visitors and improving service delivery.

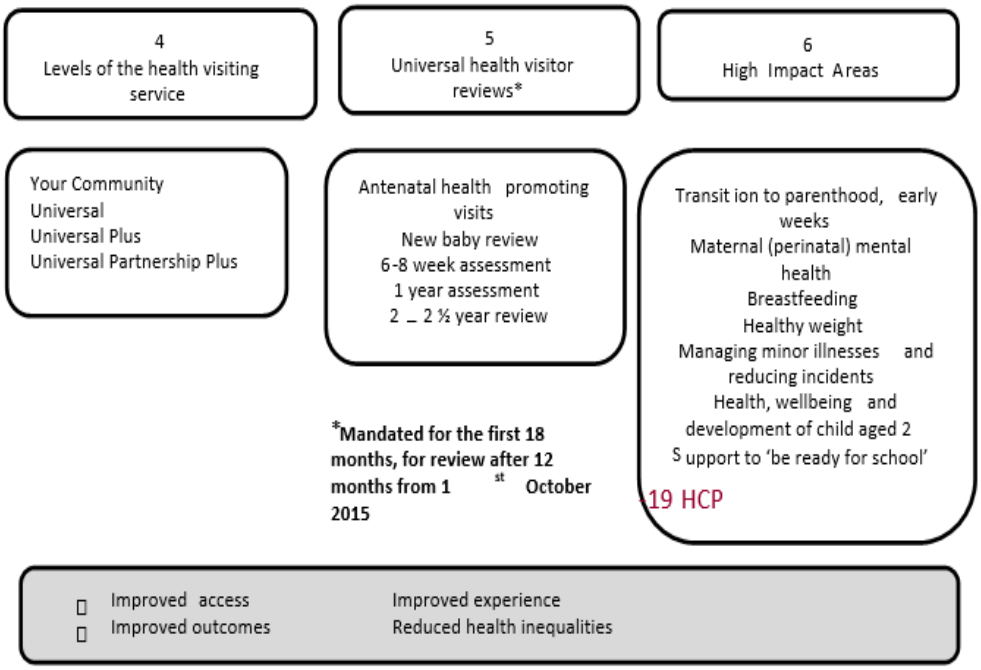
The HVIP (DH, 2011) had three key work streams: growing the workforce, professional mobilization and aligning service delivery, in the context of the new and changing NHS

architecture coming into place as part of the Health and Social Care Act 2012 alongside the local government changes in Sure Start Children's Services (Cowley et al, 2013; Whittaker et al, 2013). In effect the HVIP (DH, 2011) provided a vision for health visiting and a more focused approach to delivery of the service through the four service levels referred to as the "family offer".

The "family offer" was specified first in the "new service vision: for health visitors (DH, 2010c). This provided a new service delivery model for health visiting at four levels: your community, universal, universal plus and universal partnership plus and in addition described how health visitors contribute to the protection of children (DH, 2010c; Donetto et al, 2013; Cowley et al, 2013). The four-level service delivery model was then interpreted and developed in the HVIP (DH, 2011) and brought together with the HCP programme requirements and then subsequently with the six High Impact Areas (PHE, 2014). This then became known as the 4-5-6 model (see Figure 2.1) which describes the new four tier service delivery model (DH, 2010c & 2011); the five mandated reviews identified in the HCP that health visitors deliver and lead on (DH/DfCFS, 2009a,b) and the six High Impact Areas were developed for early years from evidence suggesting what specific activities health visitors should focus on based on what the evidence suggests could improve outcomes for children and families (PHE, 2014; PHE, 2016). The performance of delivery on the 'five' mandated contacts of the HCP are measured through the Public Health Outcomes Framework (PHE, 2017).

The purpose of the four-tier model was to define explicitly what health visitors have skills and knowledge in and provide an evidence base, something that was believed to be missing previously (DH, 2007; Laming, 2009). Figure 2.1 became the model of practice for health visiting in England replacing previous models whilst building the model on existing requirements e.g. the Health Visiting Principles of Practice (CETHV, 1977) underpinning the NMC (2004) Standards for SCPHN (Health Visiting) training. It also became used as a visual marketing tool to articulate what health visitors do in their revitalized role (DH, 2011; PHE, 2016a).

Figure 2.1 Transformed health visiting service model (PHE, 2016a)



The introduction of the Health and Social Care Act 2012 meant that upper tier LAs were now responsible for an array of statutory duties for children, and improving the health of their local population (PHE, 2016a). This meant that services previously commissioned from NHS England e.g. public health departments transferred to LAs, in reality this has led to a reduction in budgets due to the public sector funding cuts (National Children's Bureau; 2016; Bryar et al, 2017). This resulted in, "*the responsibility for children's public health commissioning for 0-5-year olds, specifically health visiting, transferring from NHS England to LAs on 1 October 2015"* (PHE, 2016a, p. 7), hence why the mandated 'five' HCP contacts that health visitors deliver were protected until the end of March 2017. The implications of this are discussed elsewhere (Chapters 5, 7 & 8). See Appendix 2 for further explanation of the commissioning arrangements across healthcare systems and the changes in how they are delivered now as a result of the Health and Social Care Act 2012.

In summary, we have seen increased scrutiny and a rapid change to the role of the health visitor in England as a result of government policies directed at improving the health of

children through early years' services. This culminated in the introduction of the HVIP (DH, 2011) to rejuvenate health visiting through increasing health visiting numbers and the introduction of a new service delivery model for health visitors, re-enforced by the leadership role identified in the HCP and a re-focusing of the role in the six High Impact areas where the evidence suggests health visitors can make the biggest impact (DH, 2010c & 2011, PHE, 2014).

Undertaking the research in the middle of the HVIP (DH, 2011) meant that it seemed pertinent that the objectives I formulated as part of the research question needed to include reference to health policies and how participants were experiencing the implementation of the HVIP as central to this was the statement about strengthening leadership in health visiting. This informed my research design in terms of the themes and questions that I formulated from undertaking the literature review.

It appeared that top down policies had a key role in shaping the role of the health visitor (DH, 1999 & 2002; DfES, 2004; DH, 2011) and this was a key factor in terms of how the phenomenon leadership was constructed. Therefore, it reinforced my chosen methodology as I wanted to understand the meaning that health visitors gave to the impact of such top down policies and if this impacted on how they gave meaning to leadership. It also shaped my thinking in terms of my chosen methods in that I didn't just want to interview health visitors in focus groups. I wanted to interview national strategic leaders who were deciding on and implementing these changes in policy through the HVIP. This would provide me with a wider understanding from different viewpoints to compare and contrast. Interviewing middle managers and team leaders would also provide an opportunity to understand how this and other health policies were implemented locally.

2.3 Leadership theories

Many theories of leadership were developed throughout the 20th century to attempt to explain how leadership works. Several approaches to leadership have been identified

based on different assumptions and theories (Pearson et al, 2007). Most definitions and theories include what Drath et al, (2008, p. 635) call the "tripod" of leadership i.e. "*leaders, followers and their shared goals*." It has been suggested that research into leadership is dominated by examining "*who the leader is (leader identity) and what the leader does (leader behaviour)"* (Jackson & Parry, 2011, p. 25).

Who the leader is has been examined through the trait approach (Kirkpatrick & Locke, 1996). This was popular until the late 1940's and it is based on the premise that leaders have specific personality traits that differentiate them from non-leaders. Thus, one is seen as a born leader (Parry & Bryman, 2006). However, research into this approach examining consistent and unique personality traits showed no definite pattern (Cacioppe, 1997).

What the leader does has been explained by the style approach (Northouse, 2016). This was prominent until the late 1960's. It emphasises the personal behaviour of the leader and what they do rather than their personal characteristics (Parry & Bryman, 2006). This implies that leaders' behaviour can be changed through training therefore; leadership programmes are frequently structured using the style approach (Northouse, 2016). Criticism of the style approach focuses on the lack of evidence to show how leadership styles are associated with performance outcomes and it is suggested that there is no one best style of leadership that works in every situation (Yukl, 2013; West et al, 2015; Northouse, 2016).

Transactional leadership is focused on transactions between leaders and others. It is driven by self-inducement (Davidson, Elliott & Daley, 2006). It works within an existing culture by basing decisions and actions on the organisation's norms and procedures (Bass & Avolio, 1993). This approach was very popular in nursing in the 1990's and was seen as the predominant style (Cook, 2001) it has been described by Bryman (1986) as the perfect bureaucratic manager, which has fitted well within a bureaucratic organisation like the NHS.

New leadership emerged in the 1980's (Bryman, Gillingwater & McGuiness, 1992). These different approaches were viewed as a new way of understanding leadership. The leader was viewed as a manager of meaning rather than an influencing process, somebody who can make sense of the situation in which leadership is occurring particularly in relation to the culture of the organisation (Smircich & Morgan, 1982; Parry & Bryman, 2006; Parry et al, 2014).

Relationships have been seen to be a key factor in understanding leadership irrespective of how scholars conceptualize leadership (Cummings et al, 2010; Curtis & O'Connell, 2011). This therefore led to the recognition of different approaches to leadership e.g. authentic leadership which focuses on finding meaning through leadership behaviour (Avolio & Gardner, 2005) which has become popular in nursing more recently as it is believed to promote patient safety and high-quality care by creating better work environments (Wong, Laschinger & Cummings, 2010).

Transformational leadership (Bass, 1990) has been characterised by four factors: idealised influence, the followers' needs are put ahead of the leaders; inspirational motivation, leaders motivate by providing meaning; intellectual stimulation, the leader encourages followers to be innovative and creative and individualised consideration, the leaders acts as a coach or mentor (Bass, Avolio, Jung & Berson, 2003). A valid criticism of transformational leadership is that most research upon it has been conducted on very senior leaders (Northouse, 2016) and there is little evidence of how transformational leadership works with junior nurses (Gilmartin & D'Aunno, 2007; Wong et al, 2013).

Following the transformational theory of leadership, a dispersed or distributed leadership theory has emerged (Parry & Bryman, 2006). This theory became prevalent in the late 1990's and early 2000s. It is defined by Harris (2008, p. 176) "*as being a web of leadership activities and interactions stretched across people and situations".*

This theory sees leadership as an activity that is widely dispersed and not the sole responsibility of one individual (Parry & Bryman, 2006). This is an enticing theory that

has not been reviewed in the nursing literature to any degree although it is popular in education research (Gronn, 2008; Harris, 2008). It is of particular interest at a time when leadership in the NHS is moving increasingly towards a more shared, less heroic, approach. Whereby a whole systems approach to leadership is suggested that engages staff and followers (The Kings Fund, 2011; NHS England, 2016).

In order to understand this new focus on distributed/shared leadership in the NHS (The Kings Fund, 2011) I have reviewed these two approaches below in more depth to see if and how they contribute to the study design. In addition, I am interested in how health visitors construct meaning around leadership i.e. do they experience leadership as suggested by Drath et al (2008) and West et al, (2015) who refer to the leadership task in the NHS has been focused on direction, alignment and commitment. This is based on the definition of an alternative ontology of leadership put forward by Drath et al (2008), where the focus of leadership is based on what it achieves e.g. its outcomes as oppose to its entities e.g. leader, follower and shared goal which appears more feasible when a shared/distributed approach to leadership is in place.

2.3.1 Shared leadership

Post-heroic leadership has been most frequently described by the terms shared and distributed leadership (Fitzsimons, Turnbull-James & Denyer 2011; Turnbull-James, 2011). A term used to describe these collective more egalitarian less hierarchical (Fletcher, 2004) leadership models many of which are used interchangeably in the literature (Ensley, Hmieleski & Pearce, 2006; Bolden, 2011) although others see the two as philosophically diverse (Spillane, 2006; Fitzsimons et al, 2011).

Shared leadership originated from the team based literature on leadership (Fitzsimons et al, 2011) and the development from the self-leadership, super-leadership constructs i.e. lead others to lead themselves, by switching control from the leader to the follower (Manz & Sims, 1991; Kerfoot & Uecker, 1992) to group self-leadership which has been found to be effective with teams (Ensley et al, 2006) moving to a more collective form

of leadership also referred to as shared leadership (Day, Gronn & Salas, 2006) which has been discussed as an approach that characterizes a collective leadership culture (West et al, 2015) because it *"identifies the concept of shared leadership by identifying the team as a key source of influence"* (Drath et al, 2008, p. 639).

Shared leadership theory was developed by Pearce and Conger (2003) as an explicit attempt to shift the perspective of leadership from that of an individual undertaking a specific role to that of leadership as a social process (Day, 2001; Fletcher, 2004; Hartley & Benington, 2011; Bolden, 2011) and networks of influence (Turnbull-James, 2011) which includes interpersonal relationships focused around a specific context (Edmondstone, 2011). It questions the who of leadership, as leadership functions can be undertaken at different levels across organisations, therefore allowing leadership to become bottom up as well as top down, and refocusing the how of leadership, through a collaborative and collective learning approach i.e. as shared practices that can occur at different levels (Fletcher, 2004).

Shared leadership is an interactive process of influence of individuals in groups where the common objective is achieving collective goals and it involves sharing power within a group of individuals. In addition, the processes involved frequently includes influence of peers or colleagues as well as influence of those at different levels of hierarchical organizations (Bligh, Pearce & Kohles, 2006; Pearce, Manz & Sims, 2009) thus creating "*group interaction and negotiation of a shared understanding that creates leadership influence"* (Drath et al, 2008, p. 639). Therefore, leadership is now seen as a function that can be shared with others within a team or organization as oppose to a role, dependent on who has the right skills to achieve the goal in any given situation (Jackson & Parry, 2011; Aime, Humphrey, DeRue & Paul, 2014; West et al, 2015). This it is suggested is perhaps a useful way to try and make sense of the perceived need for leaders at all levels of the organization.

More work on shared leadership has been published in the USA than in the UK. In the USA, shared leadership has been used widely in nursing and medicine (Bolden, 2011)

particularly in the hospital environment. It has been found that shared leadership increases nurses' influence upon decision-making and it strengthens relationships between professionals within the team (Fallis & Altimier, 2006). It has also been observed to enhance leadership behaviour of staff, autonomous working and improves patient care outcomes (Rosengren, Bondas, Nordholm & Nordstrom, 2010) and can predict team effectiveness in healthcare (Carson, Tesluk & Marrone, 2007; Aime et al, 2014; D'Innocenzo, Mathieu, & Kukenberger, 2014; Wang, Walderman & Zhang, 2014).

Self-managed teams (SMT's), using the principles of shared leadership, have been utilised in health visiting and primary and community care contexts. SMT's were popular from the mid 1990's until the introduction of Every Child Matters legislation (DfES, 2004). In 2004, health visiting teams were separated from community teams and formed into health and social care teams that did not use the SMT concept. This reorganisation brought with it many positional leaders (Currie, Finn & Martin, 2007a) as opposed to the flatter structure seen in SMT's where shared leadership was employed.

2.3.2 Distributed leadership

The work of Gibb in 1954, challenged the idea of the individual approach to leadership seen in the trait, style approaches. Instead Gibb proposed that leadership displayed a distributed pattern, with two forms of leadership; distributed and focused. Distributed leadership involves different individuals taking the lead at different times, with leadership shifting as different individuals emerge to be influential. By contrast, focused leadership was concentrated in one person (Gronn, 2002a; Harris & Spillane, 2008). Gronn (2002a) suggested that Gibbs' (1954) distributed and focused leadership represented points on a continuum. This allowed an understanding of leadership distinct from idea of leader-follower. Distributed leadership involves practices that are stretched over the organisation i.e. over the leader, follower and situation (Spillane, 2006).

After Gibbs, little further work was undertaken on distributed leadership until it resurfaced through the work of Brown and Hosking (1986). Since 2000 the momentum

behind distributed leadership has grown (Thorpe, Gold & Lawler, 2011) particularly in relation to education (Gronn, 2002a; Spillane, 2006; Harris & Spillane, 2008) and Higher Education (Zepke, 2007; Bolden, Petrov & Gosling, 2009). Throughout this rediscovery of distributed leadership its boundaries have not been clear and the concept has eluded definition, because it has been subject to a variety of different interpretations (Zepke, 2007; Harris & Spillane, 2008; Martin, Currie & Finn, 2008; Thorpe et al, 2011; Currie & Lockett 2011).

Bolden et al, (2009, p. 258) studied distributed leadership in Higher Education. They found that it was unclear in the delivery of "*distributed leadership, what is distributed i.e. power or accountability,"* and what the process for distribution entails. Harris (2008) and Bolden et al, (2009) have suggested that distributed leadership as a way of describing leadership practices is too wide. What needs more clarity and to be explicit is the underlying dynamics of power and how this effects the distribution of leadership and therefore, what this means in practice i.e. who does the distribution and who is in receipt of distribution. In the NHS and in education, leadership is shaped by the power and discretion available to the leader. These two variables are affected by health policies (NHS England, 2014). This is particularly the case for medical staff who have autonomy over service delivery and over self-regulating activities (Currie et al 2007a; Currie & Lockett, 2011) therefore, it raises the question can health visitors have autonomy over service delivery bearing in mind the introduction of a new service delivery model (DH, 2010c & 2011) and can they self-regulate leadership activities. An objective arose out of the literature review for the study to explore what leadership activities health visitors undertake and what autonomy they have to decide this.

In summary, there has been a shift in thinking about the most appropriate leadership approaches best suited for the NHS, guided by health policies and influenced by the breakdown in the quality of care at the Mid Staffordshire NHS Foundation Trust (Francis, 2010 & 2013) in conjunction with the developments outlined above in leadership theories. This culminated recently in the publication from NHS Improvement (2016) that sets the vision for a national framework for action that brings together leadership

approaches namely the need for systems leadership that is inclusive and compassionate and for the first time in health policy it directly aligns a leadership framework with quality improvement methods an area that has grown substantially in the NHS in the past five years (National Advisory Group on the Safety of Patients in England, 2013) and has been suggested for some time as something that needs to be included along with leadership to improve the quality of care (Ham, 2014).

I am interested in looking at exploring with health visitors how they use leadership approaches in their roles and what meaning they ascribe to the approaches and if they help them undertake leadership in practice. The distributed/shared approaches to leadership appear to have much to offer health visiting in terms of the notion of the request from health policies (DH, 2008 & 2010a) to have leadership at every level. Therefore, I have included a specific objective into the study on how followers make sense of leadership to gain an understanding of how leadership is constructed by health visitors i.e. do they understand leadership through the construct leader, follower and sharing a goal or in a different way.

2.4 Leadership in the NHS

An abundance of literature considers leadership in healthcare but much of this research is of variable quality (Hartley et al, 2008; Kim & Newby-Bennett, 2012; West et al, 2015). This might be because leadership is a term that is difficult to define and incorporates an abundance of different meanings and dimensions (Bryman, 1986; Hartley et al, 2008; Northouse, 2016). This may make it difficult to reach a definition that can be used across different areas i.e. nursing and business (Parry & Bryman, 2006; Cummings et al, 2010).

Leadership development within the NHS continues to be driven by heath policy because it is thought that effective leadership leads to better patient care (DH, 2008; Hartley et al, 2008). However, how effective leadership is best achieved is not clear.

As Bryman (1986) discussed, there has been a movement away from leadership and management on an individual level to a focus on leadership as the growth of a corporate culture within the total organization of the NHS (Ham, 2014; West et al, 2015). This change has provided the NHS with a new way of focusing on leadership (NHS Improvement, 2016). Whilst it is recognized that the vision of leaders can impact on the meaning that pervades the whole organization (Faugier & Woolnough, 2003), in this case the NHS, it is also recognised that a barrier to clinical leadership is organisational structures (Hewison & Griffiths, 2004; Davidson et al, 2006) and that the leadership style of the organisation can impact on the motivation of the individual (Moody & Pesut, 2006).

It has been recognised that leadership styles are influenced by the type of organisation and its core values (Davidson et al, 2006) and culture (West et al, 2015). The NHS remains a bureaucratic organisation and it is recognised that such organisations are the most inhibiting for leadership, exhibiting transactional leadership approaches (Brazier, 2005) that has been the norm for several years.

Historically, leadership styles in the NHS have tended to be hierarchical, as is common in any bureaucracy. Morgan (2006) helps us to understand why it is difficult for health visitors to effect change through leadership. If we consider the NHS as a machine operating as an efficient, reliable and predictable organization with a fixed routine, then the idea of health visitors as agents for change is incongruous to the status quo of the NHS as an organization. In addition, nurses have been viewed by many as direct care givers (Antrobus & Kitson, 1999). This ignores the potential for nurses to influence at a strategic level on health care issues and keeps the view that nurses act on an individual mechanistic level at front line care level only i.e. they cannot influence strategy.

This view of the NHS as a bureaucracy is supported in the study undertaken by Faugier and Woolnough (2003) which evaluated the NHS National Nursing Leadership Programme Leading Empowered Organisations (LEO). In this study, participants were asked to align their own organization with three descriptions, which were as follows; the

machine, the choir and the living organization. Of the participants 45.1% described their organizations as machines. This described leadership within the organization as driven by senior management with staff feeling like cogs in a wheel. These results would suggest that whilst programmes like LEO can enhance an individual's leadership skills, without structural changes or a re- focusing of the organization as a whole, leadership at every level for nurses would appear difficult to achieve.

The implicit enthusiasm within the NHS for leadership appears to be fuelled through its apparent practical implications for organisational practice. This has driven organisational management because of the need for increasing demands of efficiency and effectiveness. This was apparent in the Francis Report on the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) recommendation 2:

> '*the NHS must adopt and demonstrate a shared culture in which the patient is the priority in everything done, and that for this to be realised 'a common set of core values and standards throughout the system is needed along with 'Leadership at all levels' committed to and capable of involving all staff with those values and standards'.*

To achieve this a different understanding of leadership is required. This must focus on the purposes of leadership as opposed to the needs of the leader (Day, 2001; Gronn, 2002b; Hartley & Benington, 2011; Thorpe et al, 2011; Edmonstone, 2011). There must be a focus on teams not individuals (Harris & Spillane, 2008) and a focus on the cultural context of leadership rather than the leader (Ross, Rix & Gold, 2005).

As a result of the failures in Mid Staffordshire NHS Trust, there was great concern about the adequacy and nature of leadership in the NHS which prompted a review of the Leadership Framework (NHS Leadership Academy, 2011) and a recognition that there was a growing need for shared leadership approaches without clearly understanding what this meant in terms of leadership behaviours (Storey & Holti, 2013; NHS Leadership Academy, 2013) in addition the National Advisory Group on the Safety of Patients in

England (2013) highlighted the need for a culture change in health care organisations that included a focus on quality improvement and learning (West et al, 2015) this is clearly demonstrated in the most recent strategy for leadership in the NHS (NHS Improvement, 2016).

There is now recognition in health (The Kings Fund, 2011) that old organisational structures may not fit the requirements of the future. Distributed leadership necessitates flatter decision-making processes (Hargreaves & Fink, 2008) and this is why health policies since "New Labour" (DH, 2000 & 2008; Martin et al, 2008) have been working towards the introduction of structures within the NHS to facilitate the development of professional networks in healthcare. This has been coupled with a desire to devolve responsibilities to a local level, whilst simultaneously increasing local clinical leadership and decision making (DH, 2008 & 2010a).

The reason for this move away from a transactional approach to a more collective approach (Storey & Holti, 2013; West et al, 2014) is to enable all health care professionals to be leaders at every level (NHS Leadership Academy, 2011 & 2013) and therefore commit to high quality patient care across a complex matrix structure that is prevalent in the NHS (West et al, 2015; NHS Improvement, 2016). This is due to the recognition that complex organisations like the NHS need to be able to adapt quickly to changes that occur in the external environment (Reuvers, Engen, Vinkenburg & Wilson-Evered, 2008; Thorpe et al, 2011; Fitzsimons et al, 2011) and manage social and political forces (Stefl, 2008; Marinelli-Poole, McGilvray & Lynes, 2011) in order to work jointly with LAs and private companies (Roebuck, 2011) in a rapidly changing environment (Jackson, Clements, Averill & Zimbro, 2009). Moreover, they are heavily dependent on the policy set by national government (Hartley & Benington, 2011).

This notion of leadership being centred at a collective system level has grown in popularity in the NHS (NHS Leadership Academy, 2015) as a direct result of the need to foster cooperation across health and social care organisations as the two are so entwined in terms of delivering an effective overall health care system (West et al,

2015). The latest leadership strategy for the NHS is moving to a shared, more distributed approach to leadership (The Kings Fund, 2011; NHS Improvement, 2016). This is based on collective leadership (West et al, 2014) and incorporates the following "*capabilities: systems leadership skills, improvement skills, compassionate inclusive leadership skills and talent management"* (NHS Improvement, 2016, p. 2). This latest direction regarding leadership for the NHS clearly supports the move away from a transactional approach to leadership to a more collective/ shared one (NHS Leadership Academy, 2015) with a strong focus on the culture of leadership within organisations (West et al, 2015).

This is recognized in the review of the evidence on effective leadership in healthcare organizations (West et al, 2015). This document takes as the basis of the review the leadership task described by Drath et al, (2008, pgs. 635-636) as a focus on outcomes produced by leadership being identified as a combination of "*direction, alignment and commitment".* This perspective of leadership was offered by Drath et al (2008) as an alternative view of how leadership is produced at a collective level through focusing on explaining *how people "who share work in collectives produce direction, alignment and commitment"* to replace the historical ontology of leadership and in so doing the vocabulary of leadership from that "*of the tripod, leaders, followers, common goals".*

What Drath et al, (2008) advocate is a different ontology from which to view leadership and therefore, build knowledge that provides better understanding of leadership in peer and collaborative settings. By doing this they suggest that leadership is not dependent or restricted by the historical description of leadership. West et al (2015, p. 2) centre the review of leadership evidence on this definition by Drath and state clearly that the task of leadership is "*direction, alignment and commitment"*. This is a new concept in healthcare leadership and requires further discussion in terms of how this can be adopted and applied by healthcare professionals however; this critique is missing in the evaluation.

2.5 Leadership in nursing

Studies suggest (Loke, 2001; Wong & Cummings, 2009; Cummings et al, 2010) that good clinical leadership in health care organisations will improve nurses job satisfaction, productivity and therefore improve retention, and will in turn improve the effectiveness and efficiency of the organisation.

Pearson et al (2007, p. 208) undertook a systematic review around developing and sustaining nursing leadership to promote a healthy work environment in healthcare. They identified that a "*combination of leadership styles and characteristics contributed to the development and sustainability of a healthy work environment".* They provided a definition within the review of what constituted a healthy work environment and identified that "*transformational, transactional, instrumental, participatory*" (Pearson et al, p. 224) had all been found to be associated with good nurse, patient or organisational outcomes with transformational being identified as having the most positive outcomes for staff. It was clear however, from this review "*that there was no specific style or attribute that could definitely create a positive work environment*".

This is supported by Katrinli, Atabay, Gunay and Guneri, (2008, p. 354) who found in their study that "*if nurse supervisors increase their awareness of the effects of their behaviours towards the nurses they supervise they can increase the nurses' performance and achieve desired results through increasing job involvement through decision making and organizational identification".* The impact of nurse supervisor/nurse managers have also been recognized as things that increase job satisfaction in other studies (Walumbwa, Wang, Lawler, & Shi, 2004; Walumbwa, Avolio & Zhu 2008; Whittaker et al, 2013) and therefore, the work environment. Wong et al (2010, p. 889) found in their study on authentic leadership that nurse leaders can influence *work engagement* and perceived *quality of care* and therefore create healthy work environments by *facilitating positive relationships with their staff.*

Several business studies have recognised that at the core of leadership is relationships (Avolio & Gardner, 2005; Marchiondo, Myers, & Kopelman, 2015) this is also supported in the nursing leadership literature (Cummings et al, 2008; Cummings et al, 2010; Wong et al, 2013) and in social psychology (Hogg, 2001). It has been noted "*that the critical analysis of the theory and practice of leadership is poorly developed"* in nursing (Cook, 2001, p. 39). Northouse (2016, p. 3) states "*leadership is a process whereby an individual influences a group of individuals to achieve a common goal".* Leadership therefore, is explained as a transactional interactional event that occurs between leader and follower. Leadership is seen as a process of influence and not to be based upon a single person. As such leadership can be delivered by anyone within the group (Parry & Bryman, 2006; Hartley et al, 2008). The NHS Leadership Framework (NHS Leadership Academy, 2011 & 2013) adheres to the view that leadership is undertaken by all healthcare practitioners at all levels irrespective of being in a formal leadership role (Storey & Holti, 2013; NHS Leadership Academy, 2013; West et al, 2015).

In the professional nursing literature, much is written about what leadership means in nursing. Terms such as autonomy, decision making (Pearson et al, 2007; Paterson et al, 2010) visionary (Davidson et al, 2006; Hendricks et al, 2010) and building trust among colleagues are used frequently (Hendricks et al, 2010; Paterson et al, 2010). The terms emotional intelligence, empowerment and influencing (Pearson et al, 2007; Paterson et al, 2010) are used to describe the activities of a leader. Historically, the term leadership was given to a nurse as an assigned leadership or management role. More recently (DH, 2006 & 2010a) the term has taken on a more universal meaning to apply to all nurses at all levels (DH, 2008 & 2010a, NHS England, 2016). This study will explore if this is the case in health visiting and how leadership at every level in practice is understood.

Leadership is further explained by a range of studies that identify skills that leaders display e.g. problem solving (Hendricks et al, 2010) then further by a range of behaviours (Loke, 2001) personal qualities of leadership as defined by Bennis (2003) attributes as identified by Gardener (1990). A key to leadership has been described as providing

meaningfulness to all in an organisational relationship (Hendricks et al, 2010) along with negotiating the change process (Davidson et al, 2006).

The views expressed above make it clear why leadership is easy to understand but difficult to define. This may underlie why nurses find the concept of leadership at every level difficult to understand and even more difficult to deliver. If nurses/health visitors are expected to undertake all the possible forms of leadership described above it may become unclear what the parameters of leadership are and in some sense, this may devalue the concept of leadership such that it becomes seen as just another management fad (Hewison & Griffiths, 2004).

Many programmes that seek to deliver leadership to nurses and health visitors focus on the style approach to leadership. This provides a framework for pre- to post-registration nurse education. This approach has been supported by the launch of the NHS Leadership Academy framework (2011 & 2013) for NHS staff. This identifies the leadership behaviour to which all healthcare staff should aspire. However, it is widely accepted that focusing on individual behaviour is not sufficient to bring about the change required to improve patient/client care. In addition, leadership training has not on its own been found to bring about the changes in individual behaviour and organisational culture that are required to improve delivery of healthcare (West et al, 2015).

Papers exploring leadership and nursing have found transformational theory to be the favoured approach (Hyett, 2003; Degeling & Carr, 2004; Davidson et al, 2006; Paterson et al, 2010; Andrews, Richard, Robinson, Celano & Hallaron, 2012; Wong et al, 2013) and for nurses in the NHS (McIntosh & Tolson, 2008) because transformational theory has been found to link nursing leadership to positive patient outcomes in several studies (Pearson et al, 2007; Wong et al, 2013). The findings from Gilmartin and D'Aunnos', (2007) study indicate that transformational leadership results in increased staff satisfaction and better unit or team performance. This is supported in other studies that have identified similar findings in relation to the benefits of transformational leadership (Pearson et al, 2007; Wong & Cummings, 2007; Wong et al, 2013).

However, it is important to note that it is also the most researched theoretical approach to leadership in nursing and healthcare leadership research, which may be why it is seen as the most effective (Gilmartin & D'Aunno, 2007; Wong et al, 2013). In addition, it's important to note that these studies are also undertaken in the main in acute hospital settings not in the community where health visitors work (Haycock-Stuart et al, 2010).

Antrobus and Kitson's (1999) study linked leadership with seniority in the organisation. McIntosh and Tolson (2008) studied nurse consultants, a role that was introduced in the UK in 2000 as a response to health care policy (DH, 1999) to improve patient outcomes and strengthen leadership in nursing. These studies support the notion that senior nurses in positions of power can and do influence leadership and policy. However, what remains unclear is how the influence of all nurses at all levels drives this agenda. Nurses doing the right thing and influencing at all levels on a consistent basis is not shown to be always the case in the literature (Faugier & Woolnough 2003; Healthcare Commission, 2009; Francis, 2013).

2.6 Leadership in health visiting

The first national leadership training programme for health visitors and other senior nursing and Allied Health Professionals (AHP) was the NHS National Nursing Leadership programme. This programme, called Leading Empowered Organisations (LEO) was a three-day programme. Since its inception in 2004, 48,000 front line clinical nurses in senior positions (including health visitors) and 8,000 AHPs have attended this course. It is now no longer running.

LEO was evaluated by Faugier and Woolnough (2003) who asked a random sample of 12,000 participants to describe what they understood by "leadership". More than 17% described it as leadership of a supportive team, 16% cited empowerment of that team as essential to good leadership and 14.6% described leadership as a role model. Other terms used to define leadership were: responsibility, direction, communication, vision,

guidance, motivation and management. It was found that little preparatory training or development had been undertaken prior to taking on leadership roles. Less than half of those undertaking the LEO programme had coaching, mentorship or personal development plans. Similar findings were evident in a later evaluation of a Health Visiting and School Nurse Leadership programme (Wallbank, 2010).

Leadership development in health visiting has been complicated because health visitors are a heterogeneous group who deliver a service that may be fragmented depending on what local commissioners' purchase. Thus, not all health visitors will undertake the same activities in the same manner.

A study by Grove, Meredith, MacIntyre, Angelis and Neailey (2010, p. 204) focused on "*lean implementation of a health visiting service within a large Trust"*. They found that one of the barriers to implementing this lean management technique was that teams work as self-managing autonomous groups which lack leadership and clear communication. This study identified leadership for health visitors to be team-focused within these groups.

The lack of leadership research in health visiting makes this a timely study to explore how health visitors understand leadership and how they demonstrate leadership and therefore, I have focused the research question and some objectives to ascertain if and how health visitors in the context of the new "family offer" service delivery model understand leadership and what supports this knowledge development.

2.7 Leaders and leadership development

It is suggested that newly qualified nurses are not adequately prepared to undertake leadership and they do not have sufficient leadership capabilities (Heller et al, 2004; Cook & Leathard, 2004; Taylor et al, 2010, Hendricks et al, 2010) and that leadership taught within undergraduate nursing programmes is focused mainly on the transition

from student to nurse in the final year of the programme (Curtis, de Vries & Sheerin, 2011a).

The Mid Staffordshire review highlighted that leadership was weak and nurses had not received appropriate training and development (Health Care Commission, 2009). To protect patients, nurses must be able to act as leaders at all levels of highly complex healthcare organisations (Heller et al, 2004; DH, 2006; Paterson et al, 2010). Therefore, it is essential that nurses enter the workplace following training with strong leadership capabilities (Hendricks et al, 2010). What is unclear is how the training of nurses in leadership at a pre- and post-registration level should adapt to meet the requirements of a changing healthcare policy.

A systematic review by Cummings et al (2008, p. 240) suggested that leadership can "*be developed through specific educational activities, modelling and practising leadership competencies".* A further study by Cummings et al (2010, p. 363) identified that the development of "*transformational and relational leadership are needed to enhance nurse satisfaction, recruitment, retention and healthy work environments"*. These findings are similar to other studies that have found transformational leadership effective in improving nurse's leadership competencies (Martin, McCormack, Fitzsimons & Spirig, 2012). It is suggested therefore, that relationship skills should be included in leadership development programmes for nurses (Curtis, Sheerin, & de Vries, 2011b).

Initiatives have been devised to improve health visitors' leadership abilities (DH, 2011). PHE/DH invested in 154 Institute of Health Visiting (iHV) Fellows. This was an initiative that focused on building leadership knowledge and skills in experienced health visitors in order to build local leadership. The health visitors granted fellowship were selected by applying to a panel based on a set criterion, which they had to demonstrate that they met related to leadership skills. Although anecdotal success has been recognized from this initiative the scheme has not been formally evaluated.

Greening and Haydock, (2014, p. 36) developed and delivered a leadership programme in the North West of England as part of the HVIP (DH, 2011). This programme was delivered to health visitors to improve their knowledge and skills and to enable them to deliver and lead on the HCP. Ninety-six participants on the programme were asked to assess themselves against themes drawn from the NHS Leadership Academy Framework (2011). Those themes identified by the study group at the beginning of the programme as being most relevant to their work were: *demonstrating personal qualities, working with others, managing services and improving services*. The themes identified by the study group at the beginning of the programme as least related to their work were; *setting directions, creating the vision and delivering the strategy*. No further evaluation has been undertaken on participants attending this programme.

An array of leadership development and competency frameworks have been developed for NHS staff to improve leadership within the NHS as external changes continue to unfold e.g. resource constraints, changing patient expectations, which means that appropriate leadership is needed to meet these requirements (Storey & Holti, 2013; West et al, 2015). This became even more important as a result of the Francis reports (2010 & 2013) suggesting that NHS staff require stronger leadership. Competency frameworks and assessments e.g. Healthcare Leadership Model (NHS Leadership Academy, 2013) have been used to self-assess individual leadership competencies and to support the mapping of such competencies to team and organisational development and success (Gentry & Leslie, 2007; West et al, 2015).

There is however, "*little evidence that use of these frameworks translates into improved effectiveness of leaders".* There is consequently no evidence to determine which framework is most appropriate or effective (West et al, 2015, p. 19). In addition, several studies suggest that nursing leaders are less prepared for leadership roles (Heller et al, 2004; Curtis et al, 2011a; Curtis et al, 2011b) and therefore, require higher levels of support.

The scanty evidence suggests that important factors moderate interventions to develop leadership that affects the healthcare team and organisational performance. These factors include; "*the design of programmes, knowledge and skills of facilitators, motivation of trainees, support in the workplace and processes to facilitate the transfer of training"* (Yukle, 2013; West et al, 2015, p. 20). It is suggested a balance is required between development of the leader and organisational development (Edmondstone, 2011). Research suggests that experience in leadership is the most important factor in enabling leaders to develop their skills. This is particularly the case when they have guidance and support (Day, 2001; Day & Harrison, 2007; Cummings et al, 2008).

In summary evidence to support the best way to educate health visitors in leadership is limited in a changing health care environment, this provides a gap in the literature that this study can contribute to in terms of development of knowledge that can be applied in practice.

2.9 Chapter summary

Strengthening leadership has been the focus of health policy for several years in health visiting (DH, 1999, 2000, 2006, 2007, 2010a & 2011, NHS England, 2016). Despite this, leadership in health visiting is still not considered to be adequate. Whilst the NMC (2004) expect all health visitors to undertake leadership as part of their training and apply it into practice they have not devised a theoretical framework to support leadership for health visitors.

There is a paucity of research that looks at how health visitors understand leadership in their role and how they engage with the policy direction set down to lead the HCP (DH/DfCSF, 2009a, b, DH, 2011, PHE, 2016a). The literature identifies transformational leadership to be the most effective approach in nursing (Cummings et al, 2010; Wong et al, 2013) and the importance of relationships in producing effective leadership in nursing has been reported in the literature (Cummings et al, 2010; Australian College of Nursing, 2015). Therefore, the need to explore whether leadership is relational in health visiting

seems pertinent along with how this fits with a more collective approach to leadership as a way to manage the complexity of health and social care. As leadership has been defined as a way of establishing meaning (Jackson & Parry, 2008) this seems really pertinent to explore how health visitors understand leadership.

Currently, there is no structured theoretical underpinning to the training or education delivered on leadership for health visitors that recognizes how they understand leadership and apply it in their role. It is clear from the literature that this gap requires attention because many models of leadership are not evidenced based (West et al, 2015). Furthermore, what staff development is required for leadership is poorly researched (Hartley et al, 2008).

Only from understanding the concept of leadership in health visiting will it become apparent what education is required for health visitors. Therefore, the study will explore, using a constructivist grounded theory approach, what meaning health visitors ascribe to leadership, and hence the research question is *how do health visitors understand "leadership" within the NHS?* Objectives and questions for the study have been identified based on the literature review and by the use of sensitising concepts and my prior knowledge about health visiting practice.

Chapter Three

3. Methodology

3.1 Introduction

This chapter explains the research process used to explore leadership in health visiting and discusses why the research design used is the most appropriate for the study. An understanding and discussion of my own ontological and epistemological perspective is included. In addition, the study is explained and a rationale provided for the use of the theoretical perspective of interpretivism including its links to the methodology of grounded theory, this is discussed using Crotty's Knowledge Framework (1998).

The development of grounded theory is discussed including, the different schools of thought, that of the traditional model of Glaser and Strauss (1967) and the constructivist approach led by Charmaz (2014) and a justification given of why this methodology is suitable for this study. A rationale is provided as to which research methods have been chosen and how this fits with the research design. The evaluation and reflexive criteria used for the study are identified and discussed along with ethical considerations.

Chapter 4 contains information about the participants of the study and identifies the process for selection and recruitment, along with an overview of the interview process and the data analysis procedures.

The study aims to find answers to the problem identified by myself through professional experience and practice and those identified in the literature i.e. a gap in knowledge about how health visitors understand leadership in professional practice.

3.2 The research process

3.2.1 Ontology

It was necessary to structure my study to find answers to the research question and objectives and ultimately to construct a conceptual framework that would explain the phenomenon from the perspective and context of the participants who experience it, and thus provide a framework that can be applied to health visiting practice (Giles et al, 2016a). When considering the research design, I needed to consider what was required in order to make knowledge claims about the findings of the study that are credible to others: in this case health visitors. Different research questions require the use of different methods, which in turn depends upon the study aims, and the purpose of the research (Blaikie, 2007; Wertz et al, 2011).

Several philosophical perspectives exist in relation to how we search for knowledge. These approaches have a distinct ontology and epistemology. Ontology is the study of the nature of existence. It is what you as an individual believe reality to be, and how you perceive that reality to be constructed (McAuley, Duberley & Johnson, 2007; Bryman, 2008).

It has been suggested that researchers should restrict questions to those that can be aligned with their own paradigms and ways of knowing (Weaver & Olson, 2006). If this is the case then it was important to consider this point when planning the study i.e. what is my position in the research and my beliefs about what constitutes reality and how I understand the world i.e. my own ontological position (Blaikie, 2007) and the assumptions I make about existence (Wertz et al, 2011). In addition, I needed to consider what is my way of knowing in terms of knowledge produced and what is it that I want to find out and how will that knowledge be used in professional practice, which is of course the key reason for undertaking a DBA.

This began as I formulated the research question, as although aligning the question to my worldview made sense, what was imperative was choosing the right way of approaching the question and research design to develop usable findings and a conceptual framework that is credible and addresses the problem (Simmons, 1995).

For this study, I am interested in gaining meaning and understanding to explain the phenomenon of the lived experience of health visitors (Wertz et al, 2011). I want to explore through the research participants not just their subjective worlds but also their inter-subjective worlds i.e. how they create meaning themselves and together and what their experiences of doing this are in relation to leadership. Therefore, in this context knowledge cannot be separated from the known and the knower (Alvesson & Skoldberg, 2009). How health visitors make sense of leadership will be through how they interact with leadership and how they interact with others within the context that leadership is experienced. Therefore, I am interested in the emic view i.e. how the participants of the study describe their understanding from their point of view and their experience (Eriksson & Kovalainen, 2013).

As a health visitor, myself I bring a professional insight into the research, which I will be critically reflexive about. I see my position as being part of the research. I shall actively interpret and develop meaning from those I study (Locke, 2003; Charmaz, 2014). In the same way, the participants in the study will be active in the research because leadership is central to the role of the health visitor (Alleyne & Jumaa, 2007; DH, 2011). Therefore, I needed to use a methodology that would allow me to take this position, as several do not. In this study, I chose to use a constructivist grounded theory approach (the rationale for which is discussed in section 3.2.6).

In a study using grounded theory the research question should identify the phenomenon to be studied and therefore start to frame the study (Emmel, 2013). The research question that captures the phenomenon under study is:" How *do health visitors understand leadership?"* I explored this further by developing objectives. The research question and objectives were determined in part by the literature review, which showed

a gap in the literature in terms of how health visitors understand leadership from the health visitors' perspective. The literature review clearly highlighted the impact of government policies on the health visitor leadership role; hence the following questions formed part of the interview schedule.

The main focus of the questions are based on 'what' and 'how' questions. For example: '*What does the term leadership mean to health visitors?*' *'How do top-down policies, different professional discourses, and cross-boundary working affect leadership in health visiting?*' '*What does leadership at every level in health visiting mean?'* When answering 'What' and 'How' questions, it is suggested that interpretive research methods are the most useful as 'what' questions entail looking at the whole (Silverman, 2011; Charmaz, 2012).

3.2.2 Epistemology

Epistemology describes "*how we know what we know about the nature"* of the world and how this leads to the construction of knowledge and the use of specific methods. It enables us to construct our own reality by understanding how we justify claims that are made about the world (Crotty, 1998, p. 8; McAuley et al, 2007).

There exist different epistemologies; objectivism and constructionism, both represent a different world viewpoint with clear distinctions between them (Crotty, 1998). "*Constructionism views social reality as a human creation from a structure of ideas".* The source of ideas is a product of the different individual conscious minds that together produces meaning that human beings give to activities that they undertake in their lives. Meaning is not discovered from these ideas alone but instead is constructed by the shared subjective meanings given to it by the interaction between "*human beings in their everyday lives"* (Crotty, 1998; Blaikie, 2007, p. 23). Crotty (1998, pgs. 8- 9) states that: "*there is no meaning without a mind*" because meaning does not reside in things. Instead *the "observer plays an active role"* in creating meaning through engagement, therefore constructing not discovering the meaning (Blaikie, 2007, p. 19).

From this epistemological viewpoint, it is possible "*that different people will construct meaning in different ways even in relation to the same phenomenon"* (Crotty, 1998, p. 9). Subject, in this case the researcher, and object the participants in the study emerge "*as partners in the generation of meaning* "(Blaikie, 2007, p. 18; Wertz et al, 2011). This provides opportunities to view a situation from numerous perspectives (Charmaz, 2012). Social reality is assumed to be produced by social actors through social interaction. As they conduct their everyday lives, "*truth or meaning comes into existence in and out of our engagement with the realities in our world".* There is therefore *no objective truth waiting to be discovered*, instead there exists the possibility of *a "plurality of truths associated with different constructions of reality"* resulting in the creation of relative knowledge (Crotty, 1998, p. 8; Blaikie, 2007).

Relative knowledge is the result of how people make sense of things. They can change their views and understanding of social reality through interaction (Crotty, 1998; Blaikie, 2007; Charmaz, 2014). Reality is always about an individual's or a group's interpretation (Erikson & Kovalainen, 2013). "*Different cultures or communities are likely to have different constructions of reality",* rather than these ideas being there from birth as they are learned through social interaction (Blaikie, 2007, p. 23).

The epistemologies differ in "*how we know what we know"* (Crotty, 1998, p. 8). From a constructivist viewpoint, knowledge is constructed through social interaction that takes into account-shared meanings around activities e.g. historical, cultural ways of knowing. Therefore, as all research takes into account the views of the researcher, and by doing this everything that is observed by the researcher is theory-laden, you cannot construct knowledge that is separate from the researcher. There are no permanent, unvarying criteria to establish whether knowledge can be regarded as true. There are thus no absolute truths (Blaikie, 2007; Charmaz, 2014). With the rejection of a neutral, observational language there is a move to a more subjective stance which views the participants' world as unknowable and instead, what the researcher does is construct a

view of the world from the viewpoint of each individual participant (Gill & Johnson, 2010).

When looking at the different epistemological stances, constructionism aligns best to my research question. The focus of this research is to develop a conceptual framework to explain how health visitors understand leadership. It is thus imperative to choose a research design that will allow this and places the researcher within the research and not external to it. The focus of the research will be to attempt to understand, "*or interpret, phenomena in terms of the meanings that people bring to them"* from their world of lived experience (Denzin &Lincoln, 2005, p.3; Alevesson & Skoldberg, 2009; Andrews, 2012). Constructionism focuses on "*understanding the actions and meanings"* that people develop together therefore this is based on "*ontology of what exists".* What exists then depends on individual perceptions. The epistemology of constructionism is understood by the "*subjective knowledge created by individuals"*. Therefore, the methodology needs to be able to explore the subjective knowledge of these individuals (Wainwright, 1997, p. 1264; Crotty, 1998).

Thus, the methodology recognises the mutual creation of knowledge between the participant and the researcher. It aims toward interpretative understanding of participants' meanings (Emmel, 2013). In this way, constructivist grounded theory methodology allows the researcher to experience the participants' world. The co-construction of meaning, between the researcher and the participants of the phenomenon, is perfectly reconciled with the underpinning beliefs of constructionism (Charmaz, 2014). Therefore, this stance is appropriate for this study.

3.2.3 Theoretical perspective

There is no straightforward way of defining research strategy. Moreover, research strategy may also be referred to as research design and considered as part of the research process. These three terms, often used interchangeably, are not always easy to follow or consistently applied in the literature (Crotty, 1998; Blaikie, 2007). Blaikie

(2007) suggests the research strategy provides a good starting place with several stages to go through in order to answer the research question and ultimately generate new knowledge. Silverman (2011) warns of the dangers of tightly constrained boxes in research design and he suggests that others might interpret these terms differently.

Crotty (1998, p. 4) developed a Knowledge Framework to attempt to identify the components of the research process. This includes four strands: "*epistemology, theoretical perspective, methodology and methods",* which all relate to each other to make the status of the findings clear. The interlinking relationships between the four strands are not always clearly set out, but Crotty's description of the strands clarified the different ontological and epistemological views behind them.

These four strands relate to each other and inform one another. They are used from top to bottom and vice versa i.e. firstly deciding on the epistemology, then the theoretical perspective, then the methodology and finally the methods. However, Crotty also looks at them from the bottom up i.e. methods up to epistemology. What seems to be important is not top down or bottom up, but that there is a coherence to the way the four elements are put together and therefore useful for the job in hand: of collecting and evaluating data and arriving at credible conclusions.

Each strand of the research strategy is considered sequentially, individually and as a whole. Whilst I decided how to answer the chosen research question and what methods to use to do this, I looked initially at what methodology and methods answer the questions. Next, I considered how the use of such a methodology can be justified. This then leads to questions about the assumptions of reality and how this relates to the theoretical perspective adhered to when conducting research. Thus, a consideration of epistemology (i.e. how we understand how knowledge is constructed) is essential (Crotty, 1998).

Applying Crotty's (1998) Knowledge Framework helped me develop the research design for the study. Using this framework, the epistemology is that of constructionism; the

theoretical perspective is interpretivism; the methodology is constructivist grounded theory and the methods chosen for the research are in depth semi-structured interviews and focus groups (Crotty, 1998; Blaikie, 2007; Charmaz, 2014).

Therefore, and applying Crotty's framework (1998), the research question will be examined using an objectivist ontology combined with a subjectivist epistemology. This has directed my theoretical perspective to be interpretive. It will influence how I design the research study, because, different ways of viewing the world result in different ways of undertaking research (Crotty, 1998).

A theoretical perspective encompasses "*our view of the human world and social life within that world wherein such assumptions are grounded. It provides a way of looking at the world and making sense of it. It involves knowledge, therefore and embodies a certain understanding of what is entailed in knowing, i.e. epistemology"* (Crotty, 1998, pgs. 7-8).

The reality I was interested in was the experiences of my participants and the social processes displayed through these experiences, therefore, a theoretical perspective that recognised this reality was required: that of interpretivism.

The interpretive approach is a theoretical alternative to the positivist tradition. It is based upon a rejection of the positivist understanding of the stimulus-response model of human behaviour and action.

Interpretive paradigms are interested in understanding the world from the point of view of the individuals who live in it (Locke, 2003; Andrews, 2012) They explore, in an uncritical way, the cultural meaning of social actors and then make interpretations to develop understanding (Weaver & Olsen, 2006). Therefore, in interpretive theory, there may be emergent, multiple realities in line with the subjectivist reality.

Social reality is developed through shared experiences, communication and interaction. It is seen as the product of social processes; that are derived by negotiating cultural meanings from actions and situations (Crotty, 1998; Bowling, 1999; Locke, 2003; Charmaz, 2014). Charmaz (1990, p. 1165) professes that "*a social constructionist perspective assumes an active, not neutral, observer whose decisions shape both process and product throughout the research strategy."*

This research looks at how health visitors view leadership, and, how they understand it by interacting with other health visitors and other healthcare professionals in the context within which they work. To answer these questions, it is necessary to enter the world of the health visitor and see leadership as they see it. Parry et al, (2014) recognise that an interpretive perspective is essential for leadership research particularly when reviewing leadership as a social process.

Very little research has been undertaken on leadership in health visiting. Therefore, an interpretive perspective using a constructivist grounded theory methodology in order to construct a conceptual framework is appropriate. Using an interpretive paradigm appears to offer most benefit to the aims and purpose of the study as the goal of interpretive research is to understand (Weaver & Olsen, 2006).

Throughout the study the Alvesson and Skoldberg (2009) model of reflexivity was used (discussed in section 3.5) as this model allowed me to question the study design and reflect on the decisions made throughout the research process. Throughout the study I constantly asked, 'What value did the research design add to the study?" and "How did the research design direct the study?" I wished to avoid focusing on labels, but that was necessary at the start to make sense of the variety of different interpretive approaches available.

3.2.4 Methodology

Grounded theory has been used previously for research into organisations, leadership, nursing/health visiting and healthcare (Parry, 1998; Lansisalmi et al, 2006; Dellve & Wikstrom, 2009; Higginbottom & Lauridsen, 2014; Charmaz, 2014; McCrae & Purssell, 2016; Giles, de Lacey & Muir- Cochrane 2016b).

Although research in leadership has typically been undertaken from a positivistic stance there is recognition that grounded theory is a useful methodology from which to study leadership (Parry, 1998). Grounded theory seeks to illuminate social meaning where none exists. This is an essential requirement when exploring such a complex, much-debated phenomenon as leadership (Parry et al, 2014).

The use of grounded theory will give a perspective of health visitors' work from the health visitors' own voice (Locke, 2003) and will identify "*the nature of their relationships with each other and their environment"* (Stanley, 2006a, p. 23). The use of grounded theory will allow exploration of the participants concerns about the phenomenon i.e. leadership (Engward & Davis, 2015). Furthermore, the methodology allows for identification of contextual characteristics of culture within organisations (Lansisalmi et al, 2006) and it will be able to capture the complexities of the context within which the action and processes occur (Locke, 2003; Kan & Parry, 2004).

The methodology can also explain behaviour and facilitate the advancement of conceptual theories that might be applied in practical situations (Locke, 2003; Giles et al, 2016a). The identification of the fundamental social process is a key aim of grounded theory (Parry, 1998; Wertz et al, 2011; Charmaz, 2014). Several social processes will be identified through the data analysis and development of the categories that give rise to activity throughout the grounded theory study. The analysis of the data will integrate the processes into a core category and will finally result in one social process which will explain all the other categories (processes) and therefore becomes the conceptual framework (Parry, 1998).

The area under study here is one that there is little prior information about (Rowland & Parry, 2009). There are no known theories, specific to leadership and health visiting, available to test. Thus, using an inductive approach to construct a conceptual framework appears the most apt way of generating new knowledge (Blaikie 2007; Gill & Johnson, 2010).

Grounded theory has been used as a methodology by several different theoretical perspectives, for example positivism, interpretivism and pragmatism and reflects different perspectives on reality (Age, 2011; Higginbottom & Lauridsen, 2014). Obviously, this use has depended upon the question being asked and the process being explored. It is recognised that grounded theory is not exclusive to any specific epistemological or theoretical framework (Mills, Bonner & Francis, 2006a; Higginbottom & Lauridsen, 2014; Engward & Davis, 2015). The major divide in those who use grounded theory lies between those who treat what they see or hear and record as objective and, those who treat the actions of research participants and the recordings and reports of researchers as constructed. The latter position treats the research process itself as an object of scrutiny (Bryant & Charmaz, 2010).

The origins of the methodology of grounded theory are embedded in positivism, from the perspective of Glaser and from Strauss's American pragmatism (Strauss & Corbin, 1990; Locke, 2003; Charmaz, 2014). However, grounded theory has evolved and been adapted (Locke, 2003) and several scholars have shifted grounded theory from the "*positivism in Glaser and Strauss and Corbin's"* versions of the method to the constructivist epistemology (Charmaz, 2006; Higginbottom & Lauridsen; 2014, p. 10).

Grounded theory methodologists who present one version of the method share much in common with proponents of grounded theory who present another version. "*All grounded theorists begin with inductive logic, subject the data to rigorous comparative analysis, aim to develop theoretical analyses and value grounded theory studies for*

informing policy and practice. *All variants of grounded theory offer strategies for collecting managing and analysing qualitative data* "(Charmaz, 2014, pgs. 14-15).

3.2.5 Grounded theory

Grounded theory was developed by the sociologists Glaser and Strauss (1967) based on Mead's symbolic interactionism. When undertaking research, they observed that many investigators focused on testing pre-existing hypotheses rather than generating new theories (Strauss & Corbin, 1990; Lansisalmi et al, 2006; Charmaz, 2014). Interpretative research was thus mainly descriptive.

Glaser and Strauss postulated that it was possible to produce a theory from the systematic analysis of data by an inductive process. They suggested that such an approach would be able to explain and predict the findings and process being studied (Strauss & Corbin, 1990; Lansisalmi et al, 2006; Blaikie, 2007; Bryman, 2008; Alvesson & Skoldberg, 2009; Dellve & Wikstrom, 2009; Gill & Johnson, 2010; Charmaz, 2014). They suggested, based on observation of the data (Crotty, 1998), that theories do not have to be causal explanations (Bowling, 1999) instead Charmaz, (1990, p. 1164) states "*a theory explains a phenomenon, specifies concepts, which categorise the relevant phenomena, explains relationships between concepts and provides a framework for making predictions".*

A grounded theory approach provides systematic, yet flexible guidelines (Charmaz, 2014) that guide data collection and analysis (Morberg, Lagerstrom & Dellve, 2009) and follows a logical procedure (Dellve & Wilkstrom, 2009). Collection and analysis of data occur simultaneously (Morberg et al, 2009) with the objective of generating theory, which is grounded in, and from the data collected (Glaser & Strauss, 1967; Strauss & Corbin 1990; Crotty, 1998; Dreachslin, Hunt & Sprainer, 2000; Kan & Parry, 2004; Lansisalmi et al, 2006; Currie, Tolson & Booth, 2007b; Dellve & Wikstrom, 2009; Bondas, 2009).

Grounded theory is different from other qualitative approaches in that it uses the emergent theoretical categories to shape the data collection. It thus allows issues raised in the data to develop conceptual ideas (Charmaz, 1990). By doing this the researcher is using theoretical sampling to develop the theoretical categories (concepts) and this is what "*moves the research from anecdotal description to an explanation of what is occurring"* (Engward & Davis, 2015, p. 1533).

A grounded theory approach will facilitate understanding of how health visitors make sense of leadership, the "*nature of their relationships with each other and their environment"* (Stanley, 2006b, p. 110) and the interactional emergent processes between them (Currie, 2008). Using the constant comparative approach (Currie et al, 2007b; Bryman, 2008), discussed further in Chapter 4, to direct the simultaneous collection and construct analysis of the data allows the development of theory at each stage of data collection and analysis (Strauss & Corbin, 1990; Charmaz, 2014). This has the potential to deliver a conceptual framework that addresses the research question, *how do health visitors understand leadership within the NHS?*

Much has been written about the different ways of using grounded theory dependent on the theoretical perspective taken since its initial conception by Glaser and Strauss (1967). Indeed, Bryant and Charmaz (2010, p. 4) have described grounded theory *as a* "*contested concept"*. There have been clear differences of opinion between Glaser (2012) and Charmaz (2006 & 2014) regarding what constitutes grounded theory with Glaser (2012) disputing that constructivist grounded theory is actually grounded theory instead referring to it as Qualitative Data Analysis. Higginbottom and Lauridsen (2014, p. 13) however, suggest that "*the differences are not so much in the methods but rather in their overarching goals and their perspectives of the nature of reality".* This view is supported in the literature (Hallberg, 2006; Mills, Chapman, Bonner & Francis 2007).

Grounded theory methodology has developed since the initial work of Glaser and Strauss, (1967) the *Discovery of Grounded Theory,* taking into account the different thoughts about reality that have shaped the development of qualitative research (Mills

et al, 2006a; Hallberg, 2006). Thus, grounded theory has been modified and three approaches are now recognised: Glaser (positivist), Strauss and Corbin (post-positivist) and Charmaz (constructivist) (Wertz et al, 2011; Yarwood-Ross & Jack, 2015). These reflect the epistemological stance taken by the different approaches and by different researchers (Mills et al, 2007; Age, 2011; Higginbottom & Lauridsen, 2014).

The constructivist approach to grounded theory, sits within the interpretive perspective and has been situated between positivism and postmodernism (Hallberg, 2006; Mills et al, 2007; Charmaz, 2011). This has resulted in a constructivist grounded theory approach that has been described as "*adopting 21st century epistemological assumptions and methodological advances"* (Charmaz, 2011, p. 168). That recognises grounded theory strategies as "*flexible tools"* rather than "*rigid rules"* that provide guidelines for the researcher (Hallberg, 2006; Charmaz, 2014). The crux of the differences between the approaches, apart from the epistemological ones, lies around how the data is able to emerge (Glaser, 2012) as oppose to the view that it is forced (Strauss & Corbin, 1990; Age, 2011).

The most frequent variation, within the various manifestations of grounded theory, is in the approach to coding. Glaser, Strauss and Corbin and Charmaz all agree that analysis should be undertaken by constant comparison. What differs is the amount of structure applied to coding (Heath & Cowley 2004; Charmaz, 2014). In Strauss and Corbin's approach to coding they included a stage called 'axial coding' this element was seen by Glaser as too 'forceful' as it pushed the data into 'preconceived categories' therefore not allowing the data to emerge (Heath & Cowley, 2004; Charmaz, 2006, Hallberg, 2006).

Whilst recognising the strengths of the grounded theory method, several weaknesses have been identified. These include; *"premature commitment to analytic categories, unnecessary jargon and lack of clarity about key terms e.g. theory, category and saturation"* (Charmaz, 1990, p. 1164). Other criticisms include the lack of use of the literature i.e. when and how to use it (Suddaby, 2006; Yarwood –Ross & Jack, 2015).

Another weakness may be misuse of the method by not understanding its epistemological assumptions (Mills et al, 2006a). Charmaz has been criticised for not making it clear regarding her assertion that constructivist grounded theory is positioned between positivism and postmodernism (Mills et al, 2007).

3.2.6 Constructivist grounded theory

This study used the approach to grounded theory developed by Charmaz and Bryant *in the mid-1990s* (Hallberg, 2006; Charmaz, 2011; Higginbottom & Lauridsen, 2014, p. 8; Charmaz, 2014). This is termed constructivist grounded theory. I believe it offers the best approach to the research question (Gardner & McCutcheon, 2015) because it gives me an insider's view of what health visitors understand by the phenomenon leadership and allows me to hear their voices, something that is key in constructivist grounded theory (Charmaz, 2014). It also allows inference of meaning from this to understand what leadership education for health visitors should incorporate.

Both Bryant and Charmaz (2010) have developed grounded theory through a constructivist lens and have thus repositioned the methodology of grounded theory (Emmel, 2013). At the heart of constructivist theory is that social reality is made up of multiple realities rather than there being just one reality. Processes and concepts are constructed by the researcher and the participant and not discovered as suggested by Glaser (Hallberg, 2006; Bryman, 2008; Charmaz, 2011). In viewing the research as constructed not discovered entails the researcher using reflexivity to think about decisions made and actions taken by the researcher throughout the process that affects the theory development (Mills et al, 2007; Charmaz, 2014).

Charmaz disagrees with Glaser's positivist view of grounded theory i.e. that there is one "true" external reality waiting to be discovered that can be generalisable (Charmaz, 2006; Mills et al, 2007). Instead Charmaz (2011) suggests that the researcher and the participant construct interpretations of multiple realities. Thus, the investigator is not an objective, passive, neutral "*observer with little influence on the data and analytic*

processes", as this does not acknowledge the "*participation and standpoints of the researcher in shaping the data"* (Charmaz, 2006 & 2011, p. 168).

Using a constructivist grounded theory methodology allows findings "*to be suggestive rather than conclusive. What emerges are plausible, perhaps even convincing, ways of seeing things. What does not emerge is any one, true way of seeing things"* (Crotty, 1998, p. 13). This is entirely as expected when the research design is from the stance of a constructivist epistemology. The assumptions being that grounded theory allows the researcher to develop the conceptual framework and answer the research questions by observing, interpreting and reporting every aspect throughout the research process. This allows use of the assumptions inherent in an inductive grounded theory approach (Crotty, 1998). Therefore, it does not produce abstract generalisations separate from the specific conditions of their production (Charmaz, 2011).

Constructivist grounded theory takes into account the context of the research and the researcher's position, perspectives, priorities and interactions (Bryant & Charmaz, 2010). It also considers how these "*standpoints, starting points and shifting positions"* impact on the interpretations made by the researcher (Charmaz, 2012, p. 4) and therefore, the importance of reflexivity (Mills et al, 2006a). The data is considered as being constructed, it is not neutral, but reflects the positions and conditions in which it is constructed by the researcher and the participant (Hallberg, 2006; Charmaz, 2011). Charmaz (2014, p. 241) states researchers "*locate participant's meaning and actions in larger social structures and discourses of which they may be unaware."* This is done in order to understand how participants construct their reality in a specific context (Higginbottom & Lauridsen, 2014). Her emphasis is on flexible guidelines rather than methodological rules, recipes and requirements and she resists mechanical application of the method (Charmaz, 2014).

3.2.7 Flexibility in Grounded Theory

Grounded Theory is an inductive methodology that develops a theory grounded in the data. Flexibility in the process is always required irrespective of which grounded theory approach you use. This idea of flexibility is provided through the following components: theoretical sampling, comparative analysis and use of memos (Charmaz, 2014). It has always been suggested that these specific components of the grounded theory methodology should be applied in a flexible manner dependent on the research being undertaken (Strauss & Glaser, 1967; Gardner, Fedoruk & McCutcheon, 2012). This allows the researcher to follow leads that arise from the data collection and to follow up new insights whilst simultaneously analysing the data through constant comparison. This is a fluid process dictated by what emerges from the data, so a set of rules cannot be applied, and a rigid structure is not appropriate. Instead flexible guidelines provide the outline for the researcher to follow whilst still being able to react to what emerges from the data (Charmaz, 2008) and the requirements of the study. These requirements may relate to the research question being asked, in terms of what you want to find out and how you will use the findings from the study (Birks & Mills, 2015).

Constructivist grounded theory is viewed as the most flexible application of grounded theory (Kenny & Fouire, 2015) because the methodology is underpinned by an interpretive approach (Breckenridge, Jones, Elliott & Nicol, 2012). This means that the researcher is part of the research and the data is being constructed by the researcher and the participant and not discovered (Gardner et al, 2012; Evans, 2013). Thus, the interrelationship between the participant and researcher is recognised (Mills, Bonner & Francis, 2006b) resulting in the co-construction of the data.

This flexibility can however be a challenge because the researcher is making decisions all the time about how aspects of the grounded theory methodology can be used (Kenny & Fouire, 2015). For the constructivist approach to grounded theory this is not seen as an issue. As the researcher is part of the research and not separate and is part of the studied process. Moreover, the methods are reflexive and the constant challenging of

the different elements of the methods of grounded theory allows the researcher to consider this (Gardner et al, 2012; Urquhart, 2013).

From a constructivist approach the research always reflects value positions. Thus, reflexivity is essential to identify these positions and to understand the impact they may have on the research process and to subject them to scrutiny (Kenny & Fouire, 2015). Through reflexivity and a clear understanding of what you believe reality to be and how knowledge is created, in relation to the study allows the researcher to deal with these challenges (Mills et al, 2006b).

The challenges of flexibility were experienced in relation to coding and how to use the literature. This is discussed below.

The approach to collection and analysis of data devised by Strauss and Corbin (1990) incorporating axial coding has been described as a rigid prescriptive approach and has been criticised for forcing the data as opposed to letting the data emerge (Glaser, 2012; Evans, 2013). Charmaz, (2014) does not advocate this method of coding as she sees this as a move away from the more flexible approach initially devised by Glaser and Strauss (1967). Charmaz instead focusses on reflecting on the sub-categories and categories to establish links (Mills et al, 2006b; Breckenridge et al, 2012).

Whilst recognising these points I decided to try and use axial coding because as a novice researcher using grounded theory, I found the sheer volume of data difficult to organise and manage. Moreover, the flexibility of the grounded theory method does not preclude the use of alternate methods to manage date collection and analysis. After attempting to integrate axial coding however, I concurred with Charmaz (2014) that it felt that axial coding was very prescriptive and was forcing the data.

The use of the literature was a major challenge. When and how to use the literature was critical, as discussed in chapter 2 section 2.1. The use of literature in grounded theory is recognised as being contentious (Parry, 1998; Yarwood-Ross & Jack, 2015). Moreover,

the use of the literature is one of the biggest differences between classical grounded theory, and constructivist grounded theory (Evans, 2013). Glaser (1998) advises against a literature review prior to starting the research. He believes this avoids preconceptions about the data analysis, and he advocates the literature review is undertaken after the core category has been developed (Breckenridge, 2010; Glaser, 2012, Evans, 2013).

Charmaz (2012) argues delaying the literature review is not necessary or in some cases feasible and advocates a broad review at the start of the study of the literature to understand what has been undertaken previously in this area (Evans, 2013).

Strauss and Corbin (1990, p. 51) also advise that the literature can be used before the study as well as during it. As they suggest that the researcher inevitably influences the research. They also recognise the benefits of using "*the knowledge of philosophical writings and existing theories"* as a way of looking at the data in terms of how to approach and interpret the data.

Part of the DBA programme consisted of two modules that required an initial literature review to examine the topic being researched and then a more refined search in a later module. Therefore, the flexible approach to the literature review by Charmaz (2014) supported how I presented the literature. Stage one comprised a broad overview of the literature (chapter 2) and stage two used the literature to develop and explore the materials from the interviews and focus groups (chapters 5, 6 & 7) and the development of the conceptual framework (chapter 8) see appendix 1.

Another challenge was the knowledge and expertise that, as an experienced health visitor and educationalist, I brought to the study. I took the view of Charmaz (2014) that this knowledge and experience could contribute to the study. I believed that this could be managed to avoid preconceptions when analysing data and that I could take the stance of theoretical agnosticism i.e. subjecting prior theories identified in the literature and from my own experience to critical analysis rather than ignoring them (Henwood & Pidgeon, 2003). I would assert that my pre-existing knowledge allowed me to

understand issues within health visiting without imposing preconceived ideas. The use of theoretical agnosticism and reflexivity allowed me to retain an open mind and to allow the study to develop inductively (Evans, 2013).

This view might reasonably be challenged. As a health visitor educationalist, I have a strong identity underpinned by a strong set of beliefs and values. I have developed these as a professional over a sustained period. Whilst being critical of the literature I was aware that the decisions of what I included from the literature and the questions I asked (Evans, 2013) would shape the themes that would be used in the interviews and focus groups. The use of theoretical sampling (see chapter 4) allowed me to deal with the challenge of the literature.

Whilst valuing the first stage literature review my experience was that I found greater benefit from the more focused literature review undertaken at stage two, after the categories were established and the initial conceptual framework developed. I felt I had successfully managed the challenge of how and when to use the literature when I found that the data differed significantly from my initial broad literature review. Thus, the data is what developed the conceptual framework not the extant literature. The key findings of the study around identity and a conceptual framework to guide leadership development for example was not something that I explored in the literature at the start of the study.

In summary, the main differences between constructivist (Charmaz) and classical grounded theory (Glaser & Strauss) are the epistemological differences (Charmaz, 1990; Mills et al, 2007; Age, 2011) the treatment of the literature (Charmaz, 2006; Dunne, 2011; Yarwood-Ross & Jack, 2015); position of the researcher and the research participants and subjectivities (Mills et al, 2006a; Higginbottom & Lauridsen, 2014; Charmaz, 2014); coding and use of diagramming and core category identification (Hallberg, 2006; Bryman, 2008; Bryant & Charmaz, 2010).

3.2.8 Co-construction of the data

Using constructivist ground theory means looking for the meaning in the data at every level not just on the surface of what is being told to you (Mills et al, 2006b; Charmaz, 2014). Charmaz (2006, p. 402) advises that "*the researcher and researched co-construct the data as data is a product of the research process not simply observed objects of it".* Thus, as Mills et al (2006b) observe this view places the researcher and participant as co-producers. When undertaking the interviews and focus groups and then when analysing the data. I made sure that I wrote memos to reflect on the interaction between the participants in the interviews and focus groups and included my own perceptions of what was being said and how (see chapter 4 section 4.3.2). This was particularly pertinent in the focus groups where the health visitors were reframing their own views of leadership in their roles together.

Adopting this approach to the study meant that I used co-construction throughout the research process. I saw myself as part of the research. I was co-constructing the experience and meaning (Mills et al, 2006b) that participants were sharing with me. I then used the constant comparison technique and theoretical sampling to develop that meaning into concepts that became categories through further interviews. At all times the voices of the participants were central to build an understanding of the phenomenon (Gardner et al, 2012; Evans, 2013; Charmaz, 2014). As a result of recognising the importance of the interrelationship between the researcher and the participants (Charmaz, 2006). I was able to devise through the data a shared co-constructed meaning involving both parties of the phenomenon in this case leadership in health visiting.

To enable me to do this I considered my position in the research as well as the participants and the effect that I had on the research process (Kenny & Fouire, 2015). I did this by reconstructing the experience and meaning taken from the participants during interviews and focus groups through the data and analysis whilst being reflexive (Mills et al, 2006b; Charmaz, 2008). I therefore, constructed the conceptual framework

through the interactions with the participants and their perspectives of the phenomenon making sure that their narrative was visible in the framework (Mills et al, 2006b; Gardner et al, 2012). I did this by keeping the focus on the multiple voices of the participants using gerunds helped me to keep the action in the codes (Charmaz, 2014).

Charmaz suggests that you can keep the participants voice and meaning visible in the theoretical outcome using memos (Mills et al, 2006b; Charmaz, 2014). I did this in the memos (see an example chapter 4 section 4.5.5) and through direct quotes included in chapters 5, 6, 7 and 8. This was reinforced using gerunds for coding, something recommended by Charmaz (2014) to build action into the codes (see chapter 4 section 4.5.1 for more detail). The use of gerunds preserves the voice of the participants and helps the researcher to co-construct the meaning from the interviews.

Thus, the methods of in depth interviews and focus groups was the main way in which I co-constructed the data aided by theoretical sampling and memo writing.

3.3 Research methods

Once methodology has been selected the means of collecting and analysing the data must be defined.

The choice of a research method is guided "*by the epistemological and ontological assumptions of the researcher"* (Steyaert & Bouwen, 2006, p. 140) and the research question (Silverman, 2011; Eriksson & Kovalainen, 2013). Therefore, it is important to provide a rationale for the research methods to justify the research process used and ensure the research is high quality (Crotty, 1998). When selecting what methods to use, the researcher must choose the best method(s) that answer the questions being asked (Oliver, Serovich & Mason, 2005). Methods in themselves have no intrinsic value (Silverman, 2011). Incorporating the objectives of the research must lead to the methodology and methods. The methods used in this study were in depth semi structured interviews and focus groups (Charmaz, 2014).

Below is a rationale for choosing interviews and focus groups as methods to collect data. An overview of the interview process and how the interviews were affected by the chosen methodology is provided in Chapter 4.

3.3.1 Interview Technique

Interviews are one of the most widely used methods in qualitative research because they are a flexible activity and commonly accepted as a way of gathering data (Cassell & Symon, 2006; Charmaz, 2014).

Different theoretical assumptions exist in the approaches used to undertake interviews (King, 2006; Silverman, 2011). The epistemological positions have been described as realist approaches at one end and radical constructionist at the other end. The former assumes that facts are provided in the interview by the participants that relate directly to their real experiences about the world outside the interview setting. The latter involves both interviewer and participant making sense together, within the context of the interview to construct understanding on the topic being discussed from their lived experiences (King, 2006; Silverman, 2011).

There are several terms applied to interviews used in qualitative research as follows*:* in depth, semi-structured or unstructured and exploratory interviews (King, 2006; Bryman, 2008; Eriksson & Kovalainen, 2013). They all have commonalities in that they "*see the research topic from the* participant's" view of the world and they wish "*to understand how and why they"* have come to that perspective (King, 2006, p. 11; Bryman, 2008; Morberg et al, 2009).

I reflected on the epistemological position of constructionism that directed the research and what information I expected to get out of the interviews and I used this to frame the interviews. I recognised that I wanted to explore the participants' voices and experiences about leadership and health visiting but that interviews cannot offer direct

access to facts or to events. Interviews cannot inform us of people's experiences, they can however proffer indirect representations of those experiences and form an interaction set in the construct of an interview (Silverman, 2011).

Qualitative interview methods are based on the relationship between the researcher and the participant in the interview setting. In a quantitative study standardised questions are used, and the participant is viewed as a passive research subject in terms of eliciting information about facts, behaviour and attitudes in the outside world. The qualitative researcher however, does not believe that there can be a "*relationship-free interview*. *Indeed, the relationship is part of the research process",* and is central to it. The researcher is part of the research, actively engaged in constructing meaning and therefore, moulding the interview by interacting with the participants to try to understand their experience, opinion and ideas rather than having a passive role in the interview (King, 2006, p. 11; Silverman, 2011; Eriksson & Kovalainen, 2013).

The benefits of qualitative interviewing are that it is a useful method to access participants experiences and understandings and to explore topics which contain different levels of meaning (King, 2006; Silverman, 2011) and for ascertaining attitudes and values that cannot be observed (Silverman, 2011). This study is looking at meaning on the same phenomenon across three different groups of health visitors.

Disadvantages of using interviews are the time needed for the researcher to develop the interview guide, undertaking the interviews and analysing transcripts (King, 2006). However, when compared to other methods, interviews are relatively economical of resource (Silverman, 2011).

I used the Alvesson and Skoldberg (2009) model as part of being a reflexive researcher to ask questions of myself about how I influenced the interviews. I recognised that I had some control of the interview, as I decided which parts of the interview to follow up and when to open and close various topics.

No one interviewing style is the best. Interviewers can choose to be passive or active, even choosing to disclose information about themselves to provoke further talk (Silverman, 2011). I was aware that participants might be concerned about sharing information and specifically about issues of confidentiality. Indeed, some participants asked if their interviews would be confidential. This is not unusual when interviewing. Interviews may be seen as a form of social control to shape what is said (Engward & Davis, 2015). I recognised that what I said was central to the trajectories of the interviews (Silverman, 2011). This was something I reflected on when reviewing the interviews and performing analysis (Chapter 4).

Every interview can be interpreted in a number of different ways, there is no right way of doing this (King, 2006) because reality is always about how participants interpret and give meaning to phenomenon (Erikson & Kovalainen, 2013). As the interviewer of the participants I was engaged in constructing aspects of reality to give meaning (Silverman, 2011).

In the interviews and subsequent analysis, I have tried to show how interview responses are produced as an interaction between me and the respondent. I believed it was crucial not to lose sight of the meanings produced or the circumstances in which the meanings were made. Therefore, the objective was not merely to describe what was said in the interview but to demonstrate what participants said relates to their experiences and lives and how they create meaning (Silverman, 2011). Therefore, the participants were co-constructing the direction of the study not just providing data as I changed the focus of the questions in light of what the participants told me and my own focus for example an issue I thought was important i.e. that health visitors didn't understand the difference between management and leadership was not important to the participants therefore I didn't pursue that line of enquiry.

The approach to interview may change as the study develops because the interviewer may seek to understand the participants' language, meanings, actions, emotions and body language and then act to follow up on these points (Charmaz, 2014). As a way of

understanding these experiences I chose to use in depth semi-structured interviews. These require a clear understanding of the aims of the project, rapport with the participants and some further probing of the participants (Silverman, 2011).

When using grounded theory in leadership research it has been recommended that data should be collected using unstructured or semi-structured interviewing. Exploring leadership as a social process is not an easy subject to dissect so using semi structured interviews (Parry, 1998) allowed me to focus on specific experiences of leadership whilst still giving the participants room to expand on aspects not immediately apparent to me (Bryman, 2008; Agard & Lomborg 2010).

3.3.2 Focus groups

Focus groups are recognised as an established research method (Happell, 2007; Silverman, 2011) used widely in marketing and nursing studies (Steyaert & Bouwen, 2006; Curtis & Redmond, 2007; Bryman, 2008). Their use entails recruiting a small group of individuals and discussion is then focused on a specific issue or topic (Dreachslin et al, 2000; Bryman, 2008; Dellve & Wikstrom, 2009).

"Focus group theory is based on the belief that we are a product of our environment and we are therefore, influenced by others" (Curtis & Redmond, 2007, pgs. 25-26). It is the nature of the discussion and interaction within the group that provides the researcher with the means to explore, articulate and clarify the group participants own views and opinions about specific topics. Ascertaining why participants feel the way they do and getting them to disclose this is the aim of the focus group and it is hoped that this will provide insight and understanding of their lived experience *(*Curtis & Redmond, 2007; Bryman, 2008; Silverman, 2011) and how they are influenced by other members of the focus group viewpoints (Eriksson & Kovalainen, 2013). What is key is the interaction within the group that allows the participants to construct joint meaning; this aspect distinguishes the focus group from an individual interview (Bryman, 2008).

Focus groups also referred to as group interviews advocate the role of the interviewer as being key in facilitating the informal group discussion with members to actively encourage group interactions on a specific topic (Bryman, 2008; Silverman, 2011; Eriksson & Kovalainen, 2013). All group members are encouraged to share their personal experiences and opinions, which provide vital insight into behaviour (Curtis & Redmond, 2007; Silverman, 2011). Some focus group studies do advocate the use of a more structured approach, using a range of specific questions with the members of the group, whilst still maintaining the importance of group discussion and enabling them to share their views and experiences (Bryman, 2008; Silverman, 2011).

The use of focus group interviews has several advantages (Happell, 2007; Curtis & Redmond, 2007). Principal amongst these are that they allow "*access to a large number of participants";* they provide an opportunity for informal discussion and the exchange of ideas between participants, and can thus be an efficient way of collecting information (Happell, 2007, p. 19; Eriksson & Kovalainen, 2013) which is focussed around a particular topic or set of issues drawn from personal experience that are crucial to further explore the phenomenon in question (Curtis & Redmond, 2007; Silverman, 2011).

Disadvantages with focus group interviews can include: domination of the group by individual participants or at the other end of the scale participants who do not say very much. Talking over each other can be a common problem (Happell, 2007; Bryman, 2008) power differentials may exist between the members of the group, if you are including different levels of staff that have within the group hierarchical differences e.g. managers and staff, and the researcher has less control over the group discussion (Curtis & Redmond, 2007; Happell, 2007; Bryman, 2008). Therefore, there is less control over the outcome of focus groups because the effect of the group process is quite high. For constructivist grounded theory, this is not a problem (Cassell & Symon 2006; Bryman, 2008).

Focus groups can produce a large amount of data to transcribe and analyse. Compared to individual interviews and can be more difficult to arrange, particularly as people who

have agreed to attend may not attend on the day (Curtis & Redmond, 2007; Happell, 2007; Bryman, 2008). Participants may be challenged by the views on the subject under discussion when expressed by others within the group. This may suppress an individual's view or perspective and lead to conformity (Dreachslin et al, 2000; Curtis & Redmond, 2007; Bryman, 2008) (see Chapter 4).

Focus groups are similar to individual interviews but there are distinct differences between the two methods. The interview is often directed whereas by contrast the focus group allows participants perspectives to be discussed in a different way to an individual interview, by providing more control and opportunity for the group to comment, react, and raise issues that are important to them (Curtis & Redmond, 2007; Bryman, 2008; Eriksson & Kovalainen, 2013) therefore, capturing in a condensed way a range of different views (Steyaert & Bouwen, 2006).

Constructionist methods aim to analyse the process of interaction between participants within a focus group. The purpose is to uncover how meaning is constructed in this context and through what sequence of events (Curtis & Redmond, 2007; Silverman, 2011). The constructionist focus on sequences of discussion allows a quite different grasp of the phenomenon (Silverman, 2011). The constructionist focus can emphasise the relationships and consider the multiplicity of perspectives by hearing different participants talk about the same phenomenon. Thus, different opinions are heard at the same time (Steyaert & Bouwen, 2006).

I used focus groups to interview health visitors because this adhered to the purpose of the study and the epistemology of constructionism and because they are useful when current knowledge about a subject (leadership in health visiting) is extremely scanty and the subject being investigated is complex. Constructionism emphasises the relationships and the multiplicities of social realities (Steyaert & Bouwen, 2006). Reality is always about a group's interpretation (Erikson & Kovalainen, 2013) and thus gives an insight into the participants' perceptions of leadership.

A group of health visitors may construct a perception of leadership from the interaction between them and this may shed light upon what social processes and social interactions are involved in leadership (Curtis & Redmond, 2007; Bryman, 2008; Dellve & Wikstrom, 2009). Focus groups were chosen as a research method based on the purpose of the study and because it provided the means to explore how participants collectively make sense of (Curtis & Redmond, 2007) how health visitors understand leadership as a social process (Pearce, Conger & Locke, 2008) and the meanings that they construct around this phenomenon (Bryman, 2008).

In assembling a group for a focus group discussion, it is important that they have something in common in terms of their background not in relation to their attitudes or views (Curtis & Redmond, 2007; Bryman, 2008; Eriksson & Kovalainen, 2013). It has been suggested that some heterogeneity in the group is a good thing (Higginbottom, 2004; Bryman, 2008) to reflect the broadest range of views possible.

In this study, the focus groups comprised health visitors with common professional experiences (see Chapter 4). There is debate regarding whether selection of participants should be known to each other and if they should be existing groups (Steyaert & Bouwen, 2006; Howatson-Jones, 2007; Bryman, 2008). In this study, the group falls between these two stools. The two focus groups were not existing groups, but the participants did know each other, as they worked in the same locality and attended the same professional meetings.

3.4 Data collection technique

From a subjective perspective there are several things that influence the interview guide, these are: the literature, my own personal knowledge and experience of health visiting and leadership within the NHS, from working within this arena and from discussions with colleagues who are experienced in the topic area being studied. Moreover, the guide continued to develop as I progressed through the series of interviews/focus groups (Cole, Chase, Couch & Clark, 2011).

A review of the literature had shaped the research questions and objectives. Four themes emerged from the literature and were used in both the interviews and in the focus groups to frame the questions (see Appendix 3).

The questions under each theme provided the type of questions and acted as a prompt for me during the focus groups and the interviews (Charmaz, 2014). The interview guide was modified during the data collection process in response to the analysis of the interviews as well as during the interviews to ensure I was responsive to listening to what participants were saying. The questions became more refined as the interviews progressed and the questions become more focused in order to explore category development. New questions were introduced as new topics emerged from the earlier interviews and focus groups. This is entirely in keeping with the principle of theoretical sampling (Agard & Lomborg, 2010).

The questions were influenced by my own professional background. I am a health visitor who, at the time of the study, was employed to oversee the development of health visiting programmes and to lead a University Department of Nursing and Midwifery. This role meant that I spent time working with clinical practice partners and that I was aware of the changes in the health visiting role and the perception of leadership in health visiting.

Thus, the questions in the interview guide were influenced by my experience and the literature review I had performed: this is not unusual (Saevareid & Balandin, 2011). The Alvesson and Skoldberg (2009) model of reflexivity, was really helpful as it asked questions about what influence I had in how I had developed the interview guide and how this was applied in the interviews and focus groups (Engward & Davis, 2015).

I first piloted the questions I planned to use by interviewing a health visitor and by using the questions as part of a teaching session with student health visitors at the University. A Service User Group (SUG) within the Faculty of Health and Wellbeing at the University

were asked to comment on the design of the study and specifically the questions I planned to use. Using SUGs in this way is considered best practice when designing studies. I explained the purpose of the study to the SUG and discussing the potential questions with them. As a result of their input, several questions were amended. Moreover, this meeting brought another issue to the fore; why hadn't I included service users as a group to interview as part of the research?

I followed the usual process for undertaking qualitative interviews and focus groups. The interviews were flexible and there was no strict adherence to ask all the questions in the same way in every interview/focus group. This is usual for interviews that pursue a constructionist methodology. During the interviews, I used probes to follow up on some questions to gain greater detail from participants (King, 2006).

Two questions which seek information are included in the interview guide. These are more realist in approach than constructivist; however, these questions were followed up with probing questions to explore further the participants' views and experiences (King, 2006). I wanted to include the realist questions because the literature abounds with unsubstantiated rhetoric about leadership in health policy (Storey, 2011) I wanted to test whether the participants thought the concept was important and, if so, why i.e. what actions they attributed to it.

The question about theories developed from my own experience of teaching health visiting and leadership. It also drew from my understanding of professional colleagues within health visiting. I was aware that health visitors did not seem to undertake leadership training as part of CPD or indeed when they were applying for leadership jobs in health visiting. I was also aware when I taught students that many of them did not have any real understanding of leadership theories other than having heard of transformational leadership.

I used semi-structured questions to provide some structure as a novice researcher I thought this would be beneficial, whilst still ensuring that I was responsive to the

participants and avoiding presuppositions. If I had not used semi structured questions, I was concerned that I might become too engaged with the participants and how they were interacting with me, something that is well-recognised, and can result in the interview taking on more of a conversation which may result in the use of a directive approach (KIng, 2006). I was particularly aware of this, as I am a health visitor and familiar with some of the participants in the study through my professional role. I reflected on this and discuss it later (see Chapter 4).

3.5 Reflexivity

*"Reflexivity refers to the recognition that the involvement of the researcher as an active participant in the research process shapes the nature of the process and the knowledge produced through it" (*Cassel & Symon, 2006, p. 20).

Constructivist grounded theorists engage in reflexivity throughout inquiry because this enables them to recognise their own values, and attitudes and where they start from and how this can change throughout the research process (Bryant & Charmaz, 2010) From this perspective, the researcher is placed with the participants within the field of inquiry (Wertz et al, 2011).

What I wanted to achieve by being reflexive was to have an opportunity to reflect on how my own personal experiences impacted on the choices I made and my thinking throughout the research process and to make this transparent, both for the reader of the study and for myself. I used the Alvesson and Skoldberg (2009) model of reflexivity in order to do this throughout the study. The model allowed me to do this at different levels, which included consideration of my own beliefs and values when considering the epistemology and theoretical perspective of the study in terms of what knowledge I wanted to find out and how this could be used in practice, and the methodology that would allow me to do this.

Reflexivity allowed me to question my assumptions throughout the research process specifically the concepts and theories as they emerged through the data analysis process (Eriksson & Kovalainen, 2013; Engward & Davis, 2015) recognising the control that I had in making these decisions and ultimately in deciding when I had reached theoretical saturation (Bryant & Charmaz, 2010; Silverman, 2011).

I started being reflexive whilst considering my *a priori* thoughts, e.g. to begin with about why leadership in health visiting didn't appear to be sufficiently developed according to government policies (DH, 2007 & 2011). What motivated me when asking the questions and more importantly my decision making when deciding what aspects emerging from the data to explore further, was primarily to ensure that I utilised theoretical sampling (discussed in Chapter 4) and to be clear that I saw myself as co-constructing and interpreting the data and eventually the findings, recognising that I was part of this research study not an observer. By doing this and using Charmaz's (2014) evaluation criteria I felt that whoever read the research could see my beliefs and values about the research study and how I had utilised them whilst attempting to ensure rigor in my findings (Finlay, 2002; Engward & Davis, 2015).

The Alvesson and Skoldberg (2009) model of reflexivity was utilised throughout the study and is demonstrated in Chapters 4 and 9. In addition this model fits well with the criteria for evaluating grounded theory studies as used in the current study. These are enunciated by Charmaz (2014) to include: credibility, originality, resonance and usefulness. This allows reflexivity to continue throughout the process in line with the evaluation so the two activities are interlinked. By being reflexive the potential limitations of the study have been recognised (Engward & Davis, 2015).

3.6 Ethical considerations

Ethical approval was sought and received from the Research and Development Department within the NHS Trust (see Appendix 4) which involved completing an NHS Research and Development form. As part of this process I had to set up an Integrated

Research Application System account, which was a lengthy process but resulted in ethical approval from all parties with no amendments. This is an important process as it is essential to protect the participants from any harm when undertaking any type of research. In addition, I received approval from the relevant University Research Ethics Committee (see Appendix 5).

Written informed consent was received from the participants involved in the research and data collected and coded was stored in line with the Data Protection Act (1998) (Stanley, 2006b). All participants were given written and verbal information about the purpose of the study and advised that they could withdraw from the study at any time; and there was an opportunity provided to ask questions about the study (Bondas, 2009, Mahmoudirad, Ahmadi, Vanaki & Hajizadeh, 2009; Morberg et al, 2009). The information contained the aim of the study, the methods and what confidentiality means in relation to anonymity (Bondas, 2006; Agard & Lomborg, 2010). Confidentiality has been guaranteed, no personal details e.g. participant's names, workplaces have been included in any data and anonymous codes were used for participants during data analysis (Currie et al, 2007b; Attree, 2007).

3.7 Chapter summary

The study aims to understand how health visitors make sense of leadership. In order to address this research, question the research process, using Crotty's (1998) framework was discussed. I have identified my epistemological position and how this has informed the theoretical perspective, methodology and methods. These were all decided on by starting from the phenomenon under discussion and how this could be explored through my research question and objectives and ultimately what research process would help me answer this question and provide credible knowledge that health visitors would find useful.

Chapter Four

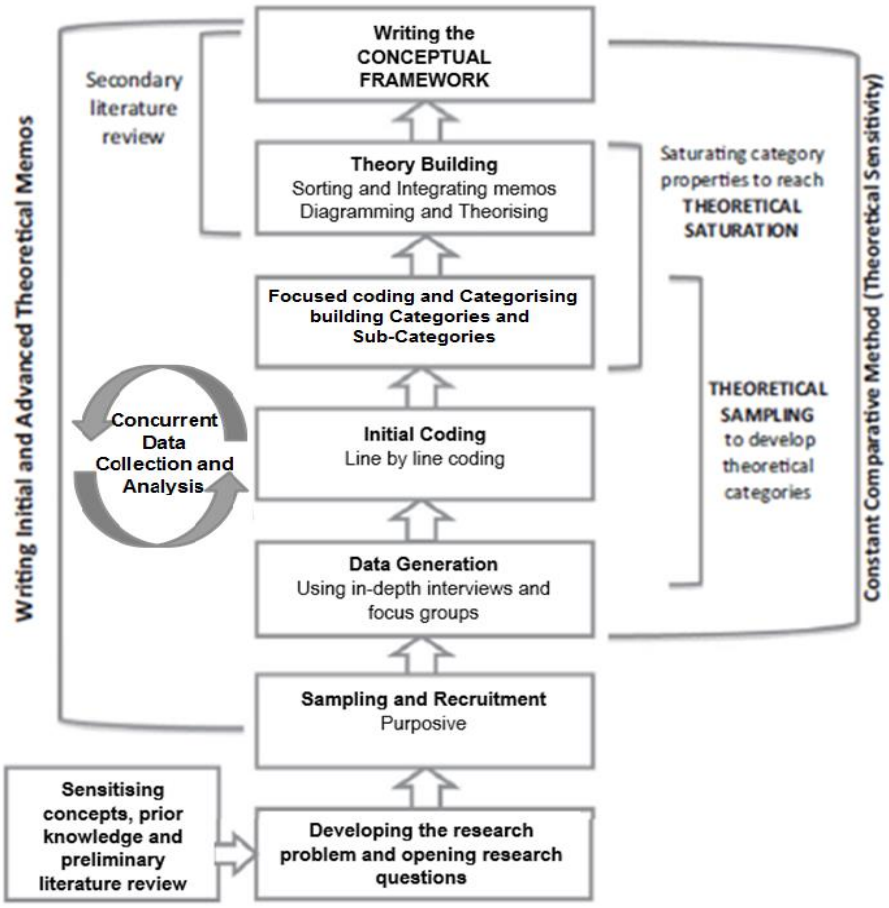
4. Data Collection and Analysis

4.1 Introduction

This chapter explains the processes used for collection and analysis of data. It discusses the characteristics of the participants and how they were selected and recruited into the study. In addition, the chapter also explains how the defining components of constructivist grounded theory were used to produce a conceptual framework (Charmaz, 2014).

Codes were developed and refined by writing memos and by the use of constant comparative analysis. From this, three categories emerged. These categories were then analysed, this led to the development of a core category and conceptual framework that addresses the aims and objectives of the study. The study postulates an explanation as to how health visitors understand leadership.

Figure 4.1 Illustrates the processes and methods involved in this grounded theory study (adapted from Tweed and Charmaz, 2011; Charmaz, 2014; Giles et al, 2016a)



4.2 Data collection

4.2.1 Selection of the participants

The sampling approach chosen for this study is purposive and theoretical sampling. This approach was chosen as grounded theory studies use a qualitative sampling approach that is not based on probability (Silverman, 2011; Patton, 2015). I chose purposive sampling as it is recognised as a sampling approach that allows the researcher to learn about the central issues in this case pertinent to health visitors about their experiences of the phenomenon of leadership in health visiting (Patton, 2015).

The sampling process in grounded theory progresses throughout data collection,

analysis and theory development. It is the theory development that directs the collection of data based on areas that need further exploration ultimately resulting in saturation. Thus, resulting in theoretical sampling derived from the emerging theory (Urquhart, 2013; Charmaz, 2014).

In quantitative research, the requirement for sampling is to allow inference of findings to a population, in order to verify theory (Emmel, 2013) and provide generalisations (Patton, 2015). In qualitative research, participants are chosen for their ability to provide information about the phenomenon being studied (Dunne, 2011). Therefore, in qualitative research the sample is not seeking to be representative, instead the sample is selected according to the needs of the study (Emmel, 2013) and to provide an in-depth understanding of a specific issue (Patton, 2015).

Sampling is not straight forward in qualitative research. A lack of clarity exists from the use of overlapping types of sampling and different terms being used interchangeably. Particular ambiguity exists around the term purposive and theoretical sampling (Coyne, 1997; McCrae & Purssell, 2016).

In a review of 134 articles claiming to use grounded theory, McCrae and Purssell (2016, p. 2284) found that 86% of the studies described an iterative data collection process and analysis. Moreover, only half of the studies demonstrated theoretical sampling. *"Many of the studies declared or indicated a purposive sampling approach throughout".*

Theoretical sampling has been described as a variation of purposive sampling (Coyne, 1997; Emmel, 2013) and is a core feature of grounded theory. "*It is closely linked to constant comparative analysis and theoretical saturation"* yet it the strand of grounded theory that is applied or reported on the most inconsistently. It is the least used aspect of grounded theory studies because of its complexity (Coyne, 1997, p. 629; Wertz et al, 2011; Charmaz, 2011 & 2014; McCrae & Purssell, 2016). The theoretical sample is different from purposive sampling as it is determined from the iterative process of data analysis (Coyne, 1997; Emmel, 2013; McCrae & Purssell, 2016). Thus, a theoretical

sample cannot be identified before the start of the research as oppose to purposive sampling which is identified at the start of the study (Coyne, 1997).

Through the process of data analysis, theoretical sampling becomes much more selective. It permits the researcher to ask increasingly focussed questions to participants to develop the categories. "*This may involve changing the interview questions as the study progresses"* (Coyne, 1997, p. 626) to crystallise the emerging theory (Emmel, 2013). The emerging theory then indicates any further requirements for data and these must be met by the sampling strategy (Coyne, 1997).

In essence, "*the researcher continues to gather data until no new properties or categories emerge"* (Emmel, 2013, p. 14; Charmaz, 2014). Thus, theoretical sampling is not necessarily a way of increasing the number of participants (Hallberg, 2006) its purpose is to develop the concepts and categories emerging from the data (Attree, 2007, Currie et al, 2007b; Mahmoudirad et al, 2009; Emmel, 2013). The result of this is continued development and refinement of the theoretical categories (Giles et al, 2016a).

With theoretical sampling, it is the properties of the categories, not the data, which becomes saturated. In grounded theory, saturation means theoretical saturation, in this context saturation is always a subjective decision. Once no further new properties of the theoretical categories have emerged the findings gain substance and begin to move beyond interesting conjectures (Hallberg, 2006; Charmaz, 2014; Giles et al, 2016a).

The emerging theory, if you choose to pursue constructing theory, is developed in part by the theoretical sensitivity of the researcher. Charmaz (2014, p. 161) defines theoretical sensitivity as "*the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena".* This view of theoretical sensitivity is one that contains much more reflection (Emmel, 2013).

For this study participants were selected using purposive sampling, i.e. on the basis that collectively they had a broad understanding of the context of health visiting and the

leadership role that health visitors undertake. This was driven by myself as the researcher in terms of the criteria required to enable me to learn about the phenomenon (Patton, 2015). It was necessary at the start to establish that the participants could provide a robust account of the area under study, relevant to the research questions (Bondas, 2006; Bryman 2008). In this case, the participants' roles meant they were experiencing the phenomenon and, therefore, appropriate for the study.

I chose participants that, by their role, were engaging in the phenomenon of interest to the study. They had a diversity of health visiting experience e.g. management, leadership operational and strategic, at both a local and national level, educationalists, practitioners. By using a purposive sampling approach, I was able to recruit participants who I knew would be able to illuminate the research question. By working with the Professional Health Visiting Lead in the Trust (see section 4.2.2 for a further detailed discussion of this). I was able to recruit participants who were willing to take part in focus groups and through personal contacts I chose a wide range of strategic health visiting leaders who were prepared to take part in in-depth interviews. I was keen to ensure that the overall sample had a variety of characteristics (see section 4.2.3 for more information) e.g. age, gender, experience of leadership and health visiting that would identify the social processes of leadership in health visiting (Silverman, 2011).

As the study progressed, questions were chosen based on specific gaps in the categories (Kan & Parry, 2004; Currie et al, 2007b): ultimately these changes directed the study (Charmaz, 2012) to saturate the categories.

Participants within the study were recruited on a voluntary basis using purposive sampling. Health Visitors, Health Visiting Managers/Leaders/Practice Teachers, National Health Visiting Leaders, who were willing to take part in the study, were recruited to participate in the following groups:

- **Group 1** consisted of two focus groups containing seven health visitors in total (band 6 in line with the AfC, pay scales, DH, 2004) from the chosen NHS Trust;

- **Group 2** consisted of five health visiting managers/leaders/practice teachers (band 7 or above in line with the AfC, pay scales, DH, 2004) from within the chosen NHS Trust;

- **Group 3** consisted of five national leaders/managers/educationalists/experts in health visiting who have a national strategic role in the professional development of health visiting.

In summary, the sampling strategy used started with purposive sampling. Subsequent collection of data was led by theoretical sampling, which allowed testing of developing theoretical categories.

4.2.2 Recruitment of participants

The Professional Lead for Health Visiting from the chosen Trust provided email addresses for ten health visitors. I then contacted each of these health visitors by sending them a personalised email together with an invitation to participate in the study and the participant information sheet (see Appendix 6).

Each health visitor who responded expressing that they would like to be involved in the study was contacted by email and in some cases by telephone. I provided each of these health visitors with full details of when and where the focus groups would take place within the Trust.

Several health visitors did not want to take part in the study. No reason was given for this. The recruitment process took longer than anticipated because more health visitors were contacted until I had received agreement from ten health visitors that they would attend a focus group. In addition, reminder emails were sent to the health visitors. Even

despite this, work commitments meant that some could not attend on the day and for focus group one, three health visitors attended.

Focus group two was rescheduled to allow all five health visitors to attend. On the scheduled day, one health visitor was not able to attend and the group went ahead with four health visitors.

Non-attendance at focus groups is not uncommon even when participants have previously agreed to attend (Happell, 2007). It is well-recognised that the organisation of focus groups is problematic, particularly if the venue for the focus groups is not a site where all the participants regularly attend (Curtis & Redmond, 2007). In this study, although the participants were all based in the same Trust, they worked across the Trust locality and were not based in the same place.

The Professional Health Visiting Lead provided email addresses for five potential participants for group two to take part in individual in-depth semi structured interviews. I contacted these candidates by emailing them an invitation to participate and the participant information sheet. Those candidates who expressed an interest in taking part were contacted further by email and phone, and sent details of when and where the interview would take place within the NHS Trust. For group two, all five candidates who were contacted wanted to take part in the study.

The participants for group three were identified from local and national professional networks. They were asked to undergo individual in-depth semi structured interviews. These individuals were first contacted by sending a personal email together with an invitation to participate and the participant information sheet. Every person who conveyed an interest in taking part in the study was contacted a second time by email to confirm when and where the interviews would take place. All five participants approached wanted to take part in the study.

All participants in Groups 2 and 3 attended; although three interviews had to be rescheduled due to participants work commitments and the weather on one occasion.

4.2.3 Descriptive characteristics of the three groups

Initially all participants were given a pseudonym to ensure confidentiality. Giving the participants names accentuates their distinctive voice and helps readers of the study picture them and their world (Wertz et al, 2011). Unfortunately, these pseudonyms were found to be distracting when writing up the findings from the study. I found that the pseudonyms affected how I thought about the participants. Instead I decided to give each interview a number in line with the sequence in which I interviewed them and along with this identified which group they belonged to. The focus groups are labelled as one interview, hence why there are 12 interviews but 17 participants (see Figure 4.2 for further information).

It was quite clear from the literature review that leadership, and how it is undertaken in organisations, is not just the responsibility of the individual. It is well documented that the culture of the organisation within which the individual works has a major impact upon how leadership is undertaken and understood (West et al, 2015). Moreover, middle managers have an impact upon both supporting and developing leadership (Whittaker et al, 2013). The purpose of this study was to examine leadership in several contexts e.g. experience of leadership in strategic roles (King, 2006). This desire made it pertinent to interview middle leaders/managers/senior health visitors who provided leadership within the chosen Trust where the health visitors worked. Interviewing these middle leaders/managers/senior health visitors should clarify whether they understood and experienced leadership in the same way as the front-line health visitors.

The literature clearly identified the impact of top-down, political policies on how leadership is enacted (DH, 2011). Therefore, it seemed highly relevant to interview key strategic/national leaders who are, or have been involved, in setting and implementing national strategies on how health visiting is delivered and developed as a profession.

Such interviews should offer an understanding of the phenomenon at a completely different level. This insight may illustrate whether the views of leadership at totally different levels bore any relation to each other.

The absolute parameter for selecting those to interview was that they must have knowledge and experience of health visiting and leadership.

Figure 4.2 Members of the three participant groups, which represent an overview of participants and their demographics.

Group 1	**Role and gender**	**Participants (Numbers)**	**Participants Health Visiting/leadership experience**	**Age**
Band 6	Health visitor-female	Interview 5	Involved in leading the Healthy Child Programme (HCP)	40-50
Band 6	Health Visitor-female	Interview 5	Involved in leading the HCP	40-50
Band 6	Health Visitor-female	Interview 5	Involved in leading the HCP	30-40
Band 6	Health Visitor-female	Interview 10	Involved in leading the HCP	30-40
Band 6	Health Visitor-female	Interview 10	Involved in leading the HCP	40-50
Band 6	Health Visitor-female	Interview 10	Involved in leading the HCP	30-40
Band 6	Health Visitor-male	Interview 10	Involved in leading the HCP	50-60
Group 2				
Band 7	Team leader/ Advanced Nurse Practitioners	Interview 1 Interview 2	Leadership experience oversees the management of a health visiting team	40-50 40-50
Band 8	Senior Manager (non- health visitor)	Interview 4	Leadership experience oversees the management of the team leaders/Advanced Practitioners amongst other staff and has overall management responsibility for the delivery of children services including health visiting	40-50

Band 7	Practice Teacher/Health Visitor	Interview 7 Interview 12	Leadership experience oversees the educational supervision of health visiting students in the practice placement setting. Also, part of the leadership team for children's services consisting of the children service manager and the team leaders/ANP's	40-50 40-50
Group 3				
Strategic leader	Senior Leadership role in Implementation of the Health Visitor Plan	Interview 3	Extensive leadership experience in strategic roles within the DH amongst other strategic leadership roles connected to nursing and health visiting.	60-70
Strategic leader	Senior National Educationalist Role	Interview 6	Leadership experience in chairing a national organisation for Specialist Community Public Health Nurses including health visiting/research leadership experience	40-50
Strategic leader	CEO Health Visiting associated organisation	Interview 8	Extensive leadership experience in strategic roles within the DH amongst other strategic leadership roles connected to nursing and health visiting.	60-70
Strategic leader	Lead commissioner/ Health Visiting	Interview 9	Extensive leadership experience in strategic roles within Health Education England at a regional level amongst other leadership roles connected to nursing and health visiting.	50-60
Strategic leader	Senior Nurse DH	Interview 11	Extensive leadership experience in strategic roles within the DH amongst other strategic leadership roles connected to nursing and health visiting.	50-60

4.3 Overview of the interview process

4.3.1 Number of interviews

In qualitative research, it is considered more important to seek authenticity rather than to be obsessed about sample size because the objective is to gain an authentic understanding of people's experiences (Silverman, 2011). When a more in depth understanding of the subject area is required, sample size should not be the aspect that the study is judged on (McCrae & Purssell, 2016) often the sample size can be relatively small and even be single case studies which are selected purposefully (Coyne, 1997; Patton, 2002; Emmel, 2013).

To obtain ethical approval via the Integrated Research Information System process I had to state how many people I wanted to interview. This was required before the study began and the inclusion and exclusion criteria for participants were also required. At this point in the study the aim was to interview 15 people. By stating this number, it offered the opportunity to do less interviews/focus groups as required and the exact numbers could be decided by theoretical sampling. In settling upon how many participants to recruit, it was necessary to strike a balance between the time and resource available and the need not to compromise the study (Strauss & Corbin, 1990; Coyne, 1997; Emmel, 2013).

In total, there were 17 participants interviewed. In Group 1, there were two focus groups containing 3 participants in focus Group 5 and 4 participants in focus Group 10. Five individual interviews were conducted with Group 2 and Group 3.

4.3.2 Organising interviews and data construction

To develop codes from the analysis of the interviews, and to compare the interviews, the interviews were organized in three sets, each held over a one-month period. Time was planned between the groups of interviews to allow analysis with the ultimate

objective of generating categories and using theoretical sampling. See Table 4.3 for a description of these sets.

Table 4.3 Indicates the schedule of interviews/focus groups and from which selected group

	Group	Interviews	Focus Groups:
Set 1 - undertaken in September 2013	Group 2 Group 2 Group 3 Group 2 Group 1	Interview 1 Interview 2 Interview 3 Interview 4	 Interview 5
Set 2 - undertaken in October 2013	Group 3 Group 2 Group 3 Group 3	Interview 6 Interview 7 Interview 8 Interview 9	
Set 3 - undertaken in November 2013	Group 1 Group 3 Group 2	 Interview 11 Interview 12	Interview 10

Potential participants were given a choice of dates to facilitate attendance at the focus groups. The interviews and focus groups were held in a convenient location for the participants. I wanted to be certain that they felt safe to discuss any pertinent topics relevant to the study. I was mindful that some participants might find that difficult if the venue wasn't appropriate. Participants were usually interviewed in their workplace. I started all interviews by reassuring the participants about how the data would be used and that the process was confidential. All participants had received the participant information sheet prior to the interview (see Appendix 6) and this was discussed again along with describing confidentiality measures.

The consent form (see Appendix 7) was signed at the interview/focus group and a copy retained by myself as per University requirements. Ensuring a suitable place to meet that is comfortable for the participant has been noted as contributing to the quality of the interview along with creating a relaxing atmosphere (Mero-Jaffe, 2011). Due to the circumstances discussed above the focus groups were smaller than planned, although

in the end I felt this was beneficial as it made it easier to guide them and to analyse the data. I conducted single one-hour interviews with all the individual participants, and 90 minutes for the focus groups which were audio taped for transcription purposes.

In set 1 the questions were organized around an in depth semi-structured interviewing approach (see Appendix 3). Throughout all of the interviews in set 1, participants were given free rein to direct the interviews if they made additional points that were important to them and their understanding of the phenomenon. These points were then followed up in subsequent interviews by asking further questions to check understanding and later on in set 2 and 3 to develop categories and properties and to deepen analysis (Wertz et al, 2011). Thus, all interviews differed to some degree. The objective was to learn about the participants' concerns from their perspectives rather than to impose a preconceived structure on them.

When I undertook the focus groups with the health visitors in Group 1, I felt very accepted as a health visitor and as somebody who they thought was genuinely interested in what they had to say. The individual interviews with senior staff in both Group 2 and 3 had a different dynamic. In Group 2 several participants asked about confidentiality and I felt like some of the responses were what they thought I wanted to hear as there appeared an element of rhetoric although the further we got into the interviews the more at ease I felt they became.

The interviews with some participants in Group 3 were interesting. As senior leaders at a national level some respondents were quite defensive as they had been involved in policy developments around health visiting and some felt, in hindsight, they might have done things differently. However, it was interesting, that by adopting a very open interested approach, how much participants shared with me; although one participant from Group 3 did say several times throughout the interview "*if you use this in the study be careful how you write it".*

This combination of semi structured questions, led by myself, and participant directed questions throughout the interviews allowed the co-construction of the data between myself and the participants. Having an understanding of the role of the health visitor and the same professional background and history was really useful. The use of professional jargon by participants was not an issue for me as a health visitor. Being part of the profession allowed me to understand their position and it put them at ease as I got the sense from the way they behaved in the interviews and their candid responses that they felt able to discuss the questions and issues/concerns freely. This was really beneficial in terms of understanding what they were saying and developing the categories through theoretical sampling, but it did require a lot of reflexivity on my part which I did through writing memos.

Being reflexive was required for two reasons: firstly, to stop me from falling into being descriptive by capturing what they were saying: Instead I was looking for broader processes emerging. Secondly to ensure I wasn't forcing the data by framing everything from my own experience in the field. "*It is accepted that researchers bring theoretical constructs to the research to co-produce theory with their participants"* (Emmel, 2013, p. 29) however, it is essential for researchers to be reflexive to consider how they are involved (Mills et al, 2006a; Charmaz, 2014).

I did this by writing down my presuppositions at the beginning of the study and referring back to this at each step of the research process. This was something that was suggested as part of my oral presentation feedback as part of the *Approval of Phase 111 Research Project*. One of my rapporteurs commented on my "*huge background of personal experience and interest* and advised me *to incorporate an element of reflection on this particular aspect into an introduction to the work to bring to life these important considerations"* (see Chapter 1 for an exert).

In the subsequent interviews with sets 2 and 3 similar questions were used to facilitate the discussion as they had been found to be pertinent, but some of the questions changed based on the emerging constructed themes from early analyses. For example,

the importance of role modeling became apparent after the first set of interviews and was subsequently discussed in sets 2 and 3. Also how participants experienced leadership in practice and responded to the changes in context differently was noted from set 1 to set 3, this particularly related to professional roles and boundaries and was discussed in set 3 to clarify the relevance of the emerging category of context. This meant that the focus of the sets also changed to allow for exploration of emerging themes. The intention was then to interview more participants if the categories were not theoretically saturated at the end of the 3 interview sets.

At the end of the interview/focus group, contact details were referred to on the participation sheets provided for all participants, for both me and my Director of Studies in case any participant wanted to discuss any element of the interview.

An intense period of analysis had to take place in between the 3 sets of interviews in order to complete the coding and build the categories in that period. On reflection although this was achieved satisfactorily it would have been better to space the interview sets to allow more time for analysis. Availability of further studies that describe how to undertake grounded theory analysis would have been beneficial to have recognized the benefit of doing this earlier, as although there are an abundance of studies that identify using grounded theory, how they undertook theoretical sampling and developing codes to categories is not easily available for the novice researcher. This is not unusual as qualitative research studies have been criticised for providing a lack of detail around how they have devised their sampling strategy. In addition, there exists a lack of studies available that actually describe how to undertake theoretical sampling (Coyne, 1997; Suddaby, 2006; McCrae & Purssell, 2016).

As a result of organizing the sets in this way, several months of analysis was undertaken at the end of the final interview set in order to ensure the categories had not been forced too early and the emerging categories were truly grounded in the data. After discussion with research colleagues and my supervisors it was felt that theoretical saturation had

been reached at the end of the third interview set and subsequent period of analysis therefore, no further participants were sought for the study.

Field notes were taken as part of the interviews/focus groups that contained information about any non-verbal cues from the participants, anything about the setting or questioning that impacted on the interview. Other points of interest were written up at the end of the interview and reviewed as part of the analysis for each interview and set. For the interviews, this mostly contained notes about how some participants had reacted to the questions as one participant was very vocal about the sequence of the questions and it was interesting for me to reflect on what that reaction had meant in the context of the discussion. How some participants had reacted to certain questions seeking confirmation of confidentiality etc. In terms of the focus groups it was interesting to note how the participants reacted to each other and the dynamics present when interviewing them as a group as oppose to individuals. These notes were kept with the transcripts of the interviews and utilized as part of the analysis as they form part of the data to code (Charmaz, 2014).

4.3.3 Recording interviews

I chose to record the individual interviews and the focus groups because I felt that without doing this I would not be able to capture the conversation within the groups. It was quite clear that if I did not capture the conversation, that this would adversely affect what data I had to code (Charmaz, 2014).

A digital recorder was used throughout the study. Ensuring the use of high quality equipment is essential to ensure adequate quality transcription as is making sure that the location is suitable (Mero-Jaffe, 2011) this was managed in all interviews so that the surroundings did not impede on the data collected.

Some grounded theorists including Glaser suggest using notes to record the interview with as oppose to transcribing and recording interviews, however, this has been

disputed as the interviewer may not remember sufficient information (Charmaz, 2014). Recording the interviews was very beneficial as it allowed me to be more aware of being in the interview/focus group and of the participants and capture additional information through note taking as mentioned above and be reflective after the interview when writing the notes.

4.3.4 Transcription

Transcription is the transfer of speech to the written word (Mero-Jaffe, 2011). It is a technique frequently used in qualitative research (Oliver et al, 2005; Bryman, 2008).

How the researcher transcribes the interviews is more than just a technical matter. This process is fundamental to the theoretical assumptions inherent in the research (Silverman, 2011). That is to say how you undertake transcription should reflect the research questions and objectives of the study (Oliver et al, 2005). In addition, using transcription provides a full response to all that has been said and avoids the potential of missing any relevant information and can result in a deeper understanding of the data. *"Coding full interview transcriptions gives you ideas and understandings that you otherwise miss"* (Charmaz, 2014, p. 136).

Transcription has been described as naturalized and denaturalized. Naturalised transcription is focused on capturing the exact details of what has been said and how. Denaturalised does not focus on the detail. Instead the focus is on the "*meanings and perceptions created and shared during an interview*" (Oliver et al, 2005, p. 1227; Mero-Jaffe, 2011). In practice, "*most researchers use a combination of both methods"* (Oliver et al, 2005; Mero-Jaffe, 2011, p. 232). Four "*factors that may influence the quality of a transcript"* have been identified by Mero-Jaffe (2011, p. 232): as the researcher, the interviewer, the transcriber and the interviewee. Therefore, I reflected on these four points to be aware of how I might have influenced and or impacted on the transcriptions as discussed below.

As I transcribed the interview I reflected at length on how to represent the data through transcription. Initially I was very keen to make sure that all voices were heard accurately. I reflected on this, discussed this challenge with my supervisors and I considered the methodology of constructivist grounded theory. I gradually realized that the essence of what I was doing was to construct meaning from what I was being told in the interviews. I did not need to describe what was said word for word; hence the choice of denaturalized transcription became a natural or automatic choice (Oliver et al, 2005). This fits with the methodology as grounded theorists "*code for possibilities suggested by the data, rather than coding for absolute accuracy"* (Silverman, 2011; Charmaz, 2014, p. 120).

The data in this study is presented in a denaturalized format (Oliver et al, 2005). This fits more closely with the constructionist approach adopted in the methodology. This format also maintained confidentiality because several of the participants in the Trust where the research was undertaken had very defined accents. These accents were lost by denaturalized transcription and this obscured the location of the Trust. Moreover, a number of colloquialisms were spoken and these interfered with the flow of the interview. I had to clarify the exact meanings of some colloquialisms.

For the transcripts of the focus groups, individual voices were identified and noted by the transcriber and overlapping conversations were noted for review. These points have been identified as having the potential to undermine the quality of the transcription (Mero-Jaffe, 2011) but these potential issues were managed because I reviewed all transcripts.

I moved employment whilst undertaking the study, and so it was not possible to use the same transcriber for all the interviews. Therefore, I completed the transcription of one focus group and two interviews. I decided to use a professional for most interviews as the amount of time taken to transcribe the interviews was substantial. This helped particularly in sets 1 and 2 as it speeded up the timeframe for me to receive the transcriptions to analyse the data before conducting the next set of interviews.

It was decided to keep two versions of the interviews, something many qualitative researchers do. The first version was the naturalized version with all the colloquialisms and dialect. This was used as a reference when reviewing the data. The second version was denaturalized (Oliver et al, 2005). This had all the colloquialisms removed and it was a copy of this that was sent out to each participant in the study for their review and comments to check that they agreed with the interview content.

Sending transcripts to participants is recognized as ethical because it is thought to reinforce informed consent. It offers participants a choice when they read the transcript and it empowers them to review what it is they have said and how they feel about that (Della Noce, 2006; Mero-Jaffe, 2011).

It was decided to send the denaturalised transcripts back to the participants not to validate the scripts, but instead to give them a chance to add anything or highlight something they were not comfortable with (Saevareid & Balandin, 2011). It was felt that this offered another way of seeing what was important to them from the interview process. This view is endorsed by Witcher (2010). As this is an interpretive study there is no requirement or desire to gain approval as this is my interpretation (Wertz et al, 2011; Charmaz, 2014).

In addition to the above benefits, by sharing the transcript with the participants it was felt that it reinforced the trust the participants had shared. The sharing of the transcript demonstrated the respect of confidentiality and this view was supported by the email responses received. Participants expressed how much they had enjoyed the interview and that they were looking forward to seeing the outcomes.

Only one of seventeen participants asked for amendments to be made to the transcript of their interview. This was of particular interest because this was the only participant who had stated at the start of the interview that they were not concerned about a

transcription of the interview because, '*they wouldn't say anything they didn't want to be used*'. The transcript was modified slightly in response to the comments.

4. Analysis of data

4.5.1 Coding

Coding is central to grounded theory. It is the beginning of the generation of the theory (Charmaz, 2014). It entails reviewing and questioning the data, to define what is seen in the data. From here interpretations are made from the data by myself as the researcher to explain what it means (Charmaz, 2014; Giles et al, 2016a). This is done by labelling component parts that appear to be theoretically significant (Bryman, 2008) and notable for participants of the study (Bowling, 1999).

In grounded theory coding permits study of actions, processes and meanings in the data by breaking it up into their properties or components and this goes on to define the actions that shape or support the data. It is recognised that codes are constructed by the researcher and therefore, this takes into account their previous experience and knowledge (Wertz et al, 2011; Emmel, 2013; Charmaz, 2014; Giles et al, 2016a). Theoretical coding allows the development of the data into categories to help clarify and identify the relationship between each category (Kan & Parry, 2004; Attree, 2007).

The coding process is interactive by constantly interacting with participants through the data collection, exploring participants' views and actions from their perspectives through the data, including tacit meanings (Charmaz, 2014; Giles et al, 2016a).

Charmaz (2014, p. 245) recommends the use of gerunds for coding. A gerund is defined as" *the noun form of a verb e.g. writing."* Charmaz believes that the use of gerunds builds action into the codes and this is in turn, then allows processes to be seen. This conveys a sense of action and keeps the researcher familiar with the data.

For this study, coding was undertaken in line with Charmaz's (2014) description. This was adapted from Glaser and Strauss (1967). Coding this way comprises two phases; initial and focused.

Initial coding is very detailed. It may involve coding line by line, naming each word or segmentation of data (Morberg et al, 2009; Charmaz, 2014; Giles et al, 2016a). It is aimed at describing and accurately reflecting the transcribed data (Bryman, 2008). This is followed by a focused, selective phase which identifies a more conceptual approach to the data (Morberg et al, 2009).

4.5.2 Initial Coding

Initial, line-by-line coding (using gerunds) and analysis of each transcript was completed after each interview. A label was allocated to each piece of the data that identified and summarized what the data was saying (Charmaz, 2014; Giles et al, 2016a). I used the framework suggested by Charmaz (2014) when coding that of a table that identifies interview statements and initial codes (see Table 4.4 for an example). Open coding was utilised which required me to remain open to all possible theoretical directions. It precluded the use of pre-conceived ideas which might drive the analysis and force the data into codes from existing theories (Charmaz 2006; Saevareid & Balandin, 2011; Giles et al, 2016a). Clearly though, what I found in the data reflected to some degree my own perspectives (Charmaz, 2014). This is why reflexivity is so important.

I reflected on my prior perspectives by writing memos as just one way of looking at the phenomenon. This ensured the development of concepts from the data, not from my own ideas. These concepts were later turned into categories (Bryman, 2008; Bondas, 2009). Being reflexive allowed me to explore how the participants constructed meanings and why they acted as they did and consider what assumptions these were based on (Charmaz, 2006; Hallberg, 2006). Whilst doing this it was crucial to be aware that these were the views of the participants realities not necessarily mine and that I

and them do not necessarily have the same world views (Charmaz, 2012; Giles et al, 2016a).

Theoretical sensitivity is a concept used in grounded theory. It reflects how a researcher can "*engage with data based on their previous"* personal and professional experiences. It also reflects how the researcher can use, but not impose, his/her methodological knowledge and "*experience and awareness"* of the phenomenon "*being examined"* (Strauss & Corbin, p. 44; 1990, Parry, 1998; Charmaz, 2014). As a constructivist grounded theorist, I am acutely aware that my "*standpoints and starting points"* influence how I see the data and what I see in them (Charmaz, 2011 & 2012, p. 4). This became apparent when I started initial coding and I was reflexive to consider my interaction with the participants and the subsequent analysis of the results that I constructed (Hallberg, 2006).

The codes that emerged from the first set of interviews and focus group were for example: *role modeling; working with others* and *using the right expertise.* As I progressed with line by line coding, as the data was reviewed further in terms of the meanings and actions it conveyed, some of the initial codes changed. This was due in part to comparing data with data taken from across the interviews (Charmaz, 2014; Giles et al, 2016a). Table 4.4 provides an example of how initial codes were developed from analysing the data.

Using gerunds proved to be a good way of looking at actions from the participants' view in the data and emerging processes. The codes that were used initially helped to separate data into tentative categories. This revealed the "*processes and actions in the data"*. As is recommended in grounded theory data was collected along with coding and analysed simultaneously (Charmaz, 2014; Giles et al, 2016a. p. E32).

Table 4.4 Excerpt from interview 1 This provides an example of line by line coding

Interview excerpt - Interview 1 - Group 2	Initial codes
KJS: So, that was an interesting point around formal and informal leadership, how would you differentiate between the two for you, what does that mean for you?	Asking for clarification between informal and formal leadership.
Interview 1: I think for me informal is almost like that you carry out that leadership role with your colleagues, it's like a natural participation, you often see it and find it in teams where there's a member of the team who seems to be the organiser and a bit more "we'll get the information and feed back to the team and look forward at things and new initiatives" I think that comes from passion and motivation around the role and what they do and seem to show those qualities but haven't got that title, for me that's where I'm talking about informal. I suppose the difference I have with the formal is that you've got this person who has been placed into that position, that is their role to do they have to lead on certain agenda, certain criteria, certain policies and procedures, that type of thing so when I talk about formal leadership it's somebody I suppose you have to answer to or go to or be guided by.	Informal a natural process participation with colleagues in teams Describing team roles e.g. organiser Informal leadership describing qualities: passion and motivation not got a formal leadership title. Formal person placed in the position, they are leading and guiding others.

The initial codes derived from the first set of interviews were compared. Then, initial coding continued for the second set of interviews. Not all interviews in the second set were coded line by line because it was felt that by interview 7 in set 2, the codes being used were sufficiently focused that this was not required.

It is advised, (Charmaz, 2012), that line by line coding is only used until the researcher has codes that they wish to explore further. The view is that then it is important to see the codes one has found can explain further data.

In later interviews, it is envisaged that the investigator shapes the questions to focus more on learning about these codes (Charmaz, 2012). By comparing the data as I progressed through the series of interviews, allowed clearer definition of which facets of leadership the participants found most problematic. It was then straightforward to allow this data to be analysed first as initial codes and then with more focused codes (Charmaz, 2014). After analyzing the data from interview set 1, processes had begun to emerge and areas for further exploration had arisen from the initial set of questions. These demanded further scrutiny in interview set 2. I amended some codes as required at a later stage to ensure they reflected the "*actions and meanings"* of the participants (Charmaz, 2012, p. 5; Giles et al, 2016a).

As a health visitor myself, I reflected throughout the study upon how I thought health visitors understood leadership from my personal experience as a health visitor by writing memos about incidents as they arose. Rather than ignoring my own experience, I did as Charmaz (2014) recommends and recognized my experience and used it to question the data and the participants. One of the initial questions I asked participants was, 'How did health visitors understand management and leadership?' In my experience, these are often confused. However, the data from the early interviews did not declare this, nor was it apparently an issue for the participants. I recorded my experience on a memo and this helped me reflect that this was my experience and yet it wasn't highlighted as a key problem by participants in this study.

I was aware of the need to keep the codes close to the data, with this in mind codes were used that explained how participants put into practice leadership or responded to external stimuli e.g. changes in government policies. For example, Group 1 had very emotive reactions to how they were communicated with by senior managers about changes. They felt that the method of communication affected how they perceived the managers as leaders. It also influenced how they saw themselves and their own identity in the context of their work (Charmaz, 2014; Giles et al, 2016a).

Through "*line- by- line- coding significant actions and processes"* can be identified as well as identifying the role of participants "*within these processes and their beliefs"* about them (Charmaz, 2014; Giles et al, 2016a, p. E34). As the analysis developed I found this to be the case in that I changed several initial codes to focused codes later in the analysis. For example, the initial code in table 4.4 relating to informal leadership qualities became the focused code attributes. This was done because it was apparent that attributes of a leader which linked to the social process of role modelling based on relationships was really important to the participants and their beliefs about what constitutes leadership. This focused code then became part of the sub category role modelling within the category leadership behaviour.

As a consequence of considering raising the initial code to a focused code this also made me think about the data I wanted to collect in future interviews to ensure this code and the developing sub-category was supported by the data (Charmaz, 2014; Giles et al, 2016a).

4.5.3 Focussed Coding

Initial coding was followed by focused coding which is the process of seeking codes that allow identification and development of the most salient codes which can then be tested against new data as the study progresses (Giles et al, 2016a). The salient codes were decided by looking at those focused codes that captured the information from the line by line coding and in doing so clustered the action and processes that appeared most important from the data during analysis. I examined interview transcripts looking for "*incidents in the data where processes/actions"* that were pertinent to leadership were evident (Charmaz 2006; Saevareid & Balandin, 2011, p. 1742; Charmaz, 2014).

The use of focused coding allowed sifting, synthesizing and analyzing of substantial data (Charmaz, 2014; Giles et al, 2016a). The important points that were found in the emerging analysis were highlighted by focused codes and the theoretical direction of the study was advanced. Thus, I began to see the relationships between and patterns

within the categories (Charmaz, 2014). A key purpose of focused coding is to determine the strength of the initial codes and consider them in terms of developing the categories (Charmaz, 2014).

Although focused coding has been described as seamless (Charmaz, 2014) in this study it was found to be difficult, probably because of the large volume of initial codes and the substantial amount of data. It took a long time to finalise the focused codes. There is little guidance on coding and few examples of how to use focused codes when building the analysis (Wertz et al, 2011). By constantly comparing the data with the focused codes, the codes were changed several times as part of the analysis. Thus, the codes used for focussed coding evolved from the initial codes and became more conceptual and selective (Charmaz, 2014; Giles et al, 2016a). See Table 4.5 for examples of focused codes developed from initial codes.

Table 4.5 Focused codes developed from initial codes (title adapted from Giles et al, 2016a).

Initial code (selected examples)	Focused code (selected examples)
Same vision, giving direction, gather the troops	Taking things forward
Challenge is good, give and take process, do as your told	Right to reply
Informal and formal leadership role as a nurse, leadership dependent on professional background, leadership crucial to the role	Professional behaviour
Part of the Healthy Child Programme, change in role, feeling saturated by change	Governed by policies above
Dog being wagged by somebody else's tail, roles and responsibilities, them and us	Professional boundaries
Right to decide, our responsibility, being allowed	Autonomy to make decisions
All involved in it, opportunity to be leaders, capacity to be leaders	Two-way process

Whilst the focused codes were being developed a decision had to be made about which initial codes "*made greatest analytic sense to categorize the data incisively and completely"* (Charmaz, 2014; Giles et al, 2016a, pgs. E34-E35). This was achieved through discussion with my supervision team using "*theoretical sensitivity and reflexivity"* (Charmaz, 2012; Giles et al, 2016a, p. E34).

By the end of set 1 the categories were only poorly developed. Their eventual form only crystallized as the interviews of set 2 were analysed. The questions in interviews for set 2 were refocused slightly because although the categories by then were not fully clear, impressions had been formed of what they might be. Thus, it was possible to explore these issues in the interviews of set 2. For example, it was becoming clear that professional background was a social process which helped health visitors to understand and define leadership.

Using theoretical sampling, to build categories meant refocusing questions for use later. This was found to be an almost intuitive process and valuable to develop the focused codes to sub categories and then categories. Charmaz, (2006) advocates the benefits of the early analysis of the initial interviews as a way of helping to focus further data collection.

4.5.4 Constant comparative analysis

The constant comparative approach is considered to be a definitive part of using the grounded theory methodology to analyse data (Hallberg, 2006; Charmaz, 2014). This involves an "*iterative interplay between data collection, data analysis and conceptualising theory"* (Parry, 1998, p. 89). In essence, this means that the researcher constantly gathers, compares and contrasts data looking for similarities and differences to develop initial codes and analytic distinctions (Parry, 1998; Attree, 2007; Currie et al, 2007b; Charmaz, 2014; Giles et al, 2016a). Using this approach maintained a close connection between the data and the concepts and subsequently the categories (Bryman, 2008) during each stage of the analysis (Parry, 1998).

The "*initial focus of constant comparison on observable incidents, such as a particular behaviour",* ensured that ample data was collected to "*be coded. From these codes, memos describing theoretical concepts were written. When elaborated"*, these memos allowed "*theoretical sampling of individuals and groups"* (Emmel, 2013, p. 15) leading ultimately to the development of a core category (Coyne, 1997). Questions that arose from the interviewing and analysing processes that deserved further inquiry were explored using memos. These memos captured the emerging thoughts, posed questions about the codes and comparisons, and permitted any other ideas about the data (Morberg et al, 2009; Mahmoudirad et al, 2009; Charmaz, 2011).

I followed the constant comparative methods described by Charmaz (2014, p. 132). Starting with "*comparing data with data to find similarities and differences,"* as advised this begins with comparing incidents within the same interview and then across other interviews, looking specifically at comparing "*process, actions and beliefs"* through developing initial then focused codes. I had to consider my own beliefs about leadership whilst undertaking coding to ensure that I wasn't imposing my views onto the coding. Charmaz advises doing this by seeing your own views as just that i.e. "*one view among many*." I then was able to compare *"codes with codes"* (Charmaz, 2014, p. 140) recognising that the meaning I give to the code is part of my involvement in the analysis process. Through constant comparison the emerging sub categories were compared with each other and through writing memos categories were compared with categories.

By studying the data, developing and comparing the codes and writing memos, ideas were defined that fitted and interpreted the data as tentative analytic categories. "*The basic elements of a grounded theory include conceptual categories and their conceptual properties,"* and the relations between them (Lansisalmi et al, 2006, p. 20; Charmaz, 2014). The category thus represents the real-world phenomena (Bryman, 2008). When questions arose and gaps in the categories appeared, more data was collected and analysis of that addressed these questions to fill the gaps (Charmaz, 2011). Thus,

additional data is gathered to check and refine the emerging categories (Charmaz, 2011) and conceptual framework (Emmel, 2013).

As has been recognised in grounded theory studies this took time (Bryman, 2008). Coding is a significant undertaking (Alvesson & Skoldberg, 2009) and theoretical sampling takes time (Lansisalmi et al, 2006). From the very start, comparison of data made it extremely clear what themes were emerging and which themes needed further exploration to refine the coding and the categories. Initially interview 1 was compared with interview 2 and emerging themes recorded on sticky notes which were placed on a flip chart. The initial codes were too broad and too numerous and so the process was reviewed and it was decided to compare the initial codes across the first set of interviews and to translate these codes directly to themes on the flip chart.

Giles et al (2016a) demonstrated in their paper explaining the data analysis phase of a grounded theory study how through the use of the constant comparison method they could demonstrate the same process experienced by different participants. I used this way of displaying the information from my own study as a way of showing the development of the codes from initial to focused.

Table 4.6 Excerpts from the interviews to show the use of the constant comparison technique to identify the same process across the participants (adapted from Giles et al, 2016a)

Excerpt (selected examples)	Initial code	Focused code
Well we all have to have the same vision haven't we or it doesn't work. I think you've got to understand it as well I think it's important (Group 1, interview 10).	Same vision	Taking vision forward
I suppose visually you think higher, don't you first of all then it's things that come to mind like championing, spearheading, taking forward, and I think when I say high its actually	Taking forward, driving forward, visionary	Taking vision forward

not about seniority its high in terms of driving forward, being upfront rather than senior in terms of management. So, I suppose visionary, a shining example so role modelling would come into it as well (Group 3, interview 6).		
Yes, leadership is about creating a vision and getting the best out of people, people realising their potential. You have to connect with their motivation and what motivates people and those three things autonomy, mastery and purpose usually are what motivate people (Group 3, interview 8).	Creating a vision	Taking vision forward
I think that's very important for leaders within health visiting, how to look at your vision, what that might be, look at your goals and what you might want to achieve so goal setting.... Looking at different cultures and how that may prevent or aid you in going forward within what you want to achieve. Looking at everything around you so national policies and how you can link what you might want to do with that sense of direction which gives you the levers to drive things forward realising that you're not alone in this big sea of mess (Group 3, interview 9).	Driving forward, vision	Taking vision forward

4.5.5 Memo writing

Writing memos is a crucial component of research using grounded theory (Charmaz, 2014; Giles et al, 2016a), it reminds the researcher to analyse the components of the data and codes early in the research process. Codes stand out and begin to form categories as memos accumulate. This clarifies the whole of the phenomenon by looking at the specifics i.e. the whole is therefore, greater than the sum of its parts (Charmaz, 2011 & 2014). Memos were written throughout the coding process to reflect the data and to help analyse ideas generated from the data. I used memos as a way of capturing

thoughts and as a way of reflecting on each interview. This facilitated the reflexive process of considering my effect on the interview and subsequently how I interpreted and analysed the data. They also helped to highlight comparisons and connections between the data and to start the analysis (Charmaz, 2014; Giles et al, 2016a).

I used memos to help me make the link between focussed codes, sub categories and categories and to track how they emerged. I also found doing this in conjunction with diagramming really helpful to see the connections. The memos then become a way of reviewing decisions made about the data and ultimately supported the construction of the conceptual framework (Strauss & Corbin, 1990; Charmaz, 2014; Giles et al, 2016a).

Diagramming has been used by Strauss and Corbin, (1990, p. 197) as a way of providing a "*visual representation of relationships between concepts."* I used diagramming as a way of capturing the connections between early focused codes and then sub categories and categories as a way of seeing the emerging conceptual framework.

Table 4.7 Memo excerpt on connections between focused codes safe to follow and two-way process and the relationship to the sub- category followership and the category purpose of leadership

Purpose of leadership
I previously thought that feeling safe and the value participants put on this would affect the extent to which they would be prepared to take on leadership and see it as a two-way process. I also thought that this feeling would value the influence that they have when undertaking leadership activities. For example, Group 1 interview 10 valued taking on leadership as part of the team to pilot a new initiative where initially two members lead the initiative and the rest of the team followed then as they had chance to see it in action and ask questions and feel safe in the context of knowing what they were doing and what the initiative was about, as a consequence the leadership passed amongst the team as some of the followers then took on the role as leader. Therefore, although barriers were present in the same way other participants had mentioned the new initiative was put in place by the team because they were engaged in the process of having a clear purpose of leadership, and were clear on their role of follower, and then when they felt safe they then could be the leader.

Through the process of writing memos, it really helped me to establish which were the important initial codes that needed raising to a focused code and which focused codes were pertinent to the emerging sub category/category. Table 4.7 provides an example of the focused code safe to follow. This code was developed to explain a "*recurring process"* (Giles et al, 2016a, p. E37) emerging from the first 2 interviews (see below) which I identified as being important to the participants and helped to explain what they believed to be good leadership. Through theoretical sampling I was able to explore this focused code further and establish it within the sub-category *followership*.

> *...I mean we all face sort of tough times don't we and tough decisions and pressures and things but when you speak to someone that is clearly a good leader and they sort of almost like you say there is prioritisation and it makes you feel much more safe and reassured that you are doing everything that you should be doing it then fills you with that motivation again that you know things are okay yes and that you can fulfil what you need to fulfil in your role (Group 1, interview 10).*

> *...if there's a natural leader or some leadership going off within their team or within a service and people are happy that they have some good leadership and they feel safe in what they're doing, and its evidence based then that's a good relationship because they're following a good model of practice (Group 2, interview 1).*

Charmaz (2014) discusses the use of early and advanced memos and differentiates between the two only in so much as the amount of data and codes is less at the start of the study as oppose to later on in the study.

4.6 Category development

Initially, line by line coding identified themes that emerged from initial interviews and analysis; these were then raised to focused codes if sufficiently grounded in the data

(Charmaz, 2011). For example, *health visitor identity* became apparent through initial coding and then moved to a focused code that had several different parts to it these were *lack of role clarity, no leadership identity, changing role, lack of goals/ objectives and lack of leadership skills.* These different elements were refined through further focused coding, by exploring what these codes contained and building the properties of the code until finally through the process of collecting further data the focused codes became the sub category identity.

The sub category *identity* was then reviewed with other emerging subcategories constructed from the data and analysis; e.g. *role modelling and developing leadership,* to form the category *leadership behaviour,* which is discussed as a process developed from participants' experiences in Chapter 7.

Focused codes *"with similar meaning were grouped together"* (Saevareid & Balandin, 2011, p. 1742). For example, these codes included *professional background* and *professional boundaries,* and this led to the sub category professionalism part of the *context of leadership* category. Charmaz (2012, p. 8) advises that a code "*treated as a tentative category must account for other data as well".* This was considered when constructing the categories by "*grouping together"* subcategories. The properties of each category, and how they relate to each other, were considered as each category arose. This process was repeated by looking at the sub categories in each of the three categories (Saevareid & Balandin, 2011, p. 1742). As the categories emerged the "*basic social process,"* also referred to as *"the core or theoretical concept,"* emerged. This core category (concept) was *making a difference.* Thus, the conceptual framework emerged as the relationships between the categories and core category were considered (Charmaz, 1990; Parry, 1998, p. 89). This was facilitated by the use of diagramming (Charmaz, 2014).

The categories in Table 4.8 all impacted on the research question how health visitors understand leadership.

Table 4.8 Summary of categories and subcategories

Context of leadership	**Purpose of Leadership**	**Leadership Behaviour**
Professionalism	Setting the direction	Role modelling
Organisational Change	Followership	Identity
		Developing Leadership

4.6.1 Core category and theory development

The core category is the basis of the conceptual framework and the subject of the theory grounded in the data (Parry, 1998; Charmaz, 2014).

The term *developing practice* was initially used as a core category because it seemed to encapsulate the overarching reason why health visitors undertook leadership. Later it was realized that the term that kept emerging from the data was that of *making a difference*. This is a very familiar term in health visiting. *Making a difference* had been recognised as a focused code because it had been mentioned several times in defining the purpose of leadership. However, it had seemed too generic and not specific enough to denote what was meant in relation to the other categories. *Making a difference* was also a phrase that I was aware of using a lot myself. It is a phrase that is used frequently in health care to explain why health professionals do the roles they do (Maben & Griffiths, 2008). I was conscious of not using the term making a difference as the core category purely because it is so familiar to me.

I discussed with my supervision team the core category and used diagrams and memos to review the data to ensure this was the term that best captured the main process i.e. *making a difference* (Parry, 1998). I then reviewed the subcategories against the core category to make sure there was a fit driven by the data (Charmaz, 2014).

Table 4.9 Development of the Core Category—Making a Difference

Focused Codes	Subcategory	Category	Core Category
1.Professional Background	1.Professionalism	1.Context of leadership	Making a Difference
2.Professional Boundaries			
1. Governed by policies above	2.Organisational Change		
2.Health Visiting Model of Practice			
3. Team Leadership			
1. Engagement in change	1. Setting the Direction	2.Purpose of Leadership	
2. Taking the vision forward			
1. Influencing	2. Followership		
2. Two-way process			
3. Safe to follow			
4. Right to reply			
1. Impact on staff/clients	1. Role modelling	3. Leadership Behaviour	
2. Attributes			
1. Health visiting leadership identity	2. Identity		
2. Autonomy to make decisions			
1. Leadership skills	3.Developing Leadership		
2. Leadership training			

Whittaker et al, (2013) had looked at retention of health visitors. Their work had identified *making a difference* as a term that captured the health visitors' professional ideology and identity. This piece of work led to a re-evaluation of each of the categories that had been developed and a reconsideration of and how this way of expressing professional ideology and identity related to the findings from the data. This is discussed further (Chapter 8) in relation to how professional ideology and identity has been used to strengthen the conceptual framework.

After the emergence of a conceptual framework, which provides "*an abstract understanding of the data,"* had been developed through finalising the core category the literature was reviewed. This enabled the conceptual framework to be situated within the existing literature and demonstrate how it built on existing knowledge (Charmaz, 2014; Giles et al, 2016a, p. E42).

The conceptual framework accounted for the health visitors' behaviour when they were engaging in leadership. *Making a difference,* the core category, "*explained the major process at work when"* health visitors were involved in leadership. Table 4.9 identifies how the core category emerged from focused codes, to subcategories, and then to categories and explains the relationship between the core category and the three categories (Giles et al, 2016a, p. E42).

Charmaz (2012, p. 3) advises "*that grounded theorists' claims to constructing theory might be a little over-stated although; using grounded theory fosters giving work an analytic edge*." It is acknowledged that much work claimed to be grounded theory is in fact descriptive in nature (Emmel, 2013). Charmaz (2012) goes onto say that what constitutes "*theory has neither been agreed upon nor codified".* She recommends using strategies that work for the investigator and for the study, whilst always remaining aware of what is done and what is claimed (Charmaz, 2012, p3). Although initially looking at developing a substantive theory which is usual in grounded theory (Charmaz, 2014). I decided, in discussion with my supervision team, that what would be most beneficial for health visitors would be the construction of a conceptual framework that can be used to explain the phenomenon and be used in practice as one way of articulating how health visitors undertake leadership. This is discussed further in Chapters 8 and 9.

The conceptual framework of *making a difference*: has been constructed to explain how health visitors understand leadership through their professional ideology (Whittaker et al, 2013). The conceptual framework identifies the meanings and actions constructed from the participants' experiences. It also explains the major social processes that are

evident when health visitors undertake leadership. M*aking a difference,* the core category depicts the main process (Parry, 1998; Giles et al, 2016a).

For this research purposive and theoretical sampling proved to be a very effective way of collecting the data. The findings are not generalizable in a positivistic sense however, this was not the purpose of the study. Instead I wanted to seek an understanding through a sample that would ensure sufficient possible variations of opinions and perceptions are captured from the participants about the phenomenon. This I feel was achieved.

I achieved theoretical saturation after interviewing 17 participants selected by purposive and theoretical sampling for the purpose of this study. This study focused on how health visitors understand leadership. No claim is made that this conceptual framework will work in settings other than the community within which health visitors' work. No claim is made that this conceptual framework might extrapolate to other professional groups (Emmel, 2013).

I found the use of purposive and theoretical sampling appropriate. In that it allowed me, through the three different groups, to recruit enough participants with the right experience to inform the phenomenon under study. Everybody interviewed, and, in the focus, groups had pertinent experience to share from different viewpoints that contributed to the co-construction of the conceptual framework.

4.6.2 Emerging conceptual framework

The following categories were developed from the data analysis and they were then raised to concepts within the conceptual framework (Charmaz, 2014).

- *context of leadership,*
- *purpose of leadership,*
- *leadership behaviour.*

Chapter 5 discusses *context of leadership*. This examines how the context in which health visitors lead and practice and being part of a profession shapes their leadership role. Central to this is the effect of health visitors' external identity and how they are viewed by the changing role they undertake, directed by health policy. It appears that much of their understanding of leadership is developed primarily as part of their developing role as a health visitor not as a separate entity. The core category *making a difference* helps health visitors in understanding their identity as a professional working in a multi professional environment.

Chapter 6 discusses *purpose of leadership*. This category describes how health visitors understand the purpose of leadership in relation to the work that they do, their role and how they would like the direction to develop from a strategic and operational perspective. The role of the health visitor as leader and follower is important to how leadership is enacted. The core category *making a difference* helps health visitors have a clear purpose of what they are leading. It appears that avoiding ambiguity is crucial to this. It supports health visitors by giving them input into decision-making and taking responsibility and accountability for their work and anything they are leading.

Chapter 7 discusses *leadership behaviour. This category* describes how health visitors value role modelling to develop as a leader and to undertake leadership. The core category *making a difference* helps health visitors understand the skills that are required to lead. It seems to help them understand the importance of being confident when leading. Central to this category is the effect of health visitor's identity looking at how they see themselves both as a professional and as a leader and how this impacts on the leadership behaviour they display.

Chapter 8 discusses the conceptual framework of *making a difference* constructed from the data and analysis*. Making a difference* provides an understanding of leadership and what being a leader means for health visitors. It suggests a different way of working that involves identity reformulation for the health visitors to see themselves not just as

professionals but also as leaders and to be able to clearly articulate their role as a leader and how they are involved in leadership.

4.8 Chapter summary

This chapter explains how the methodology has been implemented to undertake the study. This includes a discussion on the selection and recruitment of the 17 participants, an overview of the interview process and the organisation of the interviews and data construction has been presented.

How the data was analysed and the development of subcategories and categories has been discussed to show the emerging conceptual framework. The findings that make up these categories are discussed in the next three chapters. After development of *context of leadership, purpose of leadership and leadership behaviour* were developed and analysed and the core category of *making a difference* had emerged, the existing literature was reviewed to support and situate the findings. This allowed the conceptual framework to develop further and is discussed in more detail in Chapter 8 and how this is situated in existing theories.

Chapter Five

5. Context of leadership

5.1 Introduction

The previous chapter identified *context of leadership* as a main category arising from the data. This chapter presents the findings that led to the development of the category, *context of leadership,* by exploring the properties of the subcategories; *professionalism and organisational change* that make up the category as it developed from focused coding. This chapter shows how the context of leadership is a process that is central to the health visitors' leadership role, and impacts on the activities they undertake.

It is suggested that leadership is situated in specific contexts, which help to explain what it means (Parry et al, 2014). It is therefore, hard to separate the context of leadership from the historical and social surroundings that exist in the situation where leadership occurs (Drath et al, 2008). Thus, being able to understand the situation in which leadership exists i.e. the social context, is central to many leadership definitions (Degeling & Carr, 2004; Avolio & Gardner, 2005) as the context frames the processes and consequences of leadership within organisations (Hartley et al, 2008). "*The social context of organisations is often intense, dynamic, multifaceted, ambiguous, information-rich and communication-dependent"* (Day et al, 2006, p. 213). Therefore, how individuals relate to each other within organisations can only be understood by being aware of the social contexts within which they work and lead (Day & Harrison, 2007).

Different leadership approaches have discussed the importance of context for the occurrence of leadership such as situational, contingency and system approaches to leadership (Drath et al, 2008). Recognising the situation and social context that exists within the health visiting service, and how health visitors interact with both the context

and each other, is thus key to understanding how they view leadership in the work place and how they can influence the context that they work in.

As part of the HVIP (DH, 2011) three pieces of research were commissioned by the DH "*to inform and support the implementation of the new service organisation and to provide useful input for further development in health policy and practice"* (Donetto et al, 2013, p. 5). These included a scoping study and narrative review of the literature "Why health visiting?" (Cowley et al, 2013) an empirical study about service users' views and experience of the health visiting service (Donetto et al, 2013) and a study which examined the recruitment and retention of health visitors (Whittaker et al, 2013). These three reports published in 2013 were utilised as the main health visiting documents from which to support the development of the categories, after the conceptual framework had been developed.

The properties and dimensions of this category are represented in Table 5.1.

Table 5.1 Subcategory components: Context of leadership.

Focused Codes	**Subcategory**	**Category**
1. Professional Background	1.Professionalism	1.Context of leadership
2. Professional Boundaries		
1. Governed by policies from above	2.Organisational Change	
2.Health Visiting Model of Practice		
3. Team Leadership		

5.2 Professionalism

Professionalism puts the knowledge base into practice; it is defined as a set of components: understanding professional roles and norms, working with others, managing oneself and contribution (Garman, 2006, p. 219).

Health visitors are considered to be highly skilled professionals (DH, 2011; Malone, Whittaker, Cowley, Ezhova, & Maben, 2016). In the health visiting literature several models of professional practice are identified, based on the relationship between the health visitor and the client (Elkan, Blair & Robinson, 2000). The "Why Health Visiting?" Report (Cowley et al, 2013, p. 12) introduced the term health visitor "orientation to practice". It is believed that "orientation to practice" "*influences the way health visitors work in any situation and how three core practices underpinning this phrase operate together at this level: 1) the health visitor-client relationship, 2) the health visitor home visiting and 3) the health visitor needs assessment*." In addition, Donetto et al, (2013, p. 12) suggests that "*health visiting support outside the home can be seen to represent a fourth core practice that complements and supports the existing triad."*

These four elements describe the ideology and professional concept of health visiting practice; where it occurs; its core values, beliefs and relationships underpinning the role (Cowley et al, 2013, Whittaker et al, 2013). This ideology is underpinned by the four Practice Principles of Health Visiting (CETHV, 1977) embedded in the NMC (2004) Standards for SCPHN (Health Visiting) that is then combined with the "four tier" service delivery model developed as part of the HVIP (DH, 2010c & 2011) to form an overarching framework of practice for health visitors.

This section presents the findings of the study around the participants' experiences of the effect that their role has upon their professionalism and leadership. This section also looks at the concerns that health visitors have over lack of clarity of the context of their role: where and what it is they are actually leading. This is discussed under the headings *professional background and professional boundaries.*

5.2.1 Professional background

In the interviews and focus groups, participants discussed their experience of leaders and leadership. Leadership was considered to be crucial to the role of the health visitor by all participants. The ability to lead had evolved for all participants over their

professional career from nurse to health visitor, reflecting the values, beliefs and relationships inherent within the profession, this way of developing leadership is supported in the literature (Lorentzon & Bryant, 1997; Maben & Griffiths, 2008).

> *I think leadership is instilled in you from nurse training isn't it because you know we all go through the ranks and your staff nurse, senior sister, charge nurses learning leadership skills all the time, because you are left in charge of a ward. It doesn't come as a shock when you go into health visiting as you've done it, you've done the rudiments leading up to that because you're instilled in it, like at home, it's just a natural process (Group 1, interview 1).*

Here we have a view of leadership as something that you build up to through professional experience as the example above provides a trajectory from junior to senior roles. It is also considered a natural process. I wondered why if it was a natural process it appeared so hard to define and articulate (Yukl, 2013). Further interviews supported the notion that leadership is something that was seen as inherent to the role and something that you acquired as part of doing the professional role. It was recognised by some participants that informal leadership might be interpreted as leadership without authority and that this often occurred in the nursing/health visiting role. Informal leadership implies that all professionals can lead in this way i.e. undertaking leadership when you don't have a formal appointed role or title of leader, by the nature of being an experienced practitioner, or indeed having experience in general as is discussed through the notion of leadership being *a natural process* as mentioned above.

> *I think I have had experience informally of leadership and that has been through just day to day working as a qualified nurse, a health visitor through the nursing profession (Group 2, interview 1).*

Again, the above quote reinforces the notion of the situation of leadership i.e. where it occurs, being described through the nature of your professional background and the process of leadership development was interpreted to be facilitated through

professional experience and age. This is developed through one's normal actions as a professional. This is supported in the literature which identifies that nurses learn leadership mainly through experiences gained through their career and their age: generally, the older they are the more experience they are exposed to (Cummings et al, 2008).

> *Your leadership approach is dependent on your professional background ... your model of practice so if you've been trained to be a youth worker for example who has to be very facilitative and understanding and aware and strength based and thoughtful then those skills you will take with you into leadership (Group 3, interview 8).*

This implies a transferability of professional health visiting skills from the model of practice, in conjunction with the experiences that you are exposed to as a professional that influence and direct how you undertake leadership. To understand this further I explored where participants believed health visitors would learn these skills and if this included leadership training. As I was curious to find out whether leadership was seen totally as something emerging from within the professional role or if it was experienced as a separate entity that could be developed through training.

> *I've never done any leadership with a capital L. I think you learn by doing and taking responsibility and working with people you enjoy, being open to learning...what gives credibility in health visiting is all based on your model of practice i.e. how good a health visitor you are (Group 3, interview 8).*

Participants in all three groups described that health visitors learn about leadership by what they do in the context of their practice environment i.e. in their professional role this is supported in the literature (Nettleton, 2013) given nursing and health visiting is defined as a vocational qualification this is, perhaps, not surprising (NMC, 2004, 2009 & 2010). *The base for clinical leadership has two sources*: firstly, *it is collective,* from belonging to a professional body such as nursing and secondly it is individual, based on

clinical expertise (Hartley et al, 2008, p. 66). Interviewee 8 expanded on this discussion by raising the importance of model of practice.

What was surprising was that there was very little attention given to the benefit of leadership as a body of knowledge in its own right, and the usefulness of leadership theories as a way of helping participants deal with issues in practice. Across the three groups of participants it was apparent that health visitors learned about leadership and developed their leadership skills through their professional model of practice, not by attending formal leadership training. Participants recognised however, the value of leadership training as long as it was centred in clinical practice, but several participants particularly in Group 1 and 2 had not attended any formal leadership training for several years. This illustrated that participants across the three groups felt that leadership training was not a high priority for them. This is understandable if it is believed that leadership is developed through practice and the resources to be able to attend leadership training are not always available: time out of the practice environment.

> *I've never been on a leadership programme, I've both designed them and participated in them and led them but I've never been on one myself (Group 3, interview 3).*

This view might explain why in nursing and health visiting it is common practice not to undertake leadership training prior to commencing leadership roles (Heller et al, 2004). There is limited evidence in the literature to suggest how health-visiting leaders/managers should be prepared for their leadership role. This is similar to the findings in nursing (Kleinman, 2003). In addition, there is scanty evidence of how student health visitors and nurses should be educated in leadership (Heller et al, 2004; Curtis et al, 2011a) or what CPD around leadership should be offered to health visitors that will make an impact on patient/client outcomes (West et al, 2015).

The Trust where many of the participants were employed had deliberately appointed Advanced Nurse Practitioners (ANPs), who were experienced and knowledgeable in

health visiting to lead the health visiting teams. These ANPs were assumed by the Trust to possess leadership skills because of the extent of their prior professional experience. No formal leadership training was required prior to appointment or subsequently. I reflected on this issue and was wondering again if leadership theories had nothing to offer health visiting or were they so removed from health visiting practice that the relevance couldn't be recognised.

> *It's not easy but I've learnt a lot over the past few years but it's been a very big learning curve. I didn't come in with any leadership model or anything like that however, if I'd had done some sort of model or training or some element of theory behind it I might have been supported better it was just pick it up and go (Group 2, interview 1).*

> *We've recruited the ANPs to the service for their advance knowledge and skills and understanding of health visiting practice and how they can put that into practice in terms of leading those teams of staff (Group 2, interview 4).*

I reflected on this from my professional experiences both as a practitioner and an educationalist as this description of developing leadership through experience resonates and explains why leadership historically has not been seen as something that you need to learn from going on a course. All my clinical and educational roles have involved leadership, many in formal/senior leadership roles, yet it was never a prerequisite to have undertaken any leadership training prior to commencing these roles, the focus was on what leadership experience I had acquired and in what context.

However, evidence suggests that just because you are a senior clinician, or have the title leader, does not mean that you have the skills to be a leader (DeRue & Ashford, 2010; Curtis et al, 2011b). This is a commonly misplaced assumption in many professions, including nursing and health visiting. Weber identified the idea that bureaucracy within organisations supports the hierarchical roles of professionals and that legitimacy is part of hierarchy (Aime et al, 2014) which means that leadership and the power inherent in

the leadership role becomes legitimate (Degeling & Carr, 2004). In this way, clinical experience and seniority as a health professional is seen to give legitimacy to the role of leading (Cook, 2001; The Kings Fund, 2011).

Thus, the service is faced with a dilemma. On the one hand, the professional expertise of the health visitor is seen as central to being a leader: leading is learned by coming through the ranks, yet the evidence suggests that experience on its own, is not enough to lead. Or is it?

Health policies (DH, 1999, 2006, 2010a & 2011) repeatedly state that leadership must be strengthened in nursing and health visiting. If this is so, then arguably it is not enough to lead purely based upon your model of practice and how long you have been qualified. Surely, specific leadership knowledge and skills should be developed. This dilemma resulted in all the groups interviewed being asked further questions to clarify the specific leadership training participants had undertaken and in what context their experience and knowledge came together to produce leadership.

> *… I haven't personally done any other formal leadership training I'm always keen to improve my skills but I don't necessarily think that's done by leadership training, is it? I feel that in the main that's done by observing people seeing how they work…. So, I like to observe how people are leading and my manager she's seen as a great leader and her style is completely different from a lot of people's but she's able to lead make changes and just achieve things that I think many people aren't (Group 3, interview 9).*

> *I don't think it is always a course I think leadership you can pick up from many sources so sending someone on a course doesn't make them a good leader but at the same time I think it's important to provide these opportunities. It is the big thing now isn't it everywhere there has to be leadership courses do this and do that (Group 3, interview 9).*

The above quotes illustrate the credence given to knowledge and experience by health visitors when understanding leadership. It is clear that whilst developing leadership skills through training is welcomed, it is not mainstream. It seems that, what is considered important are opportunities to test out leadership skills. The literature is quite clear that experience combined with skills in leadership are key factors in supporting leaders to develop, this is particularly the case when they have guidance and support (Day, 2001; Day & Harrison, 2007; Brigham, Maxwell & Smith, 2012). This would suggest that the structure of the training is important. It should aim to develop a programme that is theoretically based but that also incorporates learning from observing practitioners lead in practice and providing opportunities to test out leadership skills. This broadened my professional understanding as what was being expressed was not that leadership theories per se are not valuable, but they must make sense in health visiting practice and be usable.

5.2.2 Professional boundaries

During the interviews, it was quite clear that all participants believed that the role of the health visitor, when working across professional boundaries, was not clear to all healthcare professionals. The participants also believed that some health visitors were not clear as to their exact role. Participants believed that this lack of clarity created difficulties for some health visitors around their role and responsibilities. That is to say that they were not clear where and what they were required to lead and it was felt that this could inadvertently create barriers. These findings are supported in a study by Brigham et al, (2012) who explored how health visitors share and develop good practice.

The participants felt that there was particularly a lack of clarity over early years services based in LAs and the role of health visitors. It was felt that much of this uncertainty reflected recent changes around how early years services are spread across the NHS and LAs (Cowley et al, 2013) and the policy drivers around the development of early years services i.e. the introduction of Children Centres discussed in the literature review (Bouchal & Norris, 2013).

There are definitely tensions still there in some cases not in all cases between Children's Centres and health visiting teams. In some places, you get really good teams that work together and they see it as a joint role the health visitor has that position within the team as being able to lead. I think it can be on both sides I've heard lots of health visitors say over the years Children's Centres have taken our role away from us which of course is completely untrue it's a perception and Children's Centres can also say similar things about health visitors so I think that still seems to persist in some areas to a very unhelpful degree. Hopefully with the commissioning through the LAs of health visiting and Children's Centres those barriers will start to break down but they certainly haven't in many places (Group 3, interview 9).

This demonstrates the complexity of working across different health and social care organisations. Without clear roles and responsibilities, it will be difficult to achieve cross boundary working. This will be a problem for health visitors but also for their partners involved in delivering children's services. Current policy (DH, 2011) identifies the health visitor as the lead for the HCP but there is a lack of clarity about how this should be implemented across organisational boundaries and what this means in reality (Brigham et al, 2012). This is not helped by the paucity of literature to guide or consider what specific skills health visitors bring to the multi professional service (Cowley et al, 2013).

That's the thing that I've seen practitioners really struggle with locally this bit about them and us we need to get away from a them and us culture. So there needs to be quite a lot of understanding of who do you work with first, they've got to win over the managers of the Children's Centres to have access, they need the managers who the support staff work for to endorse the health visitor because you've got an even more difficult challenge to work with and alongside those support staff if the manager who's managing/leading the support staff from a different agency don't trust or endorse that practitioner then why would the support staff. I think it's understanding the complex relationships who all the

players are, who the stakeholders are...how they all connect, where the chains of command are (Group 3, Interview 6).

On further analysis and after comparison with the other categories from this study, purpose of leadership and leadership behaviour, the barriers and differences expressed for this category appear to be about the lack of a clear vision for health visitors across organisations. Concern is also expressed about the impact this has on the health visitors who work across boundaries and who are being asked to lead on the HCP. A 'them and us culture' was expressed in all groups in different ways.

At the moment, we are working with our partners in the local authority to develop multi agency team working and looking at integrated working. For that to be truly successful you've got to have a good understanding of who's in the team and what their role is, what their input is and what their unique contribution is. To understand everybody's contribution what their core offer is and how it all comes together so that we're not duplicating work we're not making any gaps so I think from a health visiting perspective having a wider understanding of how everyone fits together and complements each other (Group 2, interview 4).

Another factor that impinges on the ability to lead on the HCP across professional boundaries was raised in the interviews regarding the structure of services, i.e. the level of integration of services. Services have often been restructured and called integrated whereas, in reality, services remain structured in just the same way (Brigham et al, 2012). Geographical barriers often persist with staff not being co-located and this is exacerbated by differences in terminology between professionals (Cowley et al, 2013).

Yes, definitely and complex as well because of work forces. I think because of the Children's Centre, NHS teams have 0 – 19 teams so they don't talk about the health visiting service and the school nurse service they talk about the 0 – 19 service but in reality, the health visitors still work with their corporate case load which is 0 – 5 and the school nurses work with a case load which is attached to

schools so the older age range. Then there's of course the Children's Centre people that they're working alongside that are separated by geography, building, employment and even types of contracts and yet the health visitors are constantly told that "you're leading the HCP" but of course all the other people are contributing to the HCP (Group 3, Interview 6).

Although evidently aware of the need to lead across professional boundaries many participants reported times when they found this was difficult for health visitors as expressed below in the quote from Group 1, interview 5. Sometimes this was due to professional rivalry, perceived power differentials or a difference of opinion about thresholds for intervention, particularly when undertaking child protection work. Feelings of professional rivalry are not uncommon and several studies have identified the lack of clarity and communication between professional groups and the rivalry that can derive from power differentials (Laming, 2003; Degeling & Carr, 2004; While, Murgatroyd, Ullman & Forbes, 2006).

The power struggles are with the other agencies. I just think we have allowed them to erode our role and because we've not had strong leadership nobody is selling our service because I think we are doing a good job. After many years of study, I believe it is a wider problem with who defines professions and professionalism and patriarchy. I don't think nurses and especially female nurses are acknowledged as experts in their field. I think we are just dismissed as such. But we allowed that to happen (Group 1, interview 5).

This articulation of a lack of role clarity for health visitors was highlighted by Laming (2009). In addition, communication issues and poor leadership have been found to lead to avoidable child deaths (Laming, 2003). Recognition of these issues was seen by Group 2, as one of the main reasons why health visitors needed to increase their leadership skills.

Health visitors are leaders when they're sitting in various meetings representing the service so it's giving them that good image about health visiting here in the Trust particularly the safeguarding when they've got to be that advocate again for that child or family in terms of making sure the child is safe but getting social care maybe to recognise and understand when they're saying they are concerned about a child. Sometimes the LA might have a different view and being able to challenge that and push their views and thoughts forward in terms of protecting that family (Group 2, interview 4).

I wrote several memos about these issues to interpret, from a constructivist grounded theory approach, what the actions were in this situation. Using memos allowed the theoretical development of the categories in this case the context of leadership (Charmaz, 2014). I ascertained from the coding process and constant comparison that participants were clearly concerned around role clarity. I wrote memos about this to make the connections between codes and this area was explored further in all interviews to attempt to understand what was emerging from the memos by gathering further data.

The change in the health-visiting role has been affected by what I have interpreted as the external factors i.e. what health visitors are expected to undertake governed by policies from above, discussed under organisational change. The different ways of interpreting the health visiting role is more than just about changes to the role in addition it affects the core of the health visitor identity that develops from the beliefs and values that health visitors hold. This core identity appears threatened when organisational interventions conflict with the health visitors' view of their role and thus their identity (Machin et al, 2011; Brigham et al, 2012). This is significant learning for me which has impacted on my own understanding and professional practice. Often change is applied to roles without considering how to support it or reformulate the identity of those involved. This is discussed in Chapters 7 and 8.

It would seem from this that leadership development needs to help health visitors to work across different professional boundaries and networks (Hartley et al, 2008). Therefore, the where of leadership for health visitors becomes even more important as the data shows that lack of co-location can be a barrier to leadership.

5.3 Organisational change

The changing nature of the health visiting role and the cultural context of the organisations in which they work, has had an impact on the participants' experiences in relation to the health visiting professional model of practice.

It is recognised by several authors that what constitutes the health visiting model of practice is not always clear (Dolan and Kitson, 1997; Brigham et al, 2012; Cowley et al, 2013; Whittaker et al, 2013). In the interviews what the participants referred to was the four- tier service delivery model (DH, 2011) that allows them to deliver the HCP (DH/DfCFS, 2009a, b) and the Practice Principles of Health Visiting (CETHV, 1977) embedded in the NMC (2004) Standards SCPHN (Health Visiting). Therefore, whilst recognising that the concept of a model of practice is discussed in several formats from the ones mentioned above to place based models e.g. geographical: GP attached (Hyett, 2003; Donetto et al, 2013; Bryar et al, 2017), in order to make sense of the data the models discussed by the participants are used to structure this section.

The concerns health visitors have over how 'top-down' policies are implemented in practice, the changes in their role and how they undertake leadership at a team level is discussed. This section focuses on how external drivers, identified from the data, impact on the health visiting role including *governed by policies from above, health visiting model of practice and team leadership*.

5.3.1 Governed by policies from above

As a result of the Health and Social Care Act 2012 there have been several changes in how the NHS is structured and how education for health professionals, including health visitors are organised. This is explained in relation to the HVIP (DH, 2011), by a participant who is responsible for delivering this policy strategically at a national level.

> *So, the first two years of the (HVIP) programme was traditional cascade, DH to Strategic Health Authorities (SHAs) to Primary Care Trusts (PCTs) and then through the Early Implementer sites, the direct professional line. From April 2013, the programme now has four new delivery partners. So, it has the DH which is the policy lead and the overall coordinating accountable body it has NHS England who are responsible for commissioning until the commissioning moves to LAs and it has Health Education England (HEE) who are responsible for delivering up the students and it has PHE who are responsible for the evidence and the relationship building with LAs. So, it's becoming much more complex ... so we work really closely together I know it's really confusing but we do our best to demystify it and to provide clarity (Group 3, interview 11).*

This was a key professional learning point. This explained how policy is developed, how it is implemented and rolled out and the impact it has on the role of the health visitor and how health visiting is delivered. The health care environment has changed rapidly over the past 17 years as a result of government policy. Changes in the early years workforce, as a result of Every Child Matters policies (DfES, 2004), the introduction of Children Centres and Sure Start have had a major impact upon the role of the health visitor (DH, 2007; Cowley et al, 2013). Activities historically seen as health visiting, for example health promotion, are now being undertaken by Children Centres by skill-mixed early year teams. This has left some health visitors feeling that they have lost a large part of their role that they valued.

...all the things like the weaning parties stuff that were important to me and I felt were necessary in my area were stopped by management. All group work all health promotional days. Because they weren't part of the HCP that commissioners paid for. The rationale behind the change was that Children's Centres should be taking over these things (Group 1, interview 5).

These changes have created a dilemma of role reformulation for practitioners that have not been discussed sufficiently (Brigham et al, 2012). All health visitors are expected to lead delivery of the HCP (DfCSF/DH, 2009a, b; DH 2011) yet, some health visitors believed that their public health role has been reduced by the focus on the HCP programme. At the same time health visitors were being told that they were SCPHN (Health Visitors) and had to undertake public health leadership (Carr et al, 2003; Smith, 2004; PHE, 2016b).

We call ourselves SCPHN as opposed to health visitor but we don't do any public health really apart from within our health-visiting role with regards to smoking cessation and diet. So instead of fulfilling that wider role it seems as though we've retreated doesn't it (Group 1, interview 5).

What the role entails, and who does what, is compounded by government policies that expect the delivery of the HCP across NHS and LA boundaries but which do not recognise the different cultures, or pay scales inherent in the organisations that deliver early years services. This was expressed by a strategic leader below as health visitors viewing certain public health activities as "*my territory*." What wasn't clear from the health visitors in interview Group 1 was how the *shared vision and shared team and a shared role in delivering the HCP m*entioned below had been developed for health visitors by the organisations in which they work.

Facing the Future (DH, 2007) identified the tensions with regards to where health visitors are based traditionally that had been in primary health care teams e.g. at general practice surgeries/community health clinics and since the introduction of Children's

Centres this had changed. Some of the issues associated with the health visiting role with Children Centres still appeared to be have not been addressed as discussed by participants in the study. Although the HVIP (DH, 2011) endorsed the position that "*health visitors were designated as having an overall "lead role"* (DH/DfCSF, 2009a,b) *in the HCP and in Sure Start Children's Centres" there* had been no formal authority ascribed to the health visitor to do this (Cowley et al, 2013, p. 38) which appears to compound the issues surrounding clarity of role and what health visitors realistically can lead across organisations (Brigham et al, 2012).

> *I can understand probably why health visitors thought oh my goodness that was my territory I used to be the one that knew all those families and nobody else used to interfere and it was seen very much as their territory. I understand how that happened but of course Children's Centres have changed over the years haven't they and they have less cash. Again, it's that shared vision and being part of a shared team and a shared role in delivering the HCP (Group 3, interview 9).*

Group 1 discussed at length the change of role for health visitors. It also discussed how that has affected them personally and professionally. From their discussion, I reflected how this impinged on their identity and role. This was nicely illustrated by interview five, Group 1 where it was noted that *we are called SCPHN as opposed to health visitors*, referring to the change in title (NMC, 2004). Nonetheless, all participants referred to themselves as 'health visitors' rather than SCPHNs and made the distinction only in relation to the SCPHN training programme. Many felt that the introduction of Children Centres had taken aspects of the public health role away from health visitors, although not all members of the focus group agreed.

Participants discussed the tensions created in their roles by healthcare policies that design services with a primary focus on targets, often to the exclusion of professional judgement. Several participants described instances where they could not focus on the health needs of their clients because they had to meet targets set by local commissioners. These tensions led to health visitors' displaying a range of emotions.

Some felt frustrated that they were not able to lead and practice in line with the Principles and Practice of Health Visiting (CETHV, 1977; NMC, 2004); others discussed being frustrated because it did not make sense not to address the obvious needs of your clients. Others felt resigned to these changes and recognised the limited resources and the need to set targets. Finally, some participants circumvented the system to meet their professional beliefs about health visiting and to permit them to deliver what clients needed from the service, despite this differing from organisational targets.

> *Again, the Breast-Feeding Initiative was sold to us as a target we had to achieve, we achieved it but it's as though they look at a problem in isolation without asking us why in our particular areas things aren't changing, commissioners have a figure breastfeeding in Trust 68% why isn't it 73%. Because you're not asking us what we need to drive it forward (Group 1, interview 5).*

> *We're constantly shown targets and performance indicators and Dashboards, who achieved what and who didn't achieve. Health visiting is in the home where you can do your proper assessment, we're not inviting them into clinic just to get through the numbers, but we're not held up as a good example. If you're working in a deprived area where you are doing the full assessment the core groups case conferences and everything else your contacts inevitably will be down should be down but that's not recognised anywhere (Group 1, Interview 5).*

Health visitors must be able to negotiate this paradox. How they do so is complex, as they cannot always meet public health targets whilst meeting the perceived needs of parents. Indeed, those needs that they identify as part of the professional autonomy of the health visitor role may also go unmet which impacts on their professional ideology and identity (Brigham et al, 2012; Cowley et al, 2013; Whittaker et al, 2013).

Whilst it is likely as outcomes become more focused by healthcare policy these issues will only become more challenging, however, no further advice or guidance is available on how to manage these issues in the literature. Cowley et al, (2013, p. 23) in the Why

Health Visiting? Review highlighted in the recommendations for service that "*commissioners should write service targets (Key Performance Indicators) and commission services in a way that acknowledges the need for health visiting flexibility in meeting parents perceived needs."*

Yet there is no evidence to suggest that this recommendation is routinely adopted in how health visiting services are designed and commissioned. This is key professional learning for me in that I work in an organisation that is constantly influencing national organisations about how service specifications are designed and the role of the health visitor. We know that the evidence continually advocates that focusing on targets is not effective in improving the quality of healthcare services provided. It has been recognised that NHS reforms have focused too much on targets with little success, performance management etc. as a way of improving the quality of care rather than making improvements from within (Ham, 2014).

Decisions are made about how services are delivered that potentially reduces the quality of the service that clients receive. Yet it continues with too much emphasis being placed on reaching targets that creates barriers between the different organisations involved in delivering the HCP been more focused on who achieved the target than the quality of the service provided.

Whittaker et al (2013, p. 18) felt that the solution lay *partly in improved education for managers and commissioners to understand how the health visiting process operates.* However, the second strand of the solution was to ensure that health visitors developed professional skills to navigate such conflicts in practice. Many health visitors' accounts to Whittaker et al, (2013, p. 72) *indicated that their work had intensified in recent years with less time spent on universal and community level practice*. This was similar to findings in this study.

Yet there is an irony in that health visitors were assigned the lead role of the HCP "*because of their presumed ability to shift from one level to another, reaching*

professional judgements and decisions that incorporate and balance multiple aspects of the client need and service context, which is likely to be unique to each situation and locality" (Cowley et al, 2013, p. 38). However, it seems unclear as to how they achieve this without the authority and support from their service provider to do so. A key failing of the HCP appears to be that while it asks for leadership it does not address "organizational *procedures or the deployment of staff"* (DH, 2007; Cowley et al, 2013, p. 38).

5.3.2 The model of practice for health visiting

This section builds on the discussion in Chapter 2 about how the health-visiting role has changed with the introduction of several government policies across health and education (Lindley et al, 2011) culminating in the new four level service delivery model referred to as the "family offer" (DH, 2010c & 2011) and how it was initially intended to be used when it was introduced is discussed by a strategic leader in Group 3.

> *It's only a construct ["four level model"] which because so many people had so much aspiration for the 4000 health visitors they were the panacea to everybody's problems. So, we had that at one end and at the other end we had people still not understanding what health visitors do. Descriptions that honestly, they vary from something from a Doula to a maternity nurse to a home help to a sort of baby nurse to a so actually being able to construct that in some way was really important. Once we get to 2015 and people don't use those labels again well as long as they are commissioning a service that's in that scope I think our work will be done so to speak. But at the time it was really important to have a construct to enable people to say and understand this is what we do. Yes, the evidence yes people can, and it wasn't just other people it was us [health visitors] as well what the offer was (Group 3, interview 11).*

In the new four level delivery model, introduced as part of the HVIP, (DH, 2010c & 2011) a key part of the family service offer included health visitors offering a community level

service using their public health skills with children, families and communities. It was clear from the participants that although there was a desire expressed particularly by members of group 3 that eventually at the end of the HVIP (DH, 2011) the health visitor role would incorporate both *personalised and population health* (Group 3, interview 11) this was not evident from participants in group 1 and 2. This could of course be because the study was undertaken in the middle of the HVIP.

Noting longstanding debates about this issue of how personalised and population health are balanced in the health-visiting role and indeed what constitutes public health leadership by health visitors (Carr et al, 2003; Smith, 2004; Carr, 2005; Poulton, 2009; Machin et al, 2011; Baldwin, 2012) the data from this study indicated that the balance between the individual and community public health role may still be difficult to implement. As historically health visitors have always been commissioned in such a way as to prioritise caseload work especially with regards to safeguarding that has always taken precedence (DH, 2007; Poulton, 2009; Brigham et al, 2012; Cowley et al, 2013). This is despite a long history of government policies requesting health visitors to have a stronger public health leadership role (DH, 1999 & 2001, DH/CPHVA, 2003, DH, 2005 & 2010d; NHS England, 2014). This tension historically has compounded the confusion around the role and the identity of the health visitor.

> *When we talk about the health visiting HCP you will always hear us say Universal, Universal Plus, Universal Partnership Plus we all forget that there is another level Community (Group 1, interview 10).*

As a result of these debates, and in order to reconcile these two aspects of the role of the health visitor, i.e. community development and caseload responsibilities, work has been undertaken by strategic leaders as part of the HVIP (DH, 2011) around personalised care and population health, as a way of describing how health visitors undertake both within the “four level” model. This is discussed below in interview 11, Group 3 regarding being able to have a public health voice and therefore the impact on being a public health nursing leader. This was something that resonated with me in terms of the work

by Day and Harrison (2007) on leadership identity i.e. if you do not see yourself as a leader you will not develop a leadership identity. This was a key piece of learning for me professionally and a real moment of clarity from constructing meaning from the data.

I had not considered the relevance of having clarity over the health visiting role and the impact that this has on leadership identity and that both identities will not just happen but need to be developed (Chreim, Williams & Hinings; 2007). Nor had the literature on health visiting or government policy considered, when asking for strong leadership (DH, 1999, 2010a; & 2011), that leadership identity is so crucial to making this a reality (Lord & Hall, 2005; Day & Harrison, 2007; DeRue & Ashford, 2010). Therefore, are there in fact two issues? Firstly, we accept that leadership is developed through professional expertise and the model of health visiting practice. However, if the model of practice lacks clarity, this further compounds developing a leadership identity. Secondly the model of practice can only be endorsed, and therefore the leadership identity, by how the health visiting service is commissioned.

> *A piece of work that we have been doing is around population health and personalised care some of the practitioners [health visitors] have found that quite useful; so how do they both deliver the HCP on a long-term basis and be mindful of the population both in terms of needs and a response. I think health visitors are trained to do that. Over the last ten years what people say is that they haven't had the opportunities to do that. They have been commissioned for individual responses and people feel that they have lost their Public Health focus and their Public Health voice. If you don't think you have that Public Health voice it's very hard to be the Public Health nursing leader (Group 3, interview 11).*

These quotes link to the earlier quotes from Group 1 who lamented the changes to the role and the tension between health policies based on targets and professional judgement. These issues were recorded in a memo to seek to understand what health visitors perceived was happening to them e.g. blaming Children Centres for covering enjoyable aspects of their role.

In linking these themes, by comparing focused codes, sub-categories and across categories it was clear that the changed role of the health visitor coupled with its impact upon identity crossed all three categories but in different ways. The consequence of lack of clarity about role impinged upon leadership identity i.e. what are they leading? The change in location and organisational structures impacted on where they are leading. Identity emerged as a key aspect of the findings of this study and is discussed further in Chapters 7 and 8.

Initially it had appeared that *clarity of role* needed to be a core category but on reviewing the data and by being reflexive through subsequent interviews, and writing memos it became clear this didn't capture all the concerns and meanings as aptly as *context of leadership*.

It was quite apparent from the interviews that the model of practice varies across England and even varies within the same Trust. Although all health visitors have a commissioned service specification and the HCP to follow, nonetheless, the complex needs of the area where they work overwhelmingly influences their model of practice and what leadership activities they feel able to undertake. This was discussed by participants across the three groups, however, all spoke about the "four level" delivery model and how this is used in practice to structure their workload.

In addition, all participants expressed the views that the HVIP (DH, 2011) had driven the implementation of the HCP. The HCP had originally been introduced in 2009, (DH/DfCSF, 2009 a, b) and the delivery of this was central to the revitalised role of the health visitor (DH, 2011). Participants expressed the view that revisiting and strengthening of the health visitors' role in delivering the HCP had made the model of practice more explicit. Participants from all three groups shared many examples of where they could lead and make a difference to children and families.

We're all on the policy of the Trust HCP so that's the key document for us. We are all working with that. We all have mandatory training, which is part of that as well so were all singing from the same hymn sheet. Caseloads are split into the levels of the health visiting Implementation- Universal, Universal Plus, Universal partnership Plus but there is no Community because obviously that would be time consuming saying there is a need to gather all that research in order to change a service (Group 1, interview 10).

The model of health visiting in this study had clearly been adopted as the four-level service model (DH, 2011), albeit the community level was universally seen as not deliverable within present service specifications. This continual lack of consistent delivery of the public health leadership role by health visitors in terms of community development work has been reported for some time in other studies (Carr et al, 2003, Smith, 2004; Carr, 2005, Poulton, 2009; Brigham et al, 2012). How the four-level model was connected to the HCP was discussed by all the participants. However, in terms of the six High Impact areas this was not referred to as part of the model of practice at the time of the interviews (September - November 2013) which is not surprising as at this time the six High Impact areas were still being developed (PHE, 2014).

I think in health visiting we're delivering a HCP so we're delivering the universal HCP and the key to that is people staff workers at the forefront leading on that they're at the centre of it really that's the bread and butter of health visiting. I think it's integral to that role you're leading on the promotion of health the better outcomes for children the evidence based practice (Group 2, interview 1).

All participants agreed that the focal leadership role of the health visitor was leading on delivering the HCP which was the main role of the health visitor.

Yes, we are delivering the HCP and I think we deliver it well in the Trust. There is a core service that every client can expect and as I say this is promoted from the antenatal visit forward so we are delivering this and obviously anything above

that needs to be done. Yes, we've got a Universal Plus, Community, but I find your community and your public health work in this climate is very difficult to address (Group 2, interview 12).

Whittaker et al (2013, p. 106) suggested "*that health-visiting services should be commissioned and organised"* to preserve "*the holistic combination of approaches identified including the orientation to practice",* which forms the professional ideology and identity of the health visitor. The orientation of practice (Cowley et al, 2013) was not referred to directly by participants in this study, this may be explained by the work only being published shortly before the interviews and focus groups were undertaken.

5.3.3 Team leadership

Team work is an important factor that is highlighted in the literature as contributing to high quality health care (West & Lyubovnikova, 2012; West, 2012) and organizational success (NHS Leadership Academy, 2013; Dickinson, Ham, Snelling & Spurgeon, 2013). *Yet team leadership is recognized as being poor in health services* (West et al, 2015, p. 12).

Modern health visitors rarely work in isolation (Donetto et al, 2013). Services have been built around health visiting teams to include other early-years workers e.g. nursery nurses. Health visitors have an established role in leading within these teams (DH, 2007 & 2011; Baldwin, 2012; Cowley et al, 2013).

Many participants within this study referred to being a team member and therefore having a part to play in the leadership of that team. This is supported by government policy that clearly states health visitors have a role in leading the HCP "*and wider skill mix teams across early years settings"* (DH, 2007 & 2011, p. 12). Teams that were perceived as having good leadership were described by participants as follows:

Well the thing is if you have a full team that you have the same goals then you are working together to achieve those goals ... it's been empathetic with other team members it's been aware it's not just your responsibility you have a responsibility to the team. It's having that comradeship isn't it that you are all wanting the best for the team and you are all working at that level and if some person is struggling you step in and support them and help them (Group 1, interview 10).

This notion of having clear goals and a common vision is something that has been raised as essential for good leadership in several interviews across the three groups. This idea was combined with personal attributes that were perceived as most helpful for good team working. These attributes discussed across the three groups are; *positivity; cohesiveness; excitement*; *working together; empathy; having a responsibility to your team and yourself; comradeship; all wanting the best for the team, supporting each other and the team dynamics.* This demonstrated a clear and robust link to personal attributes that participants saw as very important for leadership. This link to desirable personal attributes is discussed in Chapter 7. These attributes and structures required for effective team working are supported in the literature, which also suggest that team leaders should have higher priority in the organisation (Ham, 2014) and that having a "*clearly designated team leader* could result in *less conflict over leadership* and thus *enhance the ability of the team members to smoothly assume leadership roles and responsibilities when their expertise is relevant"* (West et al, 2015, p. 12).

In addition to clear goals and vision in teams it was widely expressed that the allocation of roles was also important. Many of the participants in Group 1 did not think that there was sufficient recognition of team roles.

In the other Trust where I worked as a health visitor there were different roles for different health visitors to pick from everybody had a role. I find here some people don't have roles and some have…. And some people who have roles complain that they don't want to do that role because it's taking time from their caseload

work but they are doing it maybe because they were asked to do it but they can't say to the managers that they don't want to do it but they complain that its taking their time (Group 1, interview 5).

When looking at the actions and processes inherent in the data it becomes apparent that the basic tenets of team leadership are not always in place e.g. knowing your role within a team and knowing what is expected of you whilst building a team identity (Brigham et al, 2012; West et al, 2015). Participants identified their work as team based and recognised that they had a leadership role in the team. Despite this they were not always clear on the context in which they were leading in that team. This is supported in the literature (Lyubovnikova, West, Dawson & Carter, 2014).

Participants identified the desire to work in a team. They also identified characteristics to define a high performing team i.e. having clear team objectives and a desire to deliver high quality services. They knew what an effective team looked like but didn't necessarily experience working in one. Group 2, the senior management team, also knew and wanted to promote this team building amongst health visiting staff. Nonetheless this view did not seem to get transmitted further to health visiting staff even though team building activities had been rolled out by some of the team leaders. Interestingly, several members of Group 2 expressed a desire to *be an advocate and support* for other staff yet were, by their own admission, *performance managing* these staff.

I'd want to replace it with the team leader role as an advocate, adviser, support, somebody who rolls their sleeves up and gives them a hand, if they saw it more as something like that then that person could really focus. I sometimes think I'm performance managing as well, we have to look at what's in the caseloads and is it in the right level and I think advanced leads should be able to manage their own caseload and look at it and have the skills and knowledge to do that. We have to report to safeguarding do case load management overview what's the caseload numbers what's in there. I didn't really go into the role for that I went

into the role thinking that because I was enthusiastic and passionate about health visiting that I could support staff to feel like that as well and help them with skills, knowledge and support to be able to develop those leadership skills themselves (Group 2, interview 1).

Again, the same questions emerge: who has the authority to make the decisions and the power to make the changes? As discussed earlier, it does not appear to occur at middle management level. Yet middle managers are so pivotal in influencing the dynamic of the team. Participants commented that support to make change or resolve issues usually came through the team leader. With a formal position such as team leader, legitimacy and authority to lead others is recognised by staff, which attributes these formal leaders with power and influence (Hartley et al, 2008). But it would appear this is not always felt by middle managers. This is recognised in the literature that just by having a title leader does not mean you are seen as a leader or have a leader identity (DeRue & Ashford, 2010).

Group 2 recognised the benefits of non-health visiting practitioners leading in health visiting teams. They saw that this fulfilled the need for leadership at all levels. However, the data identified that hierarchy and seniority of role could be barriers to emergence of leaders from within teams, even when the non-health visitors have the skills to do so.

...when I was doing the pilot, you could see a nursery nurse maybe absolutely brilliant skills very knowledgeable and she's got leadership qualities in her own right because of all her knowledge and skills but it was quite evident she was quite happy to just go along with it. It's difficult sometimes to try and extract that from them and get them involved and make some suggestions they have all the knowledge around these kids but we found that there was somebody with the title or a manager or something leading the project (Group 2, interview 1).

These quotes illustrate how health visitors understand how national healthcare policy affects their day to day work. The quotes also show how they exhibit leadership with

their colleagues, health visiting teams and children and families. How health visitors define a situation that they lead in and frame it for others to understand is an important part of leadership (Hartley et al, 2008). However, they are clearly hampered in this by a lack of clarity around roles and expectations.

5.4 Chapter summary

This Chapter has defined and discussed the first category: *context of leadership* through the sub-categories professionalism and organisational change.

All participants in this study referred to the context of where health visitors undertook leadership as being dependent on how the health visiting service was organised and delivered and on local and national policies that affected the structure and function. This was underpinned by the assertion of the importance of organisations on leadership and the individual health visitor's own professional background.

The study revealed that all participants recognised that the role of the health visitor incorporated leadership and that leadership was important to health visitors. From the participants' perspective, professional background and clinical practice were identified as being the key to being a good leader. Background and practice were based upon experience gained through nursing and health visiting posts. Government policies shape the role and model of practice for health visitors. It is clear that a dilemma persists around individual-focused versus community focused public health work and the leadership of this work in practice. Safeguarding takes precedence followed by the mandatory five contacts set out within the HCP. Therefore, these activities are central to the model of practice health visitors adhere to and context of the leadership roles that health visitors undertake.

The changing nature of the health visiting role and the highly changing environment in which they work directed continuously by government policies, creates concerns for health visitors around how they interpret such policies. This affects their professional

identity, and how they lead across professional boundaries. Thus, the implication for practice is that leadership will not be as effectively undertaken in practice unless these issues are recognised and addressed with health visitors.

Chapter Six

6. Purpose of leadership

6.1 Introduction

Purpose in leadership is commonly understood to mean a sense of direction (Day & Harrison, 2007). The importance of the leadership role in providing purpose for organisations is well documented in the literature (Hartley et al, 2008; Jackson & Parry, 2011; Allio, 2012; NHS Leadership Academy, 2013) as direction provides an alignment around strategies, which is seen as a key part of effective leadership (Yukl, 2013).

Previously, context *of leadership* was identified as the first category to emerge from the data. Here the findings of the second category, *purpose of leadership,* are discussed along with the implications for practice and theory.

Participants clearly understood that leadership and purpose is integral to the role of the health visitor. Two main sub categories that emerged from the data that capture the participants' concerns around this are; *setting the direction and followership* (discussed below). The properties of this category are represented in Table 6.1.

Table 6.1 Subcategory components: Purpose of leadership

Focused Codes	**Subcategory**	**Category**
1. Engagement in change	1.Setting the direction	1.Purpose of leadership
2. Taking the vision forward		
1. Influencing	2. Followership	
2. Safe to follow		
3. Two-way process		
4. Right to reply		

6.2 Setting the direction

This section presents the findings of the study regarding the participants' experiences of the importance of clarity around purpose of leadership. Being clear about purpose is important for health visitors so they are able to engage in shaping their role and the design of children's services. If health visitors are to understand the strategic objectives of the multiple organisations that they work across and be able to take changes forward systematically it is essential to be clear about why they are doing this. This is discussed under the headings *engagement in change* and *taking the vision forward*.

6.2.1 Engagement in change

Group 1 felt strongly that health visitors should be listened to when changes to health visiting services were being proposed to allow health visitors to be engaged in the changes and the decision making. Haycock-Stuart et al, (2010) had similar findings in their study that explored how leadership is perceived by community nurses in Scotland. Group 1 recognised that staff engagement does not simply happen; it needs effective leadership to make it happen and is an integral part of core leadership strategies (The Kings Fund, 2012; Storey and Holti, 2013; Dixon- Woods et al 2014).

> *...I think when you look at the change process... it's about discussing and having a meeting to discuss the changes we have to put in place and getting peoples different ideas and then if you're going to pilot the changes and also listening to people about what's working and what's not working...they [senior managers] get better results from talking to people and getting people to engage instead of saying this is how we're going to do it (Group 1, interview 5).*

According to the Healthcare Leadership Model (NHS Leadership Academy, 2013) effective leadership includes high levels of engagement with staff at all levels within an organisation, central to which is listening to staff views in other words open

communication. In addition, board leadership within NHS organisations have been found to be most effective when the board listens to staff voices (West et al, 2015). This links back to the literature review where it was recognised that improving staff engagement with work, and therefore the performance of the organisation, is associated with employee productivity; organisational commitment; improved performance; increased patient satisfaction; reduced mortality; lower absenteeism and intention to leave (Katrinli et al, 2008; Cummings et al, 2010; Wong et al, 2010; Aziz, 2016).

What became apparent from the interviews are the different views on how to engage staff and that these may not be viewed in the same way by staff and managers. One participant from Group 2 recalled how they had engaged staff in the Trust by holding staff meetings. However, in discussions with staff within the Trust (Group 1) it did not always seem that this had actually achieved the goal of them feeling engaged. I reflected on why this was and looked across the data and compared the comments made across Group 2. The senior staff in Group 2 all spoke of wanting to include and empower staff, yet the data across Group 2 interviews showed language that did not imply engagement, rather the language expressed information sharing and a means for them *to get up to date with various changes* (described below).

> *…I wanted to have a monthly or six weekly meeting whereby it gave the opportunity for every member of staff to come to a meeting. I put it to all of the staff that it was their meeting and an opportunity for them to get up to date with various changes happening within the service and the wider organisation...so I was giving them information but they were given the opportunity to put things on the agenda and have a discussion.... previously staff were just sending reps from teams. I made it very clear to staff that this was part of their work... this was a legitimate piece of work that I wanted them to come and be part of, it's giving them that permission I think they wanted that permission, but they understand that and see that now and I do get quite a good attendance at that meeting (Group 2, interview 4).*

I used memo writing to reflect on this interview. Why did the manager express a wish to empower staff and involve them yet, despite this, several staff (Group 1) expressed concerns over the lack of engagement? Was the explanation simply that the most important decision should have been to consider how staff wanted to engage with the changes. Instead, *the managers, but not necessarily the health visitors saw good attendance at a meeting that was not optional,* as a surrogate marker of the success of these meetings and therefore the level of staff engagement. Yet the same manager (Group 2, interview 4, see quote below) spoke of *empowering, consulting and working with them [health visitors] rather than dictating.*

> *Just going back to these monthly meetings, I run that's where I've given the information about the service plan, the objectives and given everybody [health visitors] a copy as well as doing a presentation and saying how I want that linking back with their [health visitor] appraisals it gives their appraisals more meaning. But then to understand what we're saying these are the training programmes and these are the priorities that they understood why and how it fitted into the wider picture. It was giving them that vision but we did consult with them it wasn't just me saying this is it; it was a consultative exercise so getting from them what their ideas are. In the early days of developing that service plan we sent it out for suggestions and comments before it was finalised so everybody had an opportunity to input into it (Group 2, interview 4).*

Some participant's in Group 1 described how they had been involved, or how senior leaders had put processes in place to support engagement of health visitors and managers. Whittaker et al, (2013) found in their recruitment and retention study that health visitors feeling valued and respected is important in terms of their job satisfaction and engagement. Ensuring staff have positive attitudes to work is imperative as this is known to affect the quality of the patient experience (West, Dawson, Admasachew & Topakas, 2012). It has been suggested that trusting relationships between leaders and

nurse's results in better patient outcomes (Wong & Giallonardo, 2013). This was acknowledged with strategic leaders in Group 3.

> *Good organisations take time to make sure that people are involved in what's happening that they're influencing changes that they have some sense of control over what is happening and they're not just being done to. That there's good communication within the organisation there may not be any better opportunities for promotion or higher grades or anything like that but it's about that sense of everybody being involved in this and we can all make a difference (Group 3, interview 9).*

Some participants, particularly in Group 1, described how they had not been included in decisions that affected their work. This lack of inclusion was particularly marked in relation to the modernisation agenda and new ways of working e.g. the implementation of paper-free records. These participants suggested actions that could ensure that they were involved in decision making. An increase in the level of involvement in decision making could then result in the process of leaders then becoming followers and vice versa, as discussed below. If *control,* which I interpreted, from my professional experience of this work arena to mean power could be shared.

> *The other thing is the leaders would become followers if they were looking at the strengths of the workforce and build on that if that was one person's strength they'd step back a bit it's not about control it's about pushing some control to whoever is more appropriate. Is there not something where if people are involved in some change process they are more willing to accept it than if they feel it's forced (Group 1, interview 5).*

This is supported in the literature whereby the sharing of power is recognised to occur in situations where expertise is identified in the team context to meet the situational demand and therefore take on legitimacy for that person to lead. However, this has to be supported by the external leader who has the power to give e.g. in this case the

manager (Bryman et al, 1992; Haycock- Stuart et al, 2010; Whitaker et al, 2013; Aime et al, 2014). In addition, staff that feel engaged identify with the task that they are undertaking and describe themselves within that task e.g. health visiting/leader therefore, building identity (West & Dawson, 2012).

6.2.2 Taking the vision forward

The term *taking things forward* was used by all participants to define leadership. Participants described how vision is translated through leadership, as part of taking things forward in the workplace. The literature suggests that effective leaders create direction and alignment around strategies and objectives. They do this by been specific about key priorities to be achieved and by having a shared understanding and agreement about the direction of the organisation, what needs to be achieved and ensuring these are measurable (Drath et al, 2008; West et al, 2015).

> *Well we all have to have the same vision haven't we or it doesn't work. I think you've got to understand it as well I think it's important (Group 1, interview 10).*

What is clear is that not only is a vision required for effective leadership but there is also a need to be able to articulate, at a senior level in the organisation the change required (Bass & Avolio, 1993) so staff are able to understand and implement the change (discussed below in Group 3, interview 11). Research studies have shown that to provide high quality care organisations have to have a clear vision with equally clear goals and a way of articulating to staff how they will be achieved (Dixon-Woods et al, 2014).

> *...the ability to make complex policy at least sort of moderately understandable and to try to draw that clear line of sight down to frontline practice. I think it's really important for all strategic leaders to be able to do that (Group 3, interview 11).*

Interestingly for Group 1, understanding the vision at an organisational level and *being able to inform people about what the vision is* (Group 1, interview 5) was the most important thing, in terms of what they wanted from leaders at a local level. By contrast, Groups 2 and 3 spoke much more about understanding the vision set by government policy and meeting that. This difference is not surprising but reinforces the importance of the context of leadership because the three Groups are very different, with 2 and 3 having a more national perspective due to their roles.

> *I think leadership is very important because if you were just a manager you would just be managing the resource not really giving any direction into their professional way of working so it's looking at nationally do we need to deliver, what locally are we being commissioned for but working to high standards being that role model (Group 2, interview 4*).

The quote above implies what the social processes and actions attached to the vision should do, i.e. provide direction *into their professional way of working* for health visitors. Further exploration identified that to make the vision happen one would lead and, by explaining the vision one would get others to buy into your objective i.e. *gather the troops* (Group 3, interview 3). This makes the link between making the message clear and aligning people to that message to *take something forward* as described in the leadership task relating to *direction, alignment and commitment* (Drath et al, 2008, p. 635).

When comparing across interviews this notion of alignment related to *soul mates and like-minded people.* It also highlighted *linking to a sense of direction from national policies* to provide the sensation that *you're not alone* (Group 3, interview 9). This finding implies that having support to take the vision forward is important. This is exemplified below at a local level (first quote) and at a national level (second quote).

> *It's just having that support from colleagues to see where we are, this is a vision and we are just trying to get there but keeping at the forefront of everything we*

are doing all the time is the children, people and families we are here for. Sometimes staff forget that (Group 2, interview 4).

To lead on something as I started off saying you can't do it by yourself you have to gather the troops as it were and you need to find soul mates and like-minded people and particularly ones in other organisations because power will be in masses and the more people you can get signed up to it the easier it will be to take something forward (Group 3, interview 3).

It was recognised by all participants (see quote below) that you did not need to be senior to take something forward. Therefore, rather than seniority, what was important was *role modelling* the behaviour/action (Chapter 7). This endorses the point about informal leadership i.e. everyone is able to lead because it is part of one's professional role (Chapter 5).

I suppose visually you think higher, don't you first of all then it's things that come to mind like championing, spearheading, taking forward, and I think when I say high its actually not about seniority its high in terms of driving forward, being upfront rather than senior in terms of management. So, I suppose visionary, a shining example so role modelling would come into it as well (Group 3, interview 6).

This process of taking the vision forward was developed by exploring how this relates to the developing category purpose of leadership. Further discussion explored the meaning behind this process as the added action of *creating a vision* relates to *getting the best out of people.* It appears that leading and taking something forward and getting people on board are not enough in themselves. The quote below suggests that you also have to *connect with their motivation.* Creating a vision implies that this is not something done in isolation but something that has a purpose in itself, to build commitment to a cause. Engaging with staff motivation has been found to encourage staff engagement and involvement (West & Dawson, 2012; Leadership Academy, 2013).

Yes, leadership is about creating a vision and getting the best out of people, people realising their potential. You have to connect with their motivation and what motivates people and those three things autonomy, mastery and purpose usually are what motivate people (Group 3, interview 8).

The notion *of leading by example* to create the vision links closely to role modelling and re-emphasises how important role modelling is for health visitors in order to understand leadership. Translating the vision into action is imperative for leaders, as more attention is given by staff to actions than words (Avolio & Gardner, 2005; Wong & Cummings, 2009). *Understanding what front line staff are facing* has been identified by Whittaker et al (2013) as an important point in what makes health visitors feel valued by both their managers and organisation and improves staff retention.

Leading by example, having an understanding of what front line staff are facing setting a good example... Making sure everybody is doing the same thing and is supported to do the same thing. Having robust policies and procedures in place that are accessible and that staff know how to access them (Group 2, interview 12).

Participants suggested that clarity around the vision and recognition of the barriers to achieving the vision were both important. Participants recognised that not having a clear idea of direction would create confusion and question what, if anything, leadership has to offer. The three quotes below provide a context that recognises that vision alone will not achieve leadership. Of greater importance is that leadership cannot be just about the individual, the culture of the organisation and the context both have to be considered.

.... the direction has changed without anybody explaining why (Group 1, interview 5).

...there are things that we all want to take forward but it's not the actual taking it forward as a leader and working and running with it that's the issue its actually the bigger picture. I've got this manager to confront it's the whole system (Group 1, interview 10).

People are not clear on what the vision of the organisation is... even if there was a clear vision I'm not sure staff would find it easier to take that vision forward because of culture (Group 2, interview 7).

The 'how' of delivering on any vision appeared inextricably linked to goal setting. The quote below shows what can be achieved and the impact when this works.

I think the Children Assessment Framework system really works and when its running and the people attend and the family have goals and we've got goals things move forward and they can see it (Group 1, interview 10).

By using the constructivist grounded theory methodology and comparing data across interviews, coding and memo writing I was able to link the importance of early involvement in decision making and goal setting to professional knowledge and experience of how managers engage with staff.

Northouse (2016, p. 3) defines "*leadership as a process whereby an individual influences a group of individuals to achieve a common goal."* With this view in mind, if health visitors have no involvement in setting the goal, this may explain why the same health visitors do not feel engaged with decisions. A vital part of this process i.e. goal setting appeared, from the discussions with Group 1, to be omitted from the leadership process.

In addition, what this then led to was recognising what participants had said about making sense of policy and in turn providing meaning to the vision and the way forward. This is seen as key to effective leadership (Yukl, 2013; West et al, 2015). West et al, (2014) say the same about 'wicked' problems, in that they require leaders to make sense and

provide meaning for followers. It occurred to me, from looking at the data, that managers and senior managers talked about what needed to happen but they didn't talk in terms of making sense and bringing meaning to the changes occurring: this however was the essence of what the health visitors were saying was important.

This is a key learning point for me professionally, as I come across occurrences like this all the time with managers in health care organisations that constantly talk about wanting to empower and engage staff in change, yet never instigate their involvement at the start of the initiative when the decisions are being made about the change or consider how they make sense of "wicked" problems (Ham, 2014; West et al, 2014).

6.3 Followership

Within the NHS and health visiting/nursing there has been a focus on formal leadership. Such leadership is based on leaders and followers, with leaders in a hierarchy, normally based on a ranking, order seen as having the power to make the decisions and followers understanding this and what this means i.e. that they should follow (Cook, 2001; Aime et al, 2014). In this context leadership is viewed as legitimate power that is perceived by followers (Degeling & Carr, 2004) who then undertake the directions given. However, it is widely accepted in the literature that leadership only exists when authority and consensus is given by followers (Chreim et al, 2007; Bennis, 2007; DeRue & Ashford, 2010).

Reviews of the evidence in healthcare suggest that the concept of leadership as defined as a dyad of leader and follower is no longer fit for purpose in modern healthcare (Drath et al, 2008; NHS Leadership Academy, 2013; NHS Improvement, 2016). Understanding leadership at all levels, and how this can be undertaken is one of the objectives of this study. All health visitors are deemed to be leaders (DH, 2011), but what this means to health visitors and how this can be achieved is not addressed in the literature. Therefore, followership was explored through the interviews and data to understand if leadership

is perceived by participants as the popular concept; of *a "tripod" of leader or leaders, followers and a common goal* (Bennis, 2007, pgs. 3-4) or in another conceptual way.

The findings of this study in relation to how participants view *followership* will now be discussed under four headings: *influencing, safe to follow*, *two-way process* and *right to reply*.

6.3.1 Influencing

Influencing has been suggested as being at the core of leadership (Yukl, 2013; Northouse, 2016) and indeed influencing, as part of leadership has always been present in the nursing profession: demonstrated most notably by Florence Nightingale (Lorentzon & Bryant, 1997). The notion of everyone in an organisation being a leader can be explained by the concept that given influence is seen as a process, it can be undertaken by anyone within an organisation (Parry, 1998). All participants referred to the importance of health visitors being able to influence change. The outcome of influence is described by participants as improving children and families' health by changing activities that affect these groups by displaying what is considered to be best practice e.g. evidence based practice.

Visibility of leaders was identified by several participants as important. It was explained that one needed to know who one's leader is, so everybody could approach them and was therefore aware which *person had the most influence*. At a more basic level, if you know who the leaders are you can build a relationship with them (Haycock- Stuart et al, 2010).

> *Surely one of your biggest aspects of leadership is visibility, until you know who your leaders are and they are visible to you you've no access to them have you otherwise how do we crawl through those layers of management to the person with the most influence. A lot of things we want appear to be stopped at a certain*

level, they don't go any higher. I think even a lot lower than that why don't we feel able to approach people (Group 1, interview 5).

Members in Group 3 also highlighted this notion of leaders being visible in order to support change and offer opportunities to discuss issues as essential.

Yes, because with visibility comes contact and the opportunity to talk things through. If you're going to champion a new idea you need to allow people to express their doubts and work, it out for themselves. If they're going to buy into it they have to then enter into a dialogue about it (Group 3, interview 6).

The issue for many leaders in health visiting, and discussed in the interviews (Group 2), is the time to be able to display visibility when the team leaders are covering such large teams. That many of the leaders are working across organisations compounds this issue. This discussion was of personal interest to me as, having led a large department of nursing and midwifery visibility was an issue that was raised at that time by staff members as being very important. However, what this meant and how to achieve this when the staff base is large was always a predicament. Looking at the perspective of visibility through the interviews gave me a perspective I had not considered before i.e. the importance that individuals place on visibility and the reasons why i.e. as a basis for developing relationships, something that is well documented as important in leadership development as nurses understand leadership through relationships (Cummings et al, 2010; Cameron et al, 2011; Wong et al, 2013).

Building on relationships was described by Group 2 as the mechanism by which leaders exert influence e.g. *by ensuring a well-supported team built around a learning environment* (Group 2, interview 7). Relationships were widely recognised to hinge on trust where learning, not punitive measures, are used when adverse incidents occur.

I feel that the way I'm leading is not just about my students more so influencing the team by ensuring that we have a good well supported team that can enable

a positive learning environment mainly for students but also for the other staff as well so were all learning from each other (Group 2, interview 7).

Influencing policy is a key tenet of the Practice Principles of Health Visiting (CETHV, 1977). Interestingly, of the four Practice Principles considered fundamental to health visiting, in this study influencing policy was noted to be the one least frequently undertaken. The notion of influencing by assertiveness, and *doing what you perhaps know you ought to,* is interesting in that this is an oft said definition of leadership and what differentiates it from management i.e. doing the right thing (Bennis & Nanus, 1985). This suggests that by doing this you influence followers and appeal to their values and beliefs and, ultimately, their core motivations.

The literature recognises that the major aspect of organisational change that is *relevant to leadership is the use of influence to change the activities and relationships of people within the organization* (Parry, 1998; p. 86). Thus, influencing is recognised as a key leadership behaviour that leaders do (Hyett, 2003; Brigham et al, 2012; Yukl, 2013).

I think she probably taught us in terms of how she projected herself and how she behaved in terms of influencing policy.... Probably issues around being an advocate for and championing a cause and I think for me she was influential because of her assertiveness. I suppose it's about seeing somebody do what you know you perhaps ought to but don't know how and seeing it through (Group 3, interview 6).

It was suggested by some of the participant's in-Group 3, that health visitors could understand *leadership as using influence*. The process below describes an incremental change in influence as health visitors' experience of leadership develops so too does their role. This resonates with the work of Day and Harrison (2007) who define the leadership stages not in influence but in reach e.g. individual leader, relationships and the most complex collective.

...perhaps if people thought of leadership as using influence. When we did Leading Empowered Organisations (LEO) and the ones for more junior staff leadership at the point of care and those kinds of things it was about understanding what you could reasonably influence and then understanding where you might in two years be expected to influence and that would be part of your growth in preceptorship in the first two years. Maybe think about it like that. So, from the moment you qualify I expect it is within the practice of a health visitor to influence families in their care to influence other practitioners that they work with (Group 3, interview 11).

This notion of an incremental process of leadership for health visitors was discussed in terms of taking the influence from operational to strategic, and is denoted as a time when health visitors *felt more like a leader.* However, this does not take into account the requirements inherent in reformulation of identity required to 'become' a leader, which is arguably why there was an overwhelming agreement from all participants across all Groups that even health visitors with years of experience do not all feel like leaders (Chapter 7).

It is clear from national policy (DH/DfCSF, 2009a, b; DH, 2011) that the expectation is that all health visitors should, from *the moment they qualify*, lead the HCP. Unfortunately, leading the HCP is the most difficult area to lead. It requires leadership across several organisations (Chapter 5) and is dependent upon the model of practice, as it requires collective leadership skills to work across complex organisations. Collective leadership is described by Day and Harrison (2007) as requiring the most sophisticated leadership skills.

By the time you are two years on you might describe a more strategic influence that might be where people feel more like a leader. But leadership of the HCP means to me from the moment you qualify that is your job and actually that is about influencing all those things. So, working with Children's Centres and

working with whoever else using that influence then maybe progress to a bigger picture kind of thing (Group 3, interview 11).

This view of leadership through *influence and communication and partnership building (Group 3, interview 11)*, expressed by members of Group 3, were also recognised by Groups 1 and 2. There is something that happens in the social process of leadership that prevents this way of working i.e. in partnership, from happening at times (as discussed in section 6.2.2 taking the vision forward). *Dictate and hierarchy* (Group 3, interview 11) appear to happen even when managers are trying not to do this by not listening to health visitors and not developing joint goals early enough in the process.

...leadership through influence and communication and partnership building and all of those things are what we need rather than through dictate and hierarchy (Group 3, interview 11).

Participants also highlighted the complexity of influencing change. They recognised that service organisation and priorities were key in successfully implementing new initiatives. Being able *"to influence others to change established practices"* was a key leadership skill (Hartley et al, 2008, p. 48; Brigham et al, 2011; Yukl, 2013). However, not all participants felt that health visitors possessed this skill.

6.3.2 Safe to follow

Many participants spoke of the need to feel safe about the direction a leader was taking them in. They also spoke of the importance of a leader being able to articulate and demonstrate the skills required to achieve goals, along with the importance of being able to trust the leader to deliver on what they said they would do. These points are reflected in the literature as key for effective leadership (Germain & Cummings, 2010; West et al, 2015), as central tenets of forming good relationships are trust and respect (Rickards & Clark, 2010; Yukl, 2013).

I've worked in quite a lot of busy teams and its somebody that makes you feel safe in the fact that you are having to look at risk all the time, so we look at risk in child protection but we also look at risk when we are busy and we're not able to fulfil the HCP and it's about having that leadership guidance and ability to structure what you are doing within policies and frameworks so that you feel yes we're not completing what we should be but we are safe and we are practicing safely and that's part of good leadership really (Group 1, interview 10).

This notion of 'feeling safe to follow' was then explored further. Qualities such as *passion and being knowledgeable* were mentioned as important especially when times were tough. It was felt by some participants that leadership must define priorities and by doing so it makes you feel *safe, reassured and motivated*. This links to the literature that explains effective leadership as needing to provide clear objectives and priorities (Haycock- Stuart et al, 2010; NHS Leadership Academy, 2013; West et al, 2015).

When they are passionate about something and knowledgeable though about it as well, I mean we all face sort of tough times don't we and tough decisions and pressures and things but when you speak to someone that is clearly a good leader and they sort of almost like you say there is prioritisation and it makes you feel much more safe and reassured that you are doing everything that you should be doing it then fills you with that motivation again that you know things are okay yes and that you can fulfil what you need to fulfil in your role (Group 1, interview 10).

The relationship between the leader-follower was elaborated by Group 3 who talked of *the person I am prepared to go behind.* This made it clear that for people to follow there has to be something about the leader that motivates followers to act and to be influenced. This is supported in the literature (Chreim et al, 2007; DeRue & Ashford, 2010). It appears that this is dependent upon the leader making the follower feel safe. To do this the leader has to *have interpreted what they are doing* i.e. the goal is crucial to the health visitors. This is key professional learning that I have shared with several

managers who are trying to make changes yet have not grasped that how you sell that message and make sense of it is crucial for staff to engage.

> *There are many competencies of a leader that followers need to have seen and interpreted as "this is the person I'm prepared to go behind", there is a direct connection between the two and equally a leader has to recognise that it's no good barking about things if they haven't interpreted what they're doing clearly enough for people to be able to follow. So, its two-way traffic, about good communication, gaining understanding from people in both directions (Group 3, interview 3).*

Group 3 expand upon this point and talked about *courage and "putting your head above the parapet"* as central components of leadership. This is clearly making the action explicit, *put up or shut up,* linking leadership to personal attributes such as being *confident and competent,* in order for followers *to trust and respect the leader and therefore feel safe.* (Attributes are discussed in Chapter 7). There was a strong theme of courage/bravery, doing things even if people may not like it, being linked to having a vision. So, vision starts to develop as courage and commitment to achieve a goal, even in the face of adversity.

> *Absolutely, why would you follow a wimp of a sergeant major on a battle field, of course it takes courage because at the end of the day you have to put your head above the parapet. You've got to be prepared to stand up and be counted, that's not about being defiant, it's not about talking against the organisation or the profession you work with but if you strongly believe in something you've got to either put up or shut up. It's no good sitting in what my old matron used to call a holy huddle it's no good whinging about stuff if you believe it and I think this is where leaders can come from grass roots (Group 3, interview 3).*

> *I guess what it means for me is someone or people who are confident and competent in what they're doing so that I as a follower can trust and respect*

them sufficiently to feel safe in whatever it is that they're leading (Group 3, interview 3).

Crucial to participants' understanding of leadership was recognition of the importance of the relationship between the leader and follower (Hyett, 2003; Germain & Cummings 2010; Cameron et al, 2011).

6.3.3 Two-way process

The relationship between leader and follower has been an area of discussion for several years (Knippenberg & Hogg, 2003; Jackson & Parry 2011; Yukl, 2013). All participants noted the concept of being able to be a leader and a follower, depending on context. They were also equally clear about the importance of the relationship between the leader and follower.

The excerpt from the interview below describes an initiative by a health visiting team to develop an element of practice; this was provided as an example by a member of Group 1. After discussion within the focus group this was presented by Group 1 to explain the dynamic between leader-follower and one that exhibits shared leadership. According to Pearce, Hoch, Jeppesen, and Wegge (2010, p. 151), "*shared leadership occurs when Group members actively and intentionally shift the role of leader to one another as necessitated by the environment or circumstances in which the Group operates."*

We all meet as a team and actually two people in the team, have decided that they will trial it and they'll run it but we all work as a team to do it. And now it's got to the point when it's worked really well that we are now sharing that load and we are all involved in it. So they initially set it up and set it going so it is a team direction, so it is a bit like that really it took on a leadership role and then team members have been linked with it, suppose you should say was sort of following that lead role so it is interchangeable that now some of the followers

are taking on that lead role and taking over from it. Then someone might suggest something else to do (Group 1, interview 10).

This demonstrates the processes and actions taken by a health visiting team to achieve a goal. In this instance, the goal was to improve one aspect of practice. This example illustrates how this improvement was managed by initially having two leaders who later became followers as the team understood and engaged with the initiative. This was a good example of how follower/leader roles are interchangeable. Furthermore, this exemplifies that anyone with the appropriate knowledge and skills for the task can lead because none of the health visitors in this initiative held formal, appointed leadership roles.

Group 1 highlighted that to have this *interchangeable* role they had to be *offered the opportunity.* When this was explored further in the second focus group of health visitors (Group 1, interview 10) the example above was cited. In response, this group of health visitors expressed that the responsibility lay with the team to make the opportunity rather than waiting for it to be offered.

I think all followers have got the capacity to be leaders but they're not offered the opportunity (Group 1, interview 5).

As the leader-follower relationship was explored further it became obvious, comparing the interviews through the constant comparative technique that the concept of *sharing good practice* was manifestly something that made practitioners want to lead and therefore, was highly motivating to the health visitors (Brigham et al, 2012).

Who was doing the leading was an important caveat made by several participants with regards to if they would follow. This suggested that as an appointed leader you had to be prepared to foster an environment where you wanted followers to lead and be prepared to share power. In return, the followers had to want to follow you (Haycock-Stuart et al, 2010; Cameron et al, 2011).

I think there is a link between followership and leadership and I think probably in health visiting only in that we've all got to deliver on the HCP so we're delivering very similar services and I think probably sharing good practice that other people may follow as well, but it depends on the person who's doing the leading (Group 2, interview 2).

Yes, because people do both all the time. Yes, I suppose I'm struggling with this idea that a leader is something there where actually if it's distributed amongst us then a good leader is creating leaders in other people (Group 3, Interview 8).

It was interesting to observe the passivity ascribed to followers by some participants. This was specifically explored further in subsequent interviews and by comparing data (Charmaz, 2014).

One participant described the relationship between leader and follower as *probably more an alignment than following.* Several participants appeared clear that the relationship between leader and follower allowed the roles to be interchangeable depending on the situation. However, some participants remarked that some people would always be followers. Their implication was that this was because these 'obligate followers' either did not have the abilities to lead or because following *doesn't necessarily require thought...* and by following responsibility is not taken for your actions.

Some participants provided an alternative view. They referred to some individuals being *active followers* by which they meant followers who actively, but constructively, challenged the leader. This view supports the idea of being empowered and having a voice. The follower was seen as an active role*, they are always marching forward (Group 2, interview 12).*

You can be an active follower rather than a passive follower. I think we are quite active followers because we are a quite vocal group (Group 1, interview 10).

Well followers never want to be seen as followers everybody wants to be a leader I suppose. Sometimes I think I work for that person so maybe that's being a follower and people who I read so I suppose that's being a follower people who inspire but following I suppose has always got a slightly passive … and I think people shift around so people will align themselves with somebody it's probably more an alignment than following. Following assumes you're behind somebody (Group 3, interview 8).

Participants described themselves as following senior management because of the nature of the formal leadership role they possessed; however, this in itself wasn't enough for them to passively follow. The leader had also got to have other skills and /or attributes, already noted as important for credibility as a leader. This is supported in the literature where it has been found that to be seen as a leader you need more than a title but also need to be demonstrating competence and decision making in your role (Chreim et al, 2007; Germain & Cummings, 2010; DeRue & Ashford, 2010).

That would depend on how inspirational leadership is because we'd have to want to follow that example wouldn't we (Group 1, interview 5).

The interchangeability of the leader and follower process appears to arise by followers watching and learning from knowledgeable senior leaders and modelling their role upon them. This was encapsulated by *you've got to receive leadership before you can deliver it* (Group 1, interview 5). This again emphasises that health visitors learn to lead through experience as a professional and observation and mimicry of perceived good performance (Chapter 5 & 7).

Someone who's got more specialist knowledge than I have in a particular field, looking up to higher management where I may go and share ideas really, or maybe follow their style of leadership (Group 2, interview 2).

Thus, health visitors build confidence and then feel prepared to take on the leadership role when they understand the message or the leadership task in enough depth to share with others. In this process the experienced, knowledgeable leader can share their knowledge and skills with other staff and enable them, through the process of empowerment, and role modelling to take on a leadership role and therefore, distribute leadership. This process was explored across interviews through constant comparison of the data.

I think there'll be an extent where staff will follow but I think to really lead you've got to take that initiative to get involved. So if there's a complex family for example it's about understanding what's needed and maybe leading by example there and getting the staff that may not be too confident about engaging and doing work around that family but that Advanced Nurse Practitioner doing the lead and empowering and sharing some of the skill and knowledge they've got to empower that individual health visitor to maybe take the lead the next time (Group 2, interview 4).

The idea of learning leadership from clinical practice supports the discussion around professionalism (Chapter 5). Health visitors learn and demonstrate knowledge through their expert clinical roles. They gain experience throughout their professional career.

Learning from working alongside able leaders is seen as essential by all participants and on this basis, should be incorporated into leadership programmes. Participants discussed following the leader as being linked to attributes of that leader i.e. being inspired by that person. However, it was not just about the individual leader, or one leader the ideas espoused by the leader and the potential for a collection of different leaders to achieve the goal were seen as equally important. Thus, the relationship is not

as straightforward as the dyad leader and follower. Which suggests the follower has conscious choice and chooses to align with ideas not necessarily the individual leader.

6.3.4 Right to reply

I initially labelled this focused code as 'having a voice' and then changed it to 'right to reply' as it appeared from the data to be more than speaking up but being given the opportunity and recognition by senior managers/leaders to have a right to reply, a term coined in the interviews and is about being part of the change, to ensure these were made safely without risk to clients or staff. The literature on voice behaviour encapsulates some of these points and describes having a voice as making helpful suggestions, that can improve group performance, by identifying different opinions to the ones been expressed by the leader (Wong & Cummings, 2009; Wong et al, 2010; Brigham et al, 2012).

Participants identified the benefit of having followers to act as a sounding board for ideas that are being proposed. It was felt that they could challenge ideas. However, this was perceived differently by different groups in the study. Some participants saw resistance to following as negative.

Interestingly the approach used to manage resistance by followers was discussed in terms of *performance* management of the individual not of the environment. This raises the question of what notion of leadership is perceived to be effective i.e. transactional as opposed to a more transformational or collective approach.

> *I think following is an important part of leadership because if they didn't follow they might want to be resistant and dig their heels in and say they're not doing that so that might then become more of a performance issue and we'd have to bring some of the management processes for that (Group 2, interview 4).*

Resistance to change was seen as negative by some participants in Group 2 but Group 1 saw resistance to change as having no *right to reply.* The difference in views is unsurprising when dissent is seen by some in management roles as performance issues rather than engagement.

> *It's not a two-way process I think probably if we're talking about leadership we'd expect it to be a give and take process wouldn't we in that your followers should have some right to reply but we have none. Yes of course there should be some dialogue shouldn't there (Group 1, interview 5).*

This was explored further with Group 1. It became clear that a *right to reply* was considered essential to allow safe *challenge* of new developments. This was discussed further in terms of the process between leaders and followers, following some kind of two-way communication that allows discussion.

> *I think that's where you get conflict then if other people are followers and other people are leaders and they question the change then you get conflict because then you or the other person saying why do you have to do it this way why not the other way and that's when you need a good leader to be engaging. Conflict is good in a team or business. Challenge is good not necessarily conflict. Constructive criticism is good because then you can share and exchange get people on board and change their views or maybe do things differently other than saying this is what we do and then people just do it because it might not work or you might not fully do as you intended and it doesn't work (Group 1, interview 5).*

A process of leadership emerged from the data. This included facilitating the sharing of good practice between health visitors so that the overview/vision within the organisation about the need for change was understood. In addition, specific aspects of change could be discussed by health visitors and constructive feedback provided by them. This would influence the plan to implement the change. In this process who leads the change can be fluid, depending on who has the knowledge and skills to do so. It

became apparent that through reviewing these processes and actions emerging from the data, that these elements were properties of the emerging categories, in this case '*purpose*', but this is interwoven with '*context*' and '*behaviour*' and will not occur unless a benefit of the change is recognised as the potential to improve practice. Further testing of these theoretical emerging categories continued throughout the interviews through theoretical sampling.

> *I think leadership for me is more about sharing practice and enhancing practice so that we have opportunities for somebody to have an overview of everything and then bring us all together and say this is working really well in such and such an area can we discuss it and see if it would work in your area. Share some good practice (Group 1, interview 5).*

The idea of sharing good practice was expanded further in-Group 1, interview 10. A process emerged that considered the notion of being *fluid and moving* from leader to follower and vice versa. The action to initiate this being feedback which allowed followers to have a right to reply and if listened to, they could then share the leadership role.

> *Fluid you do move don't you along the continuum. At the end of the day you might be a leader saying I want you to implement this change but the thing is the feedback back from other people [followers] you might then become the leader and say well this isn't working because of this and this do you know what I mean and you are then directing the leader because you are giving the feedback (Group 1, interview 10).*

What happens when this loop is not put in place is described by Group 1 as feeling *disempowered.* Then you *carp and moan* rather than challenge effectively. It is then easier to understand the perspective of managers and how this can become something that the manager in-Group 2 regards as a performance management issue.

I think that depends if as a follower you feel completely disempowered or not, if all you are told is what to do all the time and that what we understand by leadership then you become like a sheep you just become disempowered and it's easier to follow and carp and moan than to challenge (Group 1, interview 5).

Creating a safe environment to challenge is essential for improving care but also for maintaining staff morale and motivation. This relates both to how health visitor's work with complex families and how they challenge low levels of parenting that are believed to be unacceptable. This is supported in the literature (Francis, 2013; NHS Improvement, 2016).

When challenge was discussed in Group 1 and then in Group 2 to understand further this notion of right to reply and what this means and how this fits within leadership, a member of Group 2 explained the concept of challenge in a positive way, almost as a measure of success and that health visitors *challenge or question* is seen positively. I wondered if the challenge was regarded as positive if it was aimed at colleagues and not managers.

I think it has empowered them and helped them with their leadership skills even if they don't recognise that I think it has and I think you can see the ones where it has because they can be more challenging with members of staff, they'll challenge or question why (Group 2, interview 2).

A manager in Group 2 explained what that action looked like when staff were demonstrating leadership, they were questioning the change rather than accepting it without consideration.

They'll go more in depth of why we're doing this, what difference is it going to make, is it a change that's going to happen just for the sake of it can you explain it further, just exploring around it more rather than just going along with it (Group 2, interview 2).

Questioning and challenging are interesting. They were explored further in group 2, interview 4, to clarify the relationship between leader and follower. The response was *you wouldn't want everybody to be a mover and shaker*. This implies that following is passive and required for things to get done. It denotes leadership not as a fluid, shared activity governed by expertise in that specific place but as a transactional leader dictating that things get done.

This begs the question; can you challenge on the one hand and be a passive follower on the other? If you do not challenge then how does that affect your identity as a leader?

> *Sometimes they do and I think some staff don't and probably there is a role for followers because you wouldn't want everybody to be a mover and a shaker because you'd not get everybody to do the work that needs to be done but I think when they're dealing with some of the challenging families it's just having some of those key skills to be able to challenge some of their behaviours back again. Is it acceptable to be a parent in this way sometimes staff can be a bit lacking in confidence to address some of those issues (Group 2, interview 4).*

Group 3 were asked, what is actually wanted? Is it a health visitor demonstrating leadership through challenging what strategic leaders ask of them? Again, it was clear that there are mixed views, some *just want a workforce that follows and does what they're told.* Memos were used to analyse whether this was why the leadership identity of health visitors was so confused. On the one hand, they are told to lead (DH, 2011). Then if they challenge they may be seen as difficult so leadership is not always reinforced by the managers. This is particularly pertinent now in healthcare organisations where there are still issues for whistle-blowers who do not always feel supported when raising concerns in practice (Francis, 2015).

> *So some organisations will have a more open and true/genuine approach to bottom up thinking and have good mechanisms for allowing people who are front*

line practitioners to inform the thinking of the organisation but some quite overtly block that and don't want it because it's harder work and they just want a workforce that follows and does what they're told (Group 3, interview 6).

What is clear in the literature and from the data is the importance of allowing challenge (Brigham et al, 2012; Ham, 2014). It is essential to incorporate feedback into the system to ensure client/patient safety and staff morale. This is a cause for concern for health visitors when systems do not allow time for, or value constructive feedback. Moreover, the system may not promote the fluidity between leaders and followers.

I think in terms of what's happening things are being said that are going to happen and you don't go through the change process and things happen before you even know what's happening. Yes, a proper leader would make their followers make them feel as though they had a hand in the change process (Group 1, interview 5).

To try to understand leadership at every level I reflected on in what context and circumstances are leader/follower roles interchangeable? This was discussed in subsequent interviews. The notion of one leader was still thought to be important by several participants with some suggestions following a traditional model of a triangle with the leader at the top.

I think it's very difficult for one person to lead on absolutely everything. If you have one person leading on absolutely everything you're not going to get the variety that you'd pick up if you have two or three people. Maybe you've got one overall person but then two or three other strong leaders underneath who work together but are separate as well if that makes sense (Group 2, interview 7).

Interview 3 expanded on this discussion. The need for one leader was seen as being about the need for clarity. Then, instead of a triangular model of leadership the notion

that what you need is *people with leadership skills.* What these leadership skills entail was discussed further with the participants and is presented in Chapter 7.

> *I think again the analogy of the forces is a good one, when you've got to jump over the top actually you only want one person giving that instruction so there is something about "the leader" but there is something about having people with leadership skills who can do other elements. So, you know members of different infantry will belong to Groups, so there'll be teams of health visitors that will be headed up by somebody who will lead them but at the end of the day you need one definitive voice and I'm very clear about that because otherwise everything goes awry (Group 3, interview 3).*

This notion of an interchangeable leader/follower fits within a more inclusive, shared/distributed notion of leadership, as discussed in the literature review. This is advocated in the NHS at present (West et al, 2014; NHS Improvement, 2016). This interchangeable leader/follower role is further explained by the relationship between the two, the importance of which is discussed widely in the literature and reaffirmed in the interviews as important to make the interchangeable roles occur as *some people need different kinds of things from a person who is leading them than others* (Group 3, interview 11). This notion of leadership then helps to understand how leadership can be at all levels.

6.4 Chapter summary

This chapter discussed the *purpose of leadership* as the second category, defined through setting the direction and followership.

All participants in this study referred to the purpose of leadership needing to be explicit for health visitors to be able to understand what it is they are leading on, and why. Therefore, clarity of direction from leadership is required.

The findings in this chapter suggest that the *purpose of leadership* is not always clear because the vision is not always clear at an organisation level. Although what is clear to health visitors is that they are working to deliver the HCP, through the four-service level model referred to as the "family offer", even though they recognise that the community level is not always provided. In order to engage health visitors further in changes in service delivery they need to be clear on the goals of what is required and be involved at the decision-making stage to ensure maximum engagement and most importantly understand why that change is occurring.

Health visitors did recognise the tripod definition of leader, follower, goal attainment, (Northouse, 2016) and could see how there could be fluidity across the roles of leaders and follower and, through recognition of their influencing role, achieve leadership at every level. Whilst not all using the same terminology as Drath et al, (2008) in essence their actions and emerging processes did coincide with the idea of a broader notion of leadership based on direction, alignment and commitment.

In summary, participants recognised that leadership is a fluid process based on social processes specifically that of the relationships between leader and follower, with the follower role being more than a passive activity. Participants in this study endorsed the importance of relationships in understanding leadership; this is supported in the literature review. The implications for practice is to recognise when the conditions of this social process of fluid leadership emerge i.e. when participants feel competent and safe to partake in leadership, and the conditions required to make this happen i.e. the requirement to facilitate leadership opportunities for health visitors and provide support for them from service managers/leaders.

Chapter Seven

7. Leadership behaviour

7.1 Introduction

The previous chapters identified the first two categories arising from the data: *context of leadership* and *purpose of leadership.* This chapter presents the findings of the third and final category, *leadership behaviour,* and builds on the previous two chapters to postulate how all three categories are interrelated.

How leaders behave is important to the leadership culture of an organisation because the leadership style they adopt within the organisation reflects the vision and beliefs of the organisation. In essence, what leaders say is not as important as how they act because those actions transmit more than the words of the leader, about what they see as important and therefore, how they influence followers to act (Avolio & Gardner, 2005, Wong & Cummings, 2009).

This chapter describes how health visitors understand the behaviour inherent in leadership and the effect that this has on their role. Three sub categories of *leadership behaviour* emerged from the data *role modelling, identity and developing leadership.* The properties of this category are represented in Table 7.1.

Table 7.1 Subcategory components: Leadership behaviour

Focused Codes	Subcategory	Category
1. Impact on staff and clients	1.Role modelling	1.Leadership behaviour
2. Attributes		
1. Health visiting leadership identity	2. Identity	
2.Autonomy to make decisions		
1. Leadership skills	3. Developing leadership	
2. Leadership training		

7.2 Role modelling

A role model has been defined *as a cognitive construction based on the attributes of people in social roles an individual perceives to be similar to him or herself to some extent and desires to increase perceived similarity by emulating those attributes* (Gibson 2004, p. 136). *"Role modelling is a traditional expectation"* in nursing, whereby "*less experienced nurses"* learn "*from more experienced nurses"* (Murray & Main, 2005, p. 101; Felstead & Springett, 2016). In the leadership literature role modelling is cited as a means of understanding and learning about leadership (Brown & Trevino, 2014; Bowers, Rosch, & Collier, 2015).

Participants were asked about their experience of leaders and leadership in the initial questions. All participants mentioned role models across all three groups to describe what the participant perceived leadership to be. By the end of the first interview set, (which consisted of 5 interviews), it become apparent those role models were very important in helping health visitors to understand leadership.

How participants described a role model, and why they were important for leadership was explored with more specific questioning in subsequent interviews. This approach fits with the grounded theory method of theoretical sampling where interviewing is used

not only to learn about the world but to advance and expand the categories to construct theory (Emmel, 2013; Charmaz, 2014).

After initial line by line coding *role modelling* was elevated to a focussed code. After completing interview set 2 (a further 4 interviews), it seemed that *role modelling* should become a category. Further comparison was made between set 1 and 2 interviews. Finally, after role modelling had been explored further as a potential category, in the interviews for set 3, I decided that *role modelling* did not explain the other sub categories sufficiently and decided it should not be a category. *Leadership performance* was initially fixed as the main category, to pull together the other sub categories. This was explored through memo writing. During the last three interviews (set 3), this concept was explored further and *leadership behaviour* was chosen as the main category because it best identified the properties of the category (Charmaz, 2014; Giles et al, 2016a).

The participants' experience of role modelling is discussed under two headings; *impact on staff and clients* and *attributes.*

7.2.1 Impact on staff and clients

All the participants noted the impact that role models had had on them. Having these role models was identified through the co-construction of the data as one of the most significant professional experiences that influenced how they understood and experienced leadership as part of professional practice. This is demonstrated below from interview 4 where the participant was identifying somebody they had worked with several years previously when newly in service, this still resonated, as encompassing what good leaders are all about years later. The second quote demonstrates how this experience of role modelling is then acted out by the health visitor in interview 5.

Whenever I think about a good leader that's the one person that does come to mind because she's got such a vast knowledge of experience of the service we were working in at that time (Group 2, interview 4).

When you are in clinic you are the lead for that clinic so being a role model, being punctual, having integrity... (Group 1, interview 5).

Included in this concept of role modelling was how they perceived leadership in terms of how the role model behaved towards them as a leader/practitioner, as well as recognising the impact of their own leadership behaviour on others e.g. colleagues and clients. The reciprocity of being treated well by a supportive manager, on how patients then experience healthcare positively has been well documented in the literature i.e. staff satisfaction from good managers/leaders is directly linked to patient satisfaction (Pearson et al, 2007; Cummings et al, 2010; Wong et al, 2013). This was discussed in interview 6 where the behaviour of the role model had inspired the interviewee and subsequently influenced their professional practice.

...it's about seeing somebody do what you know you perhaps ought to but don't know how and seeing it through...in terms of becoming a health visitor she probably influenced me, and I did used to keep her in mind what she used to speak about... (Group 3, interview 6).

This notion of seeing something through, in relation to change through leadership is discussed in Chapter 6. I wrote a memo to explore this further in terms of what it is that makes seeing it through so important in the context of a role model and the discussion in Chapter 6 regarding engagement. It then occurred to me through the constant comparison of interviews, and later comparison of sub -categories as they evolved, that actually making something happen is important on several levels. From a role model perspective, what participants described they wanted to see is a leader achieve something, so that they felt inspired that they could do it, but also to observe how to do it.

Seeing what can be accomplished through leadership action is supported in the literature as something that makes individuals feel inspired (Curtis & O'Connell, 2011; Bowers et al, 2015). This also links to the literature that recognises the importance of 'action over words' in leadership as a marker of authenticity (Avolio & Gardener, 2005; Salnova, Lorente, Chambel & Martinez, 2011) and the importance of making individuals feel the action of the leadership, through providing meaning and sense making (Smircich & Morgan, 1982; Jackson & Parry, 2011; Parry et al, 2014).

This concept of role models was explored further in interview set 2 with regards to the impact of leadership on clients as well as professionals.

> *Role modelling is a complex process probably some mirroring some neurological processes of what we unconsciously and consciously see happening in other people. The nurses would never ever think they were transmitting any of that certainty in their work with clients but clearly at some level something happens. I think that mirroring, role modelling cultural context that we create around us and other people create for us is probably what I'm thinking of here (Group 3, interview 8).*

This extended the view of role models from being purely about professional role modelling i.e. one professional to another and, instead, identified the importance of the professional modelling behaviour with the clients that they work with. This is important as we know that how staff are treated has a reciprocal effect on how they behave towards clients/patients (Wong et al, 2010; West et al, 2012). This notion of reciprocal behaviour was captured in the quote below when discussing how role models help health visitors understand leadership.

> *I suppose there's a common-sense principle that you should behave in the way you want other people to behave (Group 3, interview 8).*

To understand the value of role models to leadership I discussed further in all interviews what it was about role models that made them so important to leadership. This revealed that several attributes were ascribed to role models (this is discussed below in section 7.2.2).

It was noted that when all three groups talked about role models they were very animated and you could feel the emotional connection and impact that these role models had had on them. It was unclear initially why role models evoked such passion in the participants and why they were so important to them. On further examination, it appeared to be because what participants valued in the role model linked back to their own values and beliefs and what inspired and motivated them and also helped them feel safe. This is supported in the literature (Wong & Giallonardo, 2013; Bowers et al, 2015).

I compared the focused code *safe to follow* (Chapter 6), with the focused code role modelling. This comparator was chosen because there was a marked similarity between leadership keeping you safe and pushing you forward and how this denotes positive role models. In addition, the notion of action and *seeing it happen* supports the earlier discussion of seeing change occur from leadership being important to participants. Thus, practising in this way also resulted in participants feeling safe, even when working in difficult practice environments with competing demands. This is supported in the literature (Dirks & Ferrin, 2002; Brigham et al, 2012).

> *I can certainly identify with sisters and staff nurses in my early training people who came across as very capable very clam very happy to share. Gave you high levels of trust but were there to make sure that you were safe, patients and people were safe more to the point. So, I think all of those things people who could really tell a compelling story about what it was they wanted to achieve and people who could make things quite simple and straightforward (Group 3, interview 11).*

Several participants thought that a role model to emulate was important when learning how to lead. Looking up to others has been seen as a key component of the process of role modelling (Aliakbari, Parvin, Heidari & Haghani, 2015). This view supports the earlier discussion (Chapter 5 & 6) that how health visitors learn leadership is by observing and copying leadership in clinical practice and by the experiences they acquire as a professional (Bandura, 1977; Brigham et al, 2012). This experience of working with a role model also has the effect of verifying their own understanding of leadership by allowing health visitors to practise leading when they feel safe and confident.

The quotes below give examples of this view, namely that participants wanted to emulate positive role models. How leadership behaviour is viewed and seen in action by health visiting leaders is about seeing leaders walking the walk (Group 2, interview 12).

> *Role modelling and I think the value of what you do as a practitioner and how others view you I think leadership is very much about what people see how you practice and that role model relationship (Group 2, interview 7).*

> *You can read and spout lots and lots of things but if you can't walk the walk so it's like you do a good job I would like to be like you (Group 2, interview 12).*

> *I think for me there's nothing better than a role model they need people they [health visitors] can emulate (Group 3, interview 3).*

Further light was shone on role models by the interviews in set 2. This included the following understanding gleaned from Group 3 interview 8, where role models were felt to be not necessarily about the person rather about the time of your life or stage of your career, re-enforcing the idea that leadership is a relationship that occurs between the leader and the follower (Germain & Cummings, 2010; Jackson & Parry, 2011) and is context specific (as discussed in Chapter 5). At different times in your life/career you may need different things. Thus, you might want to follow a role model who makes you feel safe when you are junior or in a new environment. Participants discussed this as a

process, in that initially you observe that person leading and learn and then, when you feel confident, you take on the leadership role yourself.

In Group 3, interview 8, another idea was introduced. This idea was different from that proposed by the other participants who, on the whole, did want to be like their role models. In Group 3, interview 8, the discussion turned to what role models offered i.e. created a vision and connected with my motivations. This is supported in the literature (Avolio & Gardener; 2005; Cummings et al, 2010; Wong & Giallonardo, 2013).

> *I've had a long career and role models pop up in unexpected places... I think it's interesting the concept of a role model. I suppose often it isn't the person it's the time of your life when you come across them that leadership is a two way process that goes on between people...I was very young and she probably somewhere connected with me as a big sister sort of role model and was creative and imaginative and serious and made the world safe for me when I worked as a newly qualified health visitor....I was so young and confused there are people you learn from but role model assumes you want to be like them and I'm not quite sure that's the right word because I haven't worked with people I think I want to be like so I think I've been lucky to work with people who have created a vision and connected with my motivations and formed a connection that has made me want to learn from them that's as much learning from people (Group 3, interview 8).*

Social learning theory (Bandura, 1977) suggests that "*individuals learn what to do and how to behave by observing and emulating role models. This social learning begins when individuals focus their attention on modelled behaviours"*, meaning that they do not need to experience first-hand the activity to learn from it. This, it is suggested, is possible to do by observing others, rather than having to have the direct experiences (Brown & Trevino, 2014, p. 590). This almost certainly occurs *even without conscious awareness on the part of the role model* (Bandura, 1977; Ogunfowora, 2014, p. 1470). Modelling is demonstrated most effectively through actions and not words, this is similar to how

leadership is role modelled (Avolio & Gardener, 2005; Brown & Trevino, 2014) especially in ethical leadership approaches as these leaders are considered to have "*moral person attributes"* (Brown, Trevino & Harrison, 2005, p. 106).

In addition, it has been suggested that individuals can learn from both positive and negative role models (Brown & Trevino, 2014). This was demonstrated by participants who expressed learning as much from negative models of leadership as from positive ones.

The above illustrates the importance given to role modelling by participants in their understanding of leadership. From this it is abundantly clear that leadership programmes need to recognise the importance of role models e.g. mentors/managers (Ogunfowora, 2014; Brown & Trevino, 2014) and social learning theory. It also provides further understanding of how health visitors understand leadership as an unconscious activity that is undertaken through experience in their professional roles (as discussed in Chapter 5) and suggests that bringing the activity of leadership more to the forefront, as part of understanding leadership within their role and as part of identity development, could be a beneficial aspect of leadership development (this is discussed further in Chapter 8).

7.2.2 Attributes

The important attributes for a leader are discussed widely in the literature (Bennis, 2003; Avolio & Gardener, 2005; Rath, 2008; Yukl, 2013). The attributes of a leader were not something specifically focused upon in the first few interviews. Despite this, it gradually became apparent that the attributes of the leader were very important to how the participants defined leadership and understood it as a process. This concept was therefore introduced into later interviews to build and test developing sub categories and categories (Charmaz, 2014).

All participants discussed the qualities of a good leader and many described this through examples of role models. Being *fair, knowledgeable, passionate, compassionate, credible, inspiring and motivating* were seen to be particularly important. The literature supports these attributes as being seen as important in leaders (Brown et al, 2005; Germaine & Cummings; 2010; Paterson et al, 2010).

Participants described how the role models they perceived as good leaders acted and it was important that they could be seen to bring about change through action. Visibility was seen as important by some participants as, in order for health visitors to be able to role model leadership they needed to see it and have the opportunity to build a relationship with leaders in order for health visitors to know whom to approach to influence (Brigham et al, 2012) (this was discussed previously in Chapter 6).

> *My role model in nursing was a ward sister that I worked for, for quite a number of years. Her leadership style she wasn't autocratic she was I would say a democratic manager but she was very fair and the patient was always the main focus. Her disposition was kind polite you know was really aware of people's feelings and she knew how to talk to people properly very supportive (Group 1, interview 10).*

A different member of Group 1 (interview 10 & Group 2, interview 2) then moved the discussion from attributes to include the notion of motivated and passionate: how the leader makes you feel. This is supported in the literature review that highlights how effective leaders provide a sense of value to the work that staff undertake and "*a sense of purpose, which inspires staff to be committed"* (West & Dawson, 2012; Dixon-Woods et al, 2014, p. 108).

> *I think past experience I've had from team leaders and things like that is that when you come out and you feel really motivated and you can see someone's passion about the job and it fills you with all that motivation and passion doesn't it (Group 1, interview 10).*

> *I would say excellent networking skills so being visible, being out there, networking, getting to be known by your service users, your communities, other professionals, other colleagues, members of the team and I think they're good qualities of a leader. It's somebody that's seen as actually quite reliable and maybe is quite forward at motivating or inspirational or something to get on with what they need to do* (Group 2, interview 1).

Again, it seems that the idea of getting things done is important, so action not just words is relevant. This was agreed on by all participants.

> *Not just saying something but actually doing as well, so if they're standing up and saying we need to do this but also demonstrating that behaviour themselves so it's not just a talk saying this is how you should do it but then they do something completely different, it's actually building up that trusting relationship, building up respect and being able to be not somebody who's up there but working with them and working alongside them (Group 2, interview 4).*

This resonates again with compassionate/authentic/inclusive leadership theories being espoused in the NHS (NHS Improvement, 2016) and in the nursing literature (Wong et al, 2010; Wong & Giallonardo, 2013) as a way of delivering leadership in practice. Authentic leadership advocates the importance of the requirement for leaders to have consistency, in terms of how their expressed values are linked to their ethical conduct (Avolio & Gardner, 2005; Wong & Cummings, 2009).

7.3 Identity

Next, I discuss the findings from this study regarding the participant's sense of identity and how this relates to their role and to their clients. These findings are presented under two headings, *health visiting leadership identity and autonomy to make decisions*.

I initially had identity as a potential category; however, when I was exploring the process it didn't feel like it captured everything in the data in enough depth as a category should (Chamaz, 2014). In addition, identity although a key point of learning, arose across the categories in different ways. For example, Chapter 5 discusses how the context of where you work affects your identity and external factors e.g. government policies can impact on the identity of your role both as a health visitor and a leader.

In this chapter, identity is reviewed in terms of the inherent internal identity that health visitors have, in relation to leadership. For this reason, identity is discussed in Chapters 5 and 7 and in the conceptual framework it has been highlighted as a key factor that needs to be clear i.e. both health visitor and leader identity is required for leadership to occur. In this way identity supports the categories to facilitate leadership (this is discussed further in Chapter 8).

In the second set of interviews I changed the category from identity to leadership performance and then eventually, after the third set of interviews, to leadership behaviour as the connotation of performance, for some participants, gave way to thoughts of management and was distracting.

7.3.1 Health visiting leadership identity

Health visitor identity is inextricably linked to their model of practise, which is discussed in Chapter 5. This section focuses on how health visitors understand and view leadership identity. This was a key theme emerging from the data and a key piece of professional learning for me. What I had thought prior to commencing the study, and I had written down as one of my presuppositions, is that not all health visitors saw themselves as leaders although at this point I had not connected this to identity.

This view was supported in the study as all participants did not think that health visitors (band 6) always saw themselves as leaders. This was explored further in Group 3, interview 9 to understand why health visitors do not see themselves as leaders. It didn't

seem to be because they did not do leadership, something I had initially considered to be the reason. All groups when asked what leadership activities health visitors undertook, provided an abundance of examples in line with leadership definitions in the literature (Yukl, 2013; NHS Leadership Academy, 2013; Northouse, 2016) yet they didn't see themselves as leaders.

> *I don't think there is much leadership in health visiting really. I wouldn't see myself as being a leader. Its leading in that community you're working in for me we are best placed we see everybody it is a universal service we know what the needs are in that area we're just not good at leading (Group 1, interview 5).*

> *I think health visitors will probably not see themselves as leaders, if you pinned them down and said to them about leadership and how they lead they probably would say they were followers because this is what we deliver and this is what we do and I'm following the practice that I do I probably think that the front line of health visiting leadership staff don't recognise it in themselves. You often get it's my job and that's what I do and I know the evidence behind that or I know what I need to do that's my job but I don't think they do understand the quality of what they're doing as well (Group 2, interview 1).*

> *I don't know I think it's a strange thing with health visitors because my experience has been that they often come from fairly senior positions not always now but they may have been ward sisters, senior midwives that sort of background and they come into health visiting and seem to lose all those skills and don't realise that that's what they're there to do and I don't know why that is (Group 3, interview 9).*

All participants saw leadership as part of the health-visiting role however, overwhelmingly; they thought that not all health visitors saw themselves as leaders. This has been found in other studies particularly around the public health leadership role of the health visitor (Smith, 2004; Carr, 2005; Poulton, 2009). Many health visitors in Group

1 did not associate the role of a health visitor with leadership. This was interesting and a key professional learning point in terms of why this was. At the start of the study I had thought that health visitors didn't understand leadership because they were confused with the difference between leadership and management. Early in the analysis of the data it was found that health visitors were very clear about the differences between management and leadership.

I wanted to explore this further as this seemed like the crux of the study: to finally understand how health visitors understand leadership. As when asked about followership, all groups could see the potential for health visitors to be both leaders and followers (see Chapter 6). Again, copious examples were provided of how both leader/follower roles were undertaken in practice. Yet when asking them about their leader identity it appeared very few had one. Group 3, interview 9 explained this as follows:

> *Some people their own personalities although they might have fantastic skills they may not want to see themselves as leaders because they don't perhaps feel that they have sufficient skills and abilities to be a leader. They still don't see themselves in many cases as leaders because of their own inbuilt reticence and personality.... they see themselves as caseload holders and don't see themselves as leaders in change for families. They don't understand that that's what they're doing when they're working with families in many cases* (Group 3, interview 9).

From the literature, it is apparent that what identity provides for leaders is a sense of knowing who they are (Burke, 2006; Zheng & Muir, 2015), what goals and objectives they need to achieve, and what their own strengths and limitations are as a leader (Day & Harrison, 2007). Research studies have supported the notion that to be a leader you have to see yourself as a leader first i.e. you must develop a leader identity (Lord & Hall, 2005; Chreim et al; 2007; Day & Harrison, 2007). The reason being that if you think of yourself as a leader you are more likely to look for opportunities to undertake leadership, and therefore, build your leadership identity through experience and

developing leadership skills (Lord & Hall, 2005; Day & Harrison, 2007; Sorensen, McKim & Velez, 2016).

The quotes above illustrate the importance of identity to both professional practice and leadership. It is clear, that for health visitors to identify as leaders they firstly need to be clear about their role and identity professionally and then assimilate a leadership identity. This is discussed further as a major finding and contributor to the conceptual framework in Chapter 8.

7.3.2 Autonomy to make decisions

The literature suggests that autonomy improves job satisfaction and performance (West et al, 2012; Papastavrou et al, 2012; Whittaker et al, 2013) and it often cited as a reason for choosing to work as a health visitor (Haycock-Stuart et al, 2010; Whittaker, 2017).

Participants felt that health visitors needed autonomy to be able to practice effectively and to provide high quality outcomes for children and families. Without autonomy, it was felt that health visitors would be merely following orders and not really understanding and acting on the needs of children and families (Brigham et al, 2012; Whittaker et al, 2013).

> *....So those individuals believe in their level of autonomy and their right to decide what is right for the family and the woman and they exercise it but they can only do that because they have sufficient confidence and belief in what they believe is good health visiting practice and what they're prepared to defend if they were challenged as well as a belief in what the parent values (Group 3, interview 6).*

This links back to the model of practice (Chapter 5) and beliefs and values inherent in professional ideology and identity. Autonomy could be seen to be at odds with healthcare policies that require health visitors to adhere to targets and to deliver a specific commissioned service (Brigham et al, 2012; Cowley et al, 2013, Whittaker et al,

2017). The professional ideology that health visitors have relates to the overarching process of making a difference (Chapter 8). This was reflected by the extensive use of the quote: leadership being about doing the right thing (Chapter 6). This might explain why leadership and professional ideology are so intertwined for health visitors.

> *I was thinking more of our HCP and our policies that we're given the policies but it's up to us to make sure we are meeting the timescales, the manager is managing it but it's our responsibility that we are doing them in the time they're supposed to be done (Group 1, interview 5).*

Participants defined the autonomy of the health visitor as being the freedom to deliver in-line with local policies but with some decision-making left to their judgment. This is supported in the literature (Katrinli et al, 2008; Cowden & Cummings, 2012; Whittaker et al, 2013).

Participants discussed how health visitors made decisions all the time. The importance of supporting decision-making from within the team and giving time to staff to help them make decisions was seen as important to support the development of leadership within health visiting (Hyett, 2003; Brigham et al, 2012).

> *Your there for other staff members to come to you and ask your decisions, and you give time for other staff members when they've had a day that's been stressful so that they can reflect. And you reinforce their decision making wanting to know why they think like that and why they think they should be doing something else (Group 1, interview 10).*

Some participants noted that whilst the role of the health visitor involved a responsibility for the delivery and leadership of the HCP the authority to make decisions was not always available. This resulted in responsibility without the autonomy to carry out their professional obligation. It was expressed that if such autonomy was not

forthcoming then it could have an impact on developing confidence and skills required to make decisions.

In addition, it is not only about health visitors being able to make decisions, but also for health visitors to have the respect for their managers'/leaders' decision-making processes, otherwise health visitors do not engage in the relationship of leadership described as that 'two-way thing'. This links back to Chapter 6 and the concept of followership, and the importance of relationships between leader and follower when undertaking leadership. I therefore raised two-way process to a focused code as part of the subcategory of followership, as this phrase was used a lot by participants in terms of their relationship with a leader.

> *I've moved from a place where you felt that your leadership and management of yourself was overridden by the Team Leader and you lost your confidence in decision making skills everything and that's why I moved to this Trust in order to manage myself and I feel a lot better because I didn't have the respect in their decision-making processes and it's that two way thing with management and leadership you have got to have that respect. For that leadership to take effect and for change to take effect (Group 1, interview 10).*

As the interviews progressed and participants shared their concerns around decision-making, negative experiences were shared as experiences of learning. It was clearly expressed that to build confidence you had to be aware that you could make wrong decisions, but you would learn from these and not be criticised. In addition, participants recognised that they did not just need support for decision-making but also needed to feel comfortable to take risks and to learn from experiences (Currie, 2008; Curtis & O'Connell, 2011). Moreover, leadership style links back to the value placed on those leaders who displayed compassionate, inclusive leadership attributes, seen as important in the literature review and above (Gilmartin & D'Aunno, 2007; Cameron et al, 2011). The examples below show that members of Group 1 as well as 2 feel this, demonstrating that this process occurs at different levels of authority.

Also with your decision-making skills you become more confident and also negative experiences. I suppose it's being allowed to make decisions and being supported in your decision making and then that brings you confidence doesn't it and then your experience (Group 1, interview 10).

I felt I could do that and now being criticised and saying it's wrong and not right it all needs to change…that decision making. Then you lose your confidence in being that person (Group 2, interview 1).

On a similar theme, several discussions, particularly with Groups 2 and 3, focussed upon empowering staff but there was no clear view of how this would be achieved. There was, however, recognition that being given responsibility is a way of building confidence as a leader. I reflected through memos on this point asking: is responsibility the same as giving/having power? The literature advises that health professionals often use accountability and responsibility interchangeably, *as though they have the same meaning* (Papastavrou et al, 2012; Griffith, 2015, p. 146). *Accountability means being answerable to a higher authority for your actions, responsibility means to have control or authority over someone or something.* To be accountable is to be answerable for one's acts and omissions (Griffith, 2015, p. 146). Therefore, the terminology needs to extend from wanting to empower all staff to that of giving responsibility and authority to act. Both Groups 2 and 3 shared this view.

I think if you do give them a bit of responsibility sometimes …. it really tests out their knowledge and can improve your own confidence…. until you share that with somebody you don't realise what knowledge or confidence you've got yourself (Group 2, interview 2).

I think it's ultimately taking responsibility and accountability. Of course, every nurse, midwife, health visitor is accountable for their own professional practice but in terms of leading and directing people to take a particular stance and a

particular direction I think ultimately you have to be quite clear that you're taking responsibility for that (Group 3, interview 3).

Group 1 identified that when managers encourage staff to make decisions and to find solutions then staff will often rise to the challenge and address difficult issues. This is clearly supported in the literature in relation to change management theory (West, 2012; West & Dawson, 2012).

You had to sit in a meeting for three hours, which wasn't working…. In the end, the manager said talk about it and in a month's time she'd come back and wanted to know how we would reduce that meeting time. When she went away people said they better find a solution before they told them how to do it. They still have that meeting but it's a one-hour meeting. If you were sitting in that meeting you would not have thought it was going to happen but the way she dealt with it she listened to both sides and then left them with the responsibility of finding how to do it. Instead of saying this is what we're going to do and giving them nothing to do about it (Group 1, interview 10).

The participants were quite clear that what was important to them was to have clear boundaries about making decisions. The participants all agreed that health visitors were highly experienced staff and they needed to make decisions. It was felt however, that without responsibility being explicit in the role of the health visitor, their ability to make decisions would be affected. The result of this was that, we are left waiting became a focused code because it encapsulated the feeling of being in limbo. They felt they were waiting for somebody to tell them what to do yet were told that they were autonomous practitioners who needed to take the lead. This might explain why health visitors don't always see themselves as leaders. This was recognised as important across all participants. It also brings the discussion back to informal leadership and leading without positional power and how this can be achieved.

Some professional credibility because if you doubt their decision-making skills but they've also got to have the authority to make the decision because quite often when we've come from a self-led team in another Trust to using Team Leaders in this Trust and then we have our meeting and there's not the level of authority there to give us a clear decision with the team leader they don't have the level of authority that's what is difficult and we are left waiting (Group 1, interview 10).

If we're talking about health visitors that is the position they're in because actually they don't have a senior role in the organisation but they have leadership responsibilities (Group 3, interview 6).

The crux seems to be that participants felt that there was no consistent clear role or boundaries or lines of autonomy in the health-visiting role. Despite this the expectation is that health visitors must deliver the HCP, acting as informal leaders for this across several professional and agency boundaries (DH, 2011; PHE, 2016a). This has been found to be the case in a similar study exploring leadership in health visiting (Brigham et al, 2012). This issue was considered at length in several memos asking if this expectation was realistic. This was also explored further in subsequent interviews to ensure I wasn't missing anything and that this apparent concern was not simply a reflection of my own personal view.

It's having the authority; I think you need rules and responsibilities…. Having responsibility and clear lines of autonomy clear roles some direction to what you should be leading on rather than trying to do everything for everybody, which you can't, do. Make sure it's attainable not being set up to fail before you start and some recognition for what you've done (Group 2, interview 2).

Developing leadership mandates that health visitors have a clear view of their role, share knowledge with others through making decisions about elements of health visiting practice, and taking responsibility to take action and therefore be autonomous practitioners. When health visitors receive positive feedback after dealing with difficult

clinical scenarios this will build their clinical confidence and eventually their leadership skills. Several participants recognised this process, as something that enabled them to develop their leadership skills but that this required the environment that they work in to be a learning environment, in terms of support available from the organisation to develop leadership. This requirement is supported in the literature (Eraut, 2007; West & Dawson, 2012; Dixon-Woods et al, 2014).

It also entails health visitors being able to take risks, not always having to get it right, and feeling safe and supported to try out new ideas. In bureaucratic organisations, this risk-taking supportive environment may not be the culture that is prevalent (Meterko, Mohr, & Young, 2004; Kim & Newby Bennett; 2012) (as discussed in Chapter 5). It is also predicated on giving responsibility to health visitors. Several participants believe this has been reduced in the health visiting role (as discussed in Group 1, interview 10, linking the level of responsibility back to context). As discussed in Chapter 5, when I was in a self-managed team, signifying the impact that different models of health visiting delivery can have on decision-making abilities. Therefore, context again is significant on leadership (West et al, 2014; Whittaker, 2017). As Group 1, interview 5 indicates the impact of health policies' focus on numbers and targets again means external forces that impact on autonomy are governing the role.

> *I want a bit more autonomy back so that I can feel like I or we as a team are addressing the needs of our area and that it was client focused and not driven by numbers and targets whatever* (Group 1, interview 5).

Participants recognised that the dilemma for health visitors was that they were told to lead without the support and skills required to develop their leadership skills. There were mixed messages of “you are a leader”: but without authority. Although it is suggested that staff can lead informally, through influence (NHS England, 2014; NHS Improvement, 2016), this is harder to do when middle managers are focused on meeting targets (Ham, 2014).

I think leadership is important to health visiting but you might suggest in some instances that it's also impossible depending on the way the service has been organised and what's been commissioned and the level of authority the health visitor is granted. I think that then starts touching on the autonomies. If we don't have practitioners bucking the trend in that way, if the individuals were to be completely rule compliant we would lose the essence of health visiting, I think that's the point because the people who set the rules don't get health visiting (Group 3, Interview 6).

7.4 Developing leadership

All leadership training within the NHS refers to the competencies framework (called the Healthcare Leadership Model -The Leadership Academy, 2011 & 2013), which defines the nine dimensions of leadership behaviours required by NHS staff at all levels to increase leadership capabilities. Funding on behalf of the NHS for leadership training is co-ordinated through The Leadership Academy (West et al, 2015). The new Developing People- Improving Care framework of leadership has advocated the need for inclusive and compassionate leadership. This "*aims to guide team leaders at every level of the NHS to develop a critical set of improvement and leadership capabilities among their staff and themselves"* (NHS Improvement, 2016, p. 2).

The literature demonstrates that there is no empirical evidence to support any specific leadership development programme when looking for a direct link between the programme and positive effects on patient outcomes (Pearson et al, 2007; West et al, 2015) thus; there is no one best way to develop leaders or leadership. That is not to say that leadership/leader development programmes do not have benefits for the individual involved (Large, Macleod, Cunningham & Kitson, 2005). What is known to be valuable is leadership experience for individuals to be able to develop their leader/leadership skills that is supported through appropriate guidance in situ (Day & Harrison, 2007; West et al, 2015), as "*good leader development is thought to be context sensitive"* (Hartley et al, 2008, p. 77).

This section presents the study findings regarding how participants perceive what is required to develop leadership. This includes *leadership skills and leadership training.*

7.4.1 Leadership Skills

Whilst there exists a range of competency frameworks espousing what leadership behaviour should be demonstrated by health professionals (NHS Leadership Academy, 2013; West et al, 2015) there is no specific model that informs the development of leadership skills (Day, 2001; Lord & Hall, 2005) as, historically, the focus has been on traits and leadership behaviour styles (Yukl, 2013, Zheng & Muir, 2015).

Many participants discussed at length the skills they believed needed to be included in leadership training for health visitors. These skills are identified in Table 7.2 and are the same leadership skills frequently identified in the Healthcare Leadership Model (NHS Leadership Academy, 2013) and other nursing/health visiting leadership literature (Eddy et al, 2009; Greening & Haydock, 2014).

Table 7.2 Leadership skills identified by all participants that are required by health visitors

Leadership Skills	
Communication	Business
Therapeutic interventions	Change management
Theory of leader/leadership styles	The best way to get a message across to people
Dealing with conflict	Visioning
Influencing policies	Developing the individual/self
Political astuteness	Motivation

The outcomes that the participants felt would make training useful were *increased self-esteem, building confidence to feel empowered to lead and the ability to be assertive.* These are similar to those identified in the literature (Large et al, 2005; Yukle, 2013). Everyone agreed that leadership training was required for health visitors.

> *I think training would be a key factor or some sort of model or module or something that gives health visitors some support to develop those skills and use them. I think there'd have to be something around personal feelings, personal self-esteem in a leadership course or module something that increases the person's ability or confidence building that type of thing because you know it's there it's just getting it out of them (Group 2, interview 1).*

Group 2, Interview 2 identified the need for leadership training but also included the need for support to develop those skills and use them. This participant also identified the need to be aware of you as a leader and the need to be aware of personal feelings, personal esteem. Several participants identified the need for health visitors to be aware of themselves as leaders. They also recognised the need to build-up the confidence of health visitors in their ability to lead.

> *We've looked at the differences between what is a leader, what's a manager, if we we're to identify a role model or a good leader who is it and what were their qualities and building on that in terms of we've got lots of change happening. So, it's around that change management and how collectively together we can support each other when we're trying to support staff going through some major service redesigns and service change (Group 2, interview 4).*

Thus, a picture develops that leadership training; support, opportunities to try out new things and experience; are important to allow health visitors to develop as leaders. Several participants mentioned I always start from the fact that you can't be a good leader unless you understand yourself (interview 3, Group 3).

I'd look at motivational interviewing, leadership styles, dealing with conflict, roles and responsibilities. I'm thinking of models of leadership. I think it's empowering those who're going to do the leadership in training, what the leadership role entails and preparing somebody.... It's a tool kit really; leadership that's required, different models, different tools you can use to help you build your confidence (Group 2, interview 2).

Empowerment was discussed by several participants. They raised this in relation to developing leadership. What was meant by this and how this translated into action was not clear. It appeared that empowerment was a term that was used without the complexity of the process being recognised, or a discussion of what this entailed. Empowerment was at first used as a focused code. However, the data didn't support exploring this further as a sub category in interview set two.

However, it is recognised that empowerment is a key part of leadership, supported in the literature review (Wong et al, 2010; West et al, 2015). Thus, empowerment was explored by looking at how leaders develop and empower people.

In subsequent interviews views were sought on the training and skills required for health visitors to take on leadership roles. One view was that people are going to need much more political astuteness than there's been in the past. This seemed to reflect the changing nature of the role of the health visitor with the incessant change in government health policies (NHS England, 2014; Whittaker et al, 2017). This also seemed to highlight the new skills and knowledge needed by health visitors (Malone et al, 2016). Inevitably this was symptomatic of the changing nature of the environment the health visitor works in and, yet again, the need to reformulate the identity of health visitors (Machin et al, 2011).

Political astuteness is something which I think is absolutely core to any leadership programme people are going to need much more political astuteness than there's

been in the past. They're going to need much more in the way of business skills, because people have to be able to use the evidence they collect and put it into a business case and articulate clearly what it is they want. One of the things that we've put into programmes is getting people from the DH to talk about how policy is formed. I think to have people that can say that to grass roots people actually helps them to understand the politics that actually it completely invades the whole of health care (Group 3, interview 3).

Another skill that was highlighted as important for health visitors who lead was to be able to communicate with colleagues at different hierarchical levels and in different roles across a range of organisations, to carry the whole team along to achieve the goal. It was felt that listening was an essential component of this to enable health visitors, or indeed others, to lead.

I think there is something about communicating that you can teach on a leadership programme. How do I communicate with different levels of people? So how do I communicate with my commissioner, how do I sell my idea to the provider management teams, how do I sell this difficult health message to the families and communities in my care and they require different skills and they require different approaches. I think that some people are able to do that more intuitively than others and some people need more chance to think it through and practice (Group 3, interview 11).

Participants also highlighted the importance of offering opportunities to allow several key qualities to develop; *reflecting, making people feel valued and motivating people*. This seemed to reinforce how health visitors learn to lead by application to practice and having the opportunities to try out leadership skills in practice (Cameron et al, 2011; Curtis et al, 2011b; Brigham et al, 2012).

I think you also have got to have practical skills, sometimes managing a difficult situation, because it's okay with all these theories but if you don't have the

incidence where you put them theories into practice, sometimes you have still got that joined up information in your head so you have got to have some sort of practical thing to show you how you use that management and leadership style. If we are saying that a leader is a good motivator then things around how we do motivate staff on time out and look at empowering staff and giving guidance and support and breaking issues down for example we recently used the Six hats theory, with our team leader (Group 1, interview 10).

The participants recognised the importance of the leader-follower relationship (Katrinli et al, 2008; Cowden & Cummings, 2012) and the profound impact the behaviour of leader or follower might have upon leadership (discussed further in Chapter 6).

To understand some of the behaviours staff might be displaying and being able to understand what kind of response we as leaders could chose to display or some of the tools and ways of responding we can look at using (Group 2, interview 4).

It became apparent from the participants that leadership qualities were seen as something that are within all health visitors, they just needed to be recognised and nurtured. It was seen as important to make explicit the differences between manager and leader. This would allow all health visitors to take responsibility because leadership was not title/grade dependent but something that can be undertaken informally by all health visitors, as it has been suggested that many leadership qualities can be learnt (Hartley et al, 2008; Johnson & Cacioppe, 2012).

I'd want to include something that harnessed what peoples' individual strengths are and try to ensure that we could link it to the fact that everybody has leadership qualities so identifying what qualities make up a good leader. To try and ensure that everybody could see that they have some type of leadership skills even if it was just about doing something small within their team so people could accept some responsibility. I'd say things for example listening, reflecting, making people feel valued making people feel...I would look at what people understand

about what is a manager what is a leader so differences some similarities and some differences (Group 2, interview 7).

It was interesting that there was overall agreement from all participants on the key role of the health visitor in leading on the HCP (DH/DfCFS, 2009a, b). All groups recognised the need to have the skills to do this and these skills were thought to incorporate extensive understanding of the HCP and the ability to work across professional groups and agencies.

They need to have knowledge of the HCP, they need to see the benefit of it they need to be able to deliver it and have the key skills that you need to deliver all aspects of the programme. They need to be able to skill mix as well and utilise Nursery Nurses and Children's Centres and charities and everybody else and networking (Group 2, interview 12).

Participants recognised that one person did not need to have all the skills and that indeed leadership skills could, and perhaps should, be shared across the team.

…that's about recognising peoples' skills and competencies and a good leader will recognise that in order to lead they need a collection of people around them with different skills so that the sum of the parts come together to make one (Group 3, interview 3).

Although one of the Practice Principles of Health Visiting is influencing policy (CETHV. 1977), this was seen as one of the skills most lacking in students and practitioners. This was also noted in chapter 6.

So, if you literally make an appointment with your MP and go along to the surgery and say these are the things whatever if you write the letters or if you join a campaigning group and, in my understanding, they are all leadership examples that fit under that influencing policies. That's the one that students struggle

mostly with and you see that in my external examining you can see they struggle with it and you don't know if that's confidence because actually if were thinking about contacts as well maybe it's about what the course would need to have in it something about how do you manage or enact your leadership role within your working contacts which would differ between organisations because of the culture of the organisation (Group 3, interview 6).

Leadership development has been described as being more than skill improvement; instead a greater focus on values and motivation has been suggested. The leadership an individual displays is related to how well an individual's leadership identity is developed (Fagermoen, 1997; Zheng & Muir, 2015). Interestingly, the development of identity was not something that was mentioned when discussing leadership development in terms of skills and training. This is discussed further in Chapter 8.

7.4.2 Leadership training

Several participants admitted that they had not accessed leadership development/training, even when commencing leadership roles. Professional practice was what was valued and enabled a health visitor to be a leader (Chapter 5). This provides one explanation as to why some health visitors may lack leadership skills:

...the other key thing about leadership programmes is that there should be glue in the ointment, I always ensure that there are action learning sets which are facilitated during the time of the programme, but they then continue on facilitated by the group if they wish at the end and they have a named mentor while they're on the programme. I don't believe in programmes that are three days and you've done it so I like it spread over a period of time, they come in with something they have to achieve which is signed off by their manager who may or may not be their mentor, its better if it's not so they've got two people in their workplace that are supporting them and one person externally (Group 3, interview 3).

From this interview, a picture began to develop of what, in the views of the participants, was required for training in leadership. Participants' viewed effective leadership training, not as a one-off course/module, but rather as a sequence of activities and support roles that should be included whilst on the leadership programme. Participants' suggested that a mentor and Action Learning Sets (ALSs) could be introduced whilst on the programme and these activities could continue following completion. This approach to leadership development that recognises the need for continuing support is highlighted in the literature (Rouse, 2013; Yukl, 2013; West et al, 2015; Leigh, Rutherford & Williamson, 2017).

Interestingly some participants were reluctant to call a programme a leadership programme; instead it was seen as important to embed leadership within professional practice. This was in keeping with leadership being understood through professional background and context (Chapter 5).

> *I wouldn't call it a leadership programme. The content would always be clinically applied it would be about practice and the application of this in a clinical setting it wouldn't be abstract leadership that would be the content. I think you can't separate it out from the work people are doing and if it's right for the families it will be right for the practitioners and right for the system (Group 3, interview 8).*

The participants' felt that being able to test out situations was important but this needed to be in a safe environment. Feedback was considered important. This was supported in group 3, interview 11 where, again, it was suggested that *active learning* through role-playing in a safe environment would be helpful.

> *I found the performance models that I've done so strong, so kind of very active role playing or exposure or videoing/camera or whatever those things are actually really helpful once you are in a safe environment (Group 3, interview 11).*

Several participants expressed the view that a training course was not the only way to develop leadership and suggested that leadership should be a common theme through other training and development and that you didn't need to do a leadership course to be a good leader (Group 2, interview 4). A view supported by Group 3, interview 8. This emphasises the need to embed the leadership training within all professional practice so that it is not divorced from people's everyday world (Storey & Holti, 2013; Leigh et al, 2017).

> *We need to identify some kind of leader first, what do we want as a leader, a teacher, a practitioner, a separate person. Like a forum where we can debate it as simple as that (Group 1, interview 5).*

I don't think people wake up and think I'm being a leader today, Group 3, interview 8 was reflected upon at some length. Was part of the problem with developing a leadership identity that there was never a point where professionals wake up and see themselves as leaders. It was quite clear that they were always practitioners first and leadership was simply a part of being a professional.

> *People are endlessly spending time going on courses around leadership and I don't think people wake up and think I'm being a leader today so its slightly divorced from how peoples' everyday world and I think a lot of it is a sheep dip approach you take people and put them on a leadership programme and expect them to come out differently. I guess I am a bit sceptical of leadership training (Group 3, interview 8).*

What is clear from the above quotes is that how leadership programmes are designed, and the methods used to deliver them dramatically alter the effectiveness of the training. Content that reflects the context and purpose of leadership for the professional group and the behaviours required in the leadership programme, together with methods of delivery that are inclusive and allow practitioners to try out new skills in a safe environment and practice them in the workplace is required. However, central to

these developments is an understanding of the professional's identity and level of development required, as discussed by Lord and Hall, (2005) and Day and Harrison, (2007). It is accepted that leadership skills can be learnt; however, it is also clear that having leadership skills without taking into account context and the purpose of leadership will not in themselves be an effective way to improve leadership (Hartley et al, 2008; Wang et al, 2014).

7.5 Chapter summary

How professionals internalise their leadership role and demonstrate it through their behaviour is paramount to how they are viewed as leaders or as role models. It is apparent that health visitors learn in accordance with social learning theory. Therefore, what they observe and how they learn from role models is central to how they develop their leadership skills. In addition, and in order to develop their leadership identity they need to be able to practice as autonomous practitioners and make decisions based on their competency as a health visitor, as this is recognised as a key way to build leader identity.

This forms a key part of their learning, therefore, if training programmes are to be effective they need to allow health visitors the opportunity to develop leadership skills. They must however recognise the level of development health visitors possess when designing such programmes. Day and Harrison (2007) suggest that, as identity develops so does the individual's ability to be able to develop their leadership abilities as an individual through the relational to collective levels. This has implications for practice in terms of how leadership development is provided for health visitors in that these considerations need to influence education and training programmes.

Chapter Eight

8. Discussion of the construction and use of the conceptual framework

8.1 Introduction

This study found that it is believed by all participants that health visitors on the whole do not see themselves as having a leadership identity. In addition, the nature of the health visiting role can lack clarity, as whilst participants were clear on the health visitor role in delivering the HCP, and the "four levels" of service delivery (DH, 2010c & 2011) leading across other organisations to deliver the HCP was found to be not as straightforward. The balance of the role between personalised and population based care was not always found to be clear in the study with participants reporting that they do not have time to undertake the community level of delivery (Chapter 5). This is a concern as it can have a detrimental impact on the role identity of health visitors if there is a lack of role clarity (Machin et al, 2011; Brigham et al, 2012).

This is supported in the literature in that health visitors are constantly told by government policies, strategic and local leaders that they are senior public health professionals and leaders (DH, 2011; PHE, 2016b), yet they do not always have a clear public health role and this has been the case for several years (Dolan & Kitson, 1997; Smith, 2004; Carr, 2005; Cowley et al, 2013; Cowley et al, 2014; Malone et al, 2017; Royal College of Nursing (RCN), 2017). There appears to be insufficient discussion from managers and educationalists about how to support the re-formulation of the health-visiting role when government policies impact on it, and how to develop a leadership identity. In addition, this study found that there is insufficient attention paid to developing leadership identity in both pre-qualifying and CPD health-visiting programmes.

Despite these issues, that constantly threaten the leadership role of health visitors, this study found that leadership is meaningful and beneficial to health visitors. What was significant to understanding this phenomenon was the recognition and understanding of how important it is, first and foremost, of being a *professional.* In addition, *role modelling*, in terms of how health visitors understand leadership and develop it through their practice, was found to be of far greater importance than had previously been thought when I commenced the study.

I shall explore the three categories that emerged from the data: *context of leadership, purpose of leadership and leadership behaviour* and how they relate to the core category *making a difference* (first discussed in Chapter 4). Together these three categories and the core category form a conceptual framework (see Figure 8.1, p. 223) that suggests one way of providing understanding of how health visitors give meaning to leadership and, ultimately provides a way of understanding this phenomenon. The conceptual framework will be discussed and reviewed alongside the literature. Finally, I have considered what the study suggests regarding how leadership education for health visitors could be enhanced as a result of the findings of this study.

The contribution this study makes to academic and professional practice will be discussed in Chapter 9.

Four conclusions have emerged from the data:

1. A conceptual framework (Figure 8.1, p. 223) has been developed which can support the design of leadership programmes for health visiting education e.g. *context of leadership, purpose of leadership and leadership behaviour.* These three combine in *making a difference that* explains how health visitors understand leadership. This conceptual framework should be applied to both pre-qualifying health visitor curricula and to CPD, to provide a conceptual framework for leadership development.

2. Health visitors were found not to have a clear leadership identity. Therefore, health visitor and leader identity needs to be considered in all leadership education/training for health visitors.

3. The importance of how health visitors learn through experience and role modelling needs to be recognised in the development of future leadership education and training programmes.

4. Lack of clarity over the health visitor role. This is affected by perpetually changing government policies. This lack of clarity has the potential to destabilise the health visitor professional identity. Greater clarity about the role of the health visitor and what service commissioners want needs to be explicit and support should be provided to reformulate role identity.

8.2 Theory construction

Interpretive theory explains a phenomenon. In this study, the phenomenon was leadership in health visiting (Hallberg, 2006; Parry et al, 2014). Given a grounded, interpretive research approach was applied to this study; an "*inductive logic was assumed which means that the data analysis is used to develop theoretical concepts and an analytical framework from the data not from prior theory"* (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Suddaby, 2006; Charmaz, 2014, p. 244).

"Interpretive theories allow for indeterminacy rather than seeking causality". They aim to theorise "*patterns and connections*" and to understand meanings and actions and how people construct them. This type of interpretive theory study "*calls for the imaginative understanding of the phenomenon* and accepts *emergent, multiple realities, facts and values as inextricably linked. Truth is seen as provisional, and social life as"* a set of processes rather than discrete events (Charmaz, 2014, pgs. 230- 231).

Although producing a theory is the key aim for most grounded theorists few define what

this means, Charmaz (1990, p. 1164) "acknowledges that *one researcher's conceptual framework may resemble another researcher's theory."* According to Charmaz (2014, p. 344) a substantive grounded theory is a *"theoretical interpretation or explanation of a delimited problem in a particular area".* From this perspective, it is suggested that most grounded theory studies are concerned with substantive areas and therefore fit this definition, as opposed to a formal theory which has "*a broader application area"* (Hallberg, 2006, p. 143).

Charmaz (2014) differs from Glaser and Strauss and Corbin, as she does not focus on a substantive theory. "*Charmaz's definition of theory* emphasizes *a theoretical understanding that is abstract and interpretivist*, *where the understanding from the theory relies on the* researcher's *interpretation of the studied phenomenon"* (Charmaz, 2014; Giles et al, 2016a, p. E40). The "*theory depends on the researcher's view*: *this does not and cannot stand outside of"* the constructed theory by the researcher. Theories such as these incorporate the subjectivity of the participants and recognise the subjectivity of the researcher (Charmaz, 2014, p. 239). Accordingly, the theory reflects the researcher as well as the participant (Hallberg, 2006).

Charmaz suggests that what is constructed should be viewed as a story that reflects the participant and the researcher. Although there is no agreement between Glaser, Strauss and Corbin and Charmaz on what the grounded theory produces; in terms of a substantive theory, which depends on the ontological and epistemological position held, what is less contentious is that of the conceptual framework; they all agree it explains the relationships between the categories (Hallberg, 2006).

A conceptual framework, making a difference*:* how health visitors understand the social processes of leadership has been constructed to suggest how health visitors understand leadership through their professional ideology. This conceptual framework embodies the theory explaining the social processes that are evident when health visitors are undertaking leadership (Parry, 1998; Giles et al, 2016a). Rather than discussing it as a substantive theory I have chosen to discuss it as a conceptual framework, which

resonates with both Charmaz's (2014) definition articulated above and also practitioners, and can thus be utilized in practice. This is discussed in more detail in the next section.

8.2.1 Conceptual framework

A conceptual framework is concerned with "*carefully developed concepts that are put together with statements about mutual relations to form an integrated whole that explains or predicts a phenomenon or an event, and thereby guides action".* The conceptual framework articulates any theoretical claims (Charmaz, 2014, p. 342). These relate to the "*scope, depth, power, and relevance of a given analysis, and acknowledge subjectivity in theorizing. Thus, the role of experience, standpoints, and interactions (including my own)"* is recognised (Charmaz, 1990, p. 1163 & 2014). Finally, the conceptual framework "*offers an imaginative, theoretical interpretation that makes sense of the studied phenomenon"* (Charmaz, 2014, p. 215) and in so doing it explains the relationships between the categories (Hallberg, 2006).

This conceptual framework is imaginative in that it provides understanding and meaning of how health visitors view leadership in their role. It is inventive in the sense that I have found limited evidence of published work that has used this methodology to look at health visiting and leadership in this way. The conceptual framework is evidenced based and this is something that several existing frameworks lack. It has been suggested that there is a need for more evidenced-based studies that consider conceptual frameworks for leadership development (West et al, 2015).

The theoretical interpretation I have made is taken from the co-construction of the categories and core category interpreted from the data on how health visitors experience leadership. This is drawn from data derived from the focus groups. These focus groups proved a rich source of data on how health visitors articulated a shared understanding of leadership. I was able to co-construct making sure their voices were apparent in the findings chapters (5, 6 & 7). Indeed, the categories and several of the

sub- categories were named and described in the language used by the participants in the study to ensure their voices were heard.

The in- depth interviews, with group 2; managers, practice teachers, team leaders and group 3; strategic/national leaders from education or policy roles, provided rich data. This was subject to constant comparative analysis to review across all data collection groups. Therefore, the theoretical interpretation considers the experience of three different groups of health visitors in different contexts yet with a shared understanding of leadership and what this means in health visiting. Thus, the conceptual framework, is a creative way, of articulating the concerns that health visitors have, in whatever context/role, about leadership in health visiting.

The implementation of the conceptual framework into practice through the leadership development programme funded by the Burdett Trust for Nursing (see epilogue, section 9.8 for further information about this grant) offers further evidence of the innovation of the framework. The evaluations from this leadership development programme confirms that the framework makes sense to health visitors. It also seems to support them in developing a leadership identity. The feedback from this programme from practitioners indicates that what the conceptual framework can do is make the enormity of leadership specific to health visiting.

Figure 8.1 ***The conceptual framework, making a difference: how health visitors understand the social processes of leadership***

The conceptual framework is argued as providing an original and meaningful structure through which health visitors can understand how they can undertake leadership in the workplace. As the concept of leadership is much debated (Jackson & Parry, 2011) it can be difficult for health visitors to understand how these definitions of leadership apply to them. Particularly in roles where leadership is not readily recognized, and the act of leadership can be invisible for practitioners to see and feel unless they have the title leader as part of their role (Cameron et al, 2011).

Thus, the conceptual framework allows health visitors to understand the context of their leadership in terms of what they are leading, why they are leading and how they can demonstrate that leadership. This helps them to understand what aspects of leadership they need to develop by seeking leadership opportunities to make a difference; the ultimate outcome. In addition, the conceptual framework supports them to articulate succinctly their leadership role and to support the development of their leadership identity. It clarifies the different stages they go through to develop a leadership identity and what their leadership role entails within the realms of their constantly changing role/identity as a health visitor.

This conceptual framework suggests how health visitors understand and give meaning to the phenomenon, through their lived experience, by understanding the concerns that affect their *leadership context, purpose and behaviour* and, the ultimate aim of what they are trying to achieve with leadership i.e. the outcome: termed *making a difference*. Fundamental to achieving this is that health visitors have a clear understanding of both their health visitor and leadership identity.

The conceptual framework emerged from co-construction with participants of what leadership means to health visitors, this is encapsulated by the quote from Group 3, interview 11 which provided a very practical approach to thinking and acting out leadership in practise.

> *I suppose because I distil (leadership) down to the first three things I said the purpose, the situation and the behaviour then probably part of the idea of the abstract becomes fairly simple. If I thought about the whole concept of leadership perhaps I would. Perhaps my way of dealing with it is to reduce it* down *to those three things to use that (Group 3, interview 11).*

The three categories are interrelated. They mutually reinforce aspects of health visiting leadership practice as viewed by the participants of the study. They relate to each other

in different ways and in different circumstances. It is suggested that the context of leadership will inform the purpose of leadership, which will then inform leadership behaviour. However, it might also be that the context of leadership may require a direct change in leadership behaviour. Thus, the relationships are not unidirectional but can apply in both directions (represented as a circle in Figure 8.1, p. 223). It is suggested that the three categories and core category work together to support the development of an integrated health visitor/ leadership role identity.

Making a difference was the main core category (concept) because it encapsulated all three concepts (categories) therefore, recognising it as the main social process that was key for all participants. Moreover, it is related to all of the three other categories and explains how participants perceived leadership and why they lead (Parry, 1998; Saevareid & Balandin 2011).

The findings of this study suggest that if the categories are applied together health visitors will more clearly recognise the outcome of their leader/leadership role. In turn, this will reinforce their professional and leadership identity. This will also make explicit the context of leadership. By understanding the purpose of leadership, they will be clear about what goals they are working towards. Thus, they can consider their position in the leader-follower relationship and, in so doing, recognise their potential to undertake both roles within their organisation. This will also affect their leadership behaviour because how health visitor's model leadership is highly dependent on how their organisations' model leadership. This will thereby influence how they work with colleagues and families.

The categories each consider a concept (social process) that needs to be in place for leadership to occur consistently. Context is arguably the most important category as the social context in which health visitors work effects how they undertake leadership, because leadership is thought to be context specific (Hartley et al, 2008; Storey, 2011). In this study participants' understanding of leadership is dependent on the sub category professionalism (which incorporates professional background and professional

boundaries). This identifies the importance of their professional role as being the main way they understand leadership i.e. competence and credibility as a health visitor translates into being a good leader. Clarity of their health visitor role identity also supports cross boundary working when undertaking leadership without this leadership becomes more difficult for them.

In addition, the sub category organisational change shapes the "*set of social circumstances*" in which leadership occurs. Therefore, the leadership phenomenon of how health visitors understand leadership is constructed within the social context that they work within the NHS (Storey, 2011, p. 18). This means that how they understand leadership is by their health visiting model of practice, the impact of government policies and the situation of leadership within a team context. Thus, clarity around the role comes from understanding the government policies they are working with, which is central to what they do as health visitors and how they work: it is imperative that they understand how policy impacts on their role. Therefore, the phenomenon cannot exist outside of or be independent to the social context. This is discussed further in section 8.3, in terms of how identity and social identity impacts on the health visitor leadership role within the context of the organisation that they work.

The three categories are connected by how health visitors undertake leadership, through being clear on their role and leader identity. All participants described they lead to make a difference to children's and family's health outcomes. They do this by building relationships with other agencies and health professionals to prevent the fragmentation of services. It was noted, however, as part of the category context of leadership, that lack of role clarity could hamper cross- boundary working. The data identified that many of these processes were undertaken at the unconscious level and were dependent on the health visitors' experience as a professional.

Purpose and behaviour will always be affected by context. Leadership purpose will change as the sense of direction and the leader-follower relationship develops, as discussed in the sub categories: setting the direction and followership.

Leadership behaviour will change when context and culture change. At the moment in health care the desire is for inclusive, compassionate approaches to leadership (NHS Improvement, 2016). What will support the health visitor adapt to using these approaches in their practice is seeing such leadership approaches role modelled, as this study found that to be the most powerful way for health visitors to understand and learn about leadership. This was represented in the sub categories of leadership behaviour: role modelling, identity and leadership development.

The categories propose a framework of how health visitors understand leadership. From this framework, it is possible to suggest areas that need to be strengthened to support the development of leadership. Recognising that the categories are open to change from external forces the strongest external driver for change is government policies as these constantly reshape the role of the health visitor (Malone et al, 2016; Whittaker et al, 2017).

It is suggested that if role identity and leader identity are strengthened, then it becomes easier for health visitors to achieve the ultimate aim of *making a difference;* the core category discussed in the next section. It is suggested that if health visitors see themselves as leaders, they will be able to use the framework to help them apply leadership in practice. What is important is to focus on developing the two separate identities of health visitor and leader, that then become something that is experienced by health visitors as being an important part of their role identity. If this occurs, health visitors can perform their leadership activities and see themselves as a leader, whilst simultaneously recognising these activities as part of their health visitor role. Thus, eventually they should be able to assimilate the two identities into their role.

In the absence of a conceptual leadership framework specific to health visitors, this study has provided a way of understanding the social processes in leadership in health visiting by co- constructing this conceptual framework. It can be used in health visiting education in both academic and clinical practice settings. It sheds light on the

importance of building role identity that incorporates health visiting and leadership identity when delivering health visitor education.

8.2.2 Building a core category

The aim of the study was to make sense of how health visitors understand their leadership role. The objectives were to examine how leadership is demonstrated in the delivery of the health visiting service; to explore underlying assumptions about leadership in the context of the workplace and to examine how health visitors understand leadership as a social process (Parry, 1998; Charmaz, 2014).

In chapter four I discussed how I developed the core category *making a difference* which I defined as the main theoretical concept (process). In this section I discuss how this emergent core category relates to and builds on the existing literature.

Making a difference is a term commonly applied by health professionals to denote the intrinsic rewards that motivate them in their work, to be able to deliver high quality care and actions that will result in better health outcomes (Maben & Griffiths, 2008; Christmas & Millward, 2011; Whittaker et al, 2013). Indeed, it has been frequently cited as the main reason nurses enter the profession (Maben & Griffiths, 2008).

The concept of "making a difference to children and families" in health visiting was first articulated through the work of Whittaker et al (2013). They developed the concept whilst undertaking the study, 'Start and Stay: The Recruitment and Retention of Health Visitors'. In this study, they identified which "*beliefs and values influence professional identities and behaviour*, which form a distinctive *ideology of health visiting practice (p54)*. They summarised this in the phrase "*making a difference to children and families"*, they believe this single phrase best describes what health visitors see as the purpose of their role and what they are striving to achieve. It was their view that, "*fulfilment of making a difference was consistent with working to an acceptable professional health*

visiting ideology "*(p110)*, which builds on the notion of orientation to practice (discussed in chapter 5) developed by Cowley et al (2013) in Why Health Visiting?

Table 8.1 "*identifies the four key aspects of health visiting practice that were perceived to contribute to making a difference"* in the Whittaker et al (2013, p. 54) study. These elements resonate with what was constructed from this study. To demonstrate this, I have compared the three categories and their sub categories that health visitors identified as important for leadership to *make a difference,* to the four aspects of health visiting practice devised by Whittaker et al, (2013). Central to both are how key relationships are in understanding how health visitors' practice. The importance of relationships, in terms of how nurses understand leadership is well documented in the literature (Cummings et al, 2010; Wong et al, 2013). This was found to be the same for participants in this study, as it is through building relationships that health visitors understand professional practice and leadership and it is fundamental to how health visitors connect with families, communities, peers and managers/leaders.

Table 8.1 Comparison of the activities involved in the professional health visitor ideology of making a difference and the relationship to the leadership categories

Making a difference - professional ideology	**Making a difference - through leadership - professional ideology**
1. Working in collaboration with others	**1. Context of leadership**: Professionalism and organisational change
2. Connecting with families and communities	**2 Purpose of leadership**: Setting the direction and followership
3 Using knowledge skills and experience **4** Professional autonomy to respond appropriately and flexibly to needs	**3. Leadership behaviour**: Role modelling, identity and developing leadership

Within the category*: context of leadership*, participants identified that professionalism defined their own role as professionals working with other professionals across health and social care boundaries. How services are organised affects how health visitors can lead. They may need to lead across service and professionals to deliver the HCP. Central to this is the pervading culture within the organisations. This resonates with working in collaboration: a key aspect of the health visitor role (Whittaker et al, 2013; Whittaker et al, 2017).

The *purpose of leadership* category identified setting the direction and followership as central to clarifying what health visitors were leading. Participants discussed the need

to connect with managers, commissioners, clients and other health professionals to be able to lead effectively and to do so with a clarity of what they were offering i.e. having role clarity and therefore, role identity. This is recognised in their professional ideology by how health visitors connect in their everyday work with families and communities. Leadership is just another aspect of that work and therefore contained within the model of health visiting practice. Although not always at a conscious level, health visitors do not always recognise themselves as leaders because leadership is embedded in their professional identity. Thus, the leadership activities of the health visitor need to become more conscious to enable health visitors to see themselves as leaders (Lord & Hall, 2005; Day & Harrison, 2007; Chreim et al, 2007). This is discussed further in section 8.3.

The *leadership behaviour* category included the sub categories role modelling, identity and developing leadership. These aspects of health visiting practice resonate with what health visitors do all the time as part of their professional ideology i.e. use knowledge, skills and experience through professional autonomy to lead. This relates to how participants' present themselves as leaders and the behaviour that they role model as a professional. This will apply both with children and families and with other professionals and peers.

Thus, this study accepts the "*distinctive professional ideology of health visiting"* that incorporates within it the four key aspects of health visiting practice as identified in Table 8.1. This results in *making a difference,* and offers the three categories to identify how leadership is transposed onto that professional ideology. The core category *making a difference* has the same resonance to health visitors as in the Whittaker et al (2013, p. 8) study, as the meaning attached to making a difference was found to be the same in my study; in that it is defined *as the purpose of health visiting* and it acknowledges that health visitors' feel they are *making a difference* through leadership as the quote below demonstrates.

> *Leadership means being able to make a difference being able to take things forward being a role model in the widest sense of the word being able to make*

changes being able to advance things and stick to your ideals in what can be a very difficult and turbulent environment (Group 3, interview 9).

This quote incorporates all the categories that emerged from the data. *Take things forward* was a focused code that makes up part of the subcategory *setting the direction* in the category *purpose of leadership*. *Being a role model* was a focused code that was raised to a sub category in the category *leadership behaviour.* In this quite *turbulent environment,* a focused code within the sub category *organisational change* captures the points raised in the context of leadership category. *Making a difference* was an initial code and then raised to a focused code and category, but after further analysis appeared to capture the three categories in terms of the notable action involved in the process of leadership and why health visitors engage in leadership in practice.

This research has identified that the "*professional health visitor ideology"* is constantly challenged by government policy changes and service reconfigurations. These may threaten the health visitor's ability to undertake health visiting in line with their ideology; this is similar to the findings of Whittaker et al (2013, p. 8). In doing so, these challenges therefore threaten the development of leadership as the professional role changes and identities are reformed. This is particularly the case in terms of professional autonomy and the ability to respond appropriately and flexibly to need.

Organisational targets and the emergence of the organisational identity often curtail these activities. Furthermore, the data emphasised the lack of clarity over the health visitor role. This was particularly marked around public health work at the population level, rather than individual/caseload work inherent in the HCP (Brigham et al, 2012; Cowley et al, 2013). This conceptual framework offers a means of understanding leadership to be based firmly within the professional ideology of health visitors, as defined by Whittaker et al (2013).

This conceptual framework is an interpretive understanding of people's behaviours in relation to leadership. M*aking a difference* emerged from what health visitors see as the

main reason for undertaking leadership. *Making a difference* was impacted most by the extent that health visitors recognised their context to lead, the purpose of leadership and how this was displayed and developed through leadership behaviour (Giles et al, 2016b). It is suggested that whilst health visitors make a difference to children and families through leadership activities this could be improved if they had a stronger role identity i.e. a health visitor and leader identity. In addition, this needs to be supported and developed by the organisations that employ health visitors.

In order to understand further how role identity can be developed, health visitor and leadership identities are explored in relation to the literature in the next section.

8.3 Developing role identity

"Identity is a construct used throughout the social sciences to describe an individual's understanding of him or herself" as something that is distinct and separate (Burke, 2006, p. 86). Identity consists of "*an individual's values, experiences, and self-perceptions"* (Baltes & Carstensen, 1991; Lord & Hall, 2005; Day & Harrison, 2007, p. 365; Karp & Helgo, 2009) and the meanings attached to the self (Chreim et al, 2007; DeRue & Ashford, 2010) *in a social role or situation defining what it means to be who one is* (Burke, 2006, p. 88). Therefore, "*identities capture the traits and characteristics, social relations, roles, and social group memberships that define who one is"* (Zheng & Muir, 2015, p. 632).

"We all are a composite of multiple sub-identities rather than a univocal self" (Day & Harrison, 2007, p. 365). Thus, when these multiple identities are taken together and make up one's self-concept (what comes to mind when one thinks of oneself), it allows an individual to make sense of who they are in relation to others and how others in turn perceive them (Zheng & Muir, 2015). The idea of self-concept is important, as it is one of the most significant regulators of a person's behaviour. Quite simply "*who we think we are determines what we do and how we do it"* (Zheng & Muir, 2015, p. 630). This idea of self-concept can be applied to the conceptual framework i.e. leadership being

thought of as context (what), purpose (why) and behaviour (how) by health visitors allowing them to develop a leadership identity and thus *make a difference.*

From the data analysis, it was quite clear that participants recognised the importance of leadership for the health-visiting role and described leadership activities that health visitors undertook. Nonetheless, the participants overwhelmingly did not believe that health visitors consistently saw themselves as leaders. Furthermore, being a leader was not recognised as a separate identity in the manner that being a nurse or a health visitor was. Leading was discussed as an unconscious activity that health visitors developed as part of being a professional i.e. nurse/health visitor.

Leadership was seen as functioning through relationships with colleagues, managers and families and it was displayed in specific behaviours e.g. role modelling. However, the form the leadership took differed, depending on whether the health visitor had built a relationship, e.g. trust that made them feel safe. In addition, the form of leadership was based entirely on their professional ideology, from which they developed their professional identity of health visitor (Whittaker et al, 2013).

"An individual possesses multiple identities, each of which is associated with various roles and contexts" (Burke, 2006; Zheng & Muir, 2015, p. 630) and "*certain roles are reciprocally related (e.g., parent/child or leader/ follower)"* through social interaction and dialogue (Day & Harrison, 2007; DeRue & Ashford, 2010, p. 629; Hercelinskyi, Cruickshank, Brown & Phillips, 2014), which means that individuals in the situation both recognise the relationship role.

This was found to be the case in the study where participants recognised the importance of relationships to enable the reciprocal role of leader/follower (chapter 6). Having a shared understanding of such roles i.e. leader/follower facilitates role recognition, "*however individuals may debate the relative value of each aspect of"* the role if they are not practiced (Collier, 2001; Machin et al, 2011, p. 1527). Thus, if health visitors are to recognise their health visitor role as being one that incorporates population as well

as individual and for them to recognise the leadership aspect of their role it is important that these identities are valued. Otherwise role identity may fragment because the roles are not practiced consistently as a group (Collier, 2001).

Machin et al, (2011, p. 1529) studied roles and identities in health visiting. They found that "*professional role identity was influenced by feedback from: other health visitors, inter-professional colleagues and local and national policies"*. The health visitors interpret "*this feedback to establish stability and value in professional role identity*" in a process entitled: role identity equilibrium. Thus, if different aspects of role identity are not reinforced they will not be undertaken.

It is therefore essential that the feedback that health visitors receive not only recognises their role as a health visitor and is clear on what that role consists of but also reflects their role in leadership and as a leader (Hoeve, Jansen & Roodbol, 2013). It is also vital that health visitors consistently practice leadership to develop and maintain their leadership identity. It is important to recognise that if the health visiting role changes through government policies this will affect identity and potentially the understanding of the role as was discussed in chapter 5, 6 and 7.

From the current study, it was abundantly clear that not all participants could find the role equilibrium defined by Machin et al, (2011). Moreover, there was not a systematic process for recognition and reinforcement of health visitors' leadership roles. This has been found to be the case in other studies particularly with regards to public health leadership (Carr, 2005; Poulton, 2008; Haycock-Stuart et al, 2010; Brigham; 2012).

Day and Harrison (2007) applied identity theory to leadership and noted the importance of having a leader identity if the individual is to develop as a leader. The rationale behind this is that the more an individual sees themselves as a leader the more they are likely to look for "*experiences to enact and develop that aspect of"* their identity. This is supported by the identity development literature which suggests that an individual's identity "*develops as a result of challenging environments and the integration of*

*experiences with the self" (*Komives, Owen, Longerbeam, Mainella & Osteen, 2005' p. 608; Karp & Helgo, 2009). It follows therefore, that how one thinks of one-self as a leader will make this a more conscious and more cognitive decision. This should help leaders to recognise their leadership identity to understand who they are and to be clear about their goals and objectives along with personal strengths and limitations (Day & Harrison, 2007; Zheng & Muir, 2015).

It is suggested that the conceptual framework advanced by the findings of this study will facilitate this process. This framework will enable health visitors at all levels to consider *who they are* in the context of their working environment. The framework should help clarify what situation they are leading, and therefore the context of leadership. *What their goals and objectives are* will be defined by thinking about the purpose of leadership. Finally, their *personal strengths and limitations* can be explored through leadership behaviour and the skills and knowledge they need to lead. This should culminate in *making a difference*. Thus, seeing yourself as a leader is key in terms of the motivation to act as a leader and develop one's leadership identity further (Lord & Hall, 2005; Day & Harrison, 2007).

Maturity and professional identity develop as health professionals reflect on clinical practice. Research suggests that when nurses are given opportunities to develop leadership skills their confidence improves and this translates directly to their clinical practice (MisKelly & Duncan, 2014). There quite clearly is a link between how health visitors view their identity as a leader and how they behave in relation to leadership. If they do not see themselves as leaders then their behaviour may exhibit this.

Leadership identity is discussed as a development approach and has been considered as a continuum of complexity (Brewer & Gardner, 1996; Lord & Hall, 2005; Day & Harrison, 2007) it is suggested that leaders start with a leader identity of self that becomes more inclusive and focused to include the interaction of the self with followers creating what has been termed relational identity (interpersonal influence), then moving on to the more complex stage of group otherwise known as collective identity (where you identify

yourself and therefore your identity as being part of groups or organisations) (Lord & Hall, 2005; Day & Harrison, 2007; Zheng & Muir, 2015). Therefore, as the complexity of the stage in leadership identity develops so too does the level of inclusiveness i.e. the complexity and range of what leadership issues you can deal with (Lord & Hall, 2005).

The idea is that the development along this continuum is incremental, so that by the time a person demonstrates collective leadership they will also incorporate and use leader and relational identities, thus enabling any one of the three depending on the circumstances required for leadership (Day & Harrison, 2007). Lord and Hall (2005) suggest that changes in the level of inclusiveness develop at the same time as your development of knowledge of leadership structures and social processes.

Zheng and Muir's study (2015), unlike Lord and Hall (2005) and Day and Harrison (2007), did not find that the process from leader to collective was incremental. The findings suggest that collective could occur at the same time as relational. In addition, they suggest that leader identity also transforms by the act of expanding boundaries. By this they meant psychological boundaries that allow a person to seek out opportunities and interact with others. Thus, the importance of exposure to new opportunities to develop leadership skills and identity is frequently expressed in the literature (Lord & Hall, 2005; Day & Harrison, 2007).

In this study, by establishing and contextualising the participants' experience of health visiting leadership it became apparent that social identity has an impact and influences how participants viewed health visitors undertaking their role. Social identities were important to each of the participants and affected how they thought about the health visiting role in terms of how health visitors facilitated relationships with mothers/families; how health visitors interacted with colleagues and how health visitors connected to the organisation (Lidster, 2014).

The identities that were most apparent from the front-line health visitor participants in Group 1 were the health visitor identity and the nurse identity. Some participants felt a

continuing and strong attachment to their initial training as a nurse whereas others felt that their health-visiting role was more relevant, demonstrated by several participants articulating a strong public health approach to their role.

Social identity theory offers insight into the nature of social group behaviours such as reformulation of the health visitor's identity. Tajfel (2010, p.2) describes "*social identity as that part of the individual's self-concept which derives from their knowledge of their membership of a social group or (groups) together with the value and significance attached to that membership".* This theory is useful as it provides further insight into the participants' engagement with *making a difference*. Participants collectively recognised the importance of *making a difference* to health visiting practice as well as its importance to health visitors undertaking leadership.

In addition, if all health visitors are to undertake leadership at a collective level as required by health policies (Storey & Holti, 2013; NHS England 2014; NHS Improvement, 2016) which based on Day and Harrison's (2007) continuum requires your identity to be at the group level for collective leadership to occur then the notion of the development of social identity becomes even more important. Thus, what is required is both the development of role identity that incorporates health visiting and leadership and supports social identity.

In this study, it appears that leadership in health visiting is understood, as something that is essential for the role but that is not necessarily owned in terms of internal identity. The participants' discussed leadership and being a leader. They considered leadership, not only as a formal individual activity, but recognised it as something that can be created between leaders and followers within a team by building relationships, engagement and influence (see chapter 6).

The challenges to role identity were evident in the concerns expressed by participants about the change to the health visitor role, arising from the complexities of healthcare and new policy initiatives. This impact on role identity is recognised in the literature in

that governments can constrain or enable the development of role identity (Hyett, 2003; Chreim et al, 2007, Cameron et al 2011).

Concerns for participants revolved around what this meant for their own professionalism and, secondarily, how this altered their professional boundaries and responsibilities. Many participants expressed that they felt they were being held accountable for things that they could not influence. The most frequently cited example of this was that they were held accountable for leading the HCP and delivering targets set by the NHS Trust yet they had had no involvement in the development of those goals/targets. This was explained below in interview 3, Group 3.

> *Health visitors are told by DH/PHE/managers that they are leading on the HCP however, the HCP in parts is difficult to interpret so they don't understand it so they don't know how they can lead effectively on it. They need help from managers to understand the HCP and how to lead it effectively with other services/agencies (Group 3, interview 3).*

The involvement of several agencies to deliver the HCP compounds the issue for health visitors in how to lead across, although all were clear in terms of delivering it i.e. the five mandated assessments using the four levels of service delivery model (DH, 2011). The view of the participants was that effectively leading across organisations, and what this meant to health visiting and other services, was not given adequate consideration. Furthermore, the concept of leadership and the definition applied to it by all these professionals will likely differ because it is widely recognised that leadership is used to mean many different things (Hartley et al, 2008).

It has been suggested from the findings of this study that health visitors understand leadership through the formation of relationships as discussed in chapter 6. Understanding leadership through relationships is well documented in the literature (Hogg, 2001; Cummings et al, 2008; Marchiondo et al, 2015). Health visitors develop a social identity by recognising that they belong to a group of health visitors that share

values and experiences (Burke, 2006; Tajfel, 2010; Willets & Clarke, 2014). The values and beliefs that health visitors have are underpinned by their professionalism and model of health visiting practice (chapter 5) that make up their identity (chapter 7) and contributes towards their social identity. Their social identity needs to be developed further if the goal of collective leadership is to be achieved.

The development of relationships across professional boundaries and within the notion of leader- follower relationships need to understand the influence that is created within that relationship to effect change, and how social identity development is supported. In the leadership development programme discussed in chapter 9 (devised from the findings of this study) Communities of Practice (CoP) which are known to support identity development (Wenger, 1998) were established as a way of developing social identity and reinforcing leadership and health visiting identity.

The data from this study suggests that there is a problem for some health visitors of making sense of their professional role. This is supported in the literature and again this is not a new issue (Carr, 2005; Machin et al, 2011; Baldwin, 2012). Changes to this role have occurred without adequate support being provided to the reformulation of the role to allow a new identity to emerge. Moreover, there has been no focus on developing a leadership identity. This has resulted in a tension between the organisational and policy requirements that are not sufficiently aligned to the health-visiting role. It would appear that far more emphasis has been placed on managing the change driven by government policies than on reformulation and development of the health visitor identity.

For some participants in this study, the value placed upon team working reflected their motivation to *making a difference*. For these individuals, leadership was articulated by drawing comparisons of themselves with the perceived leadership of others, namely role models. They reflected upon how they interacted in the relationship between leader/follower and how easily they found it to make the transition between the two

roles. By making sense of leadership, health visitors reflect on their professionalism and by doing so they develop their identity in different contexts.

These contexts were found to relate to their individual identity i.e. the need to have role clarity as a health visitor and develop a leader identity but also participants recognised that health visitors had strong membership of groups and several examples of leadership were discussed within a team context undertaking both roles of leader and follower (see chapter 7). They then marry these experiences to the acts of leadership (Karp & Helgo, 2009), albeit often unconsciously. The literature supports the impact of role modelling on developing and reconstructing role identity (Chreim et al, 2007) and developing social identity i.e. by belonging to a group suggested as a way of building identity (Willetts & Clarke, 2014).

Therefore, to improve their leadership what is required is to raise the awareness of the leadership part of their role at all levels. This could be facilitated by the components of the conceptual framework proposed here. Thus, to address the issue around role identity and to develop a leadership identity, it is seen as important that health visitors can experience leadership that makes them feel safe (Chapter 6). This should include recognising the values that health visitors have in relation to leadership and their experiences and perceptions of themselves as leaders (Chapters 5 & 7) and their social identity.

Changing identity, or identity reformulation is required if health visitors are going to lead at all levels of the leadership continuum (Day & Harrison, 2007) as well as assume the changing role of the health visitor. It is recognised that professional identity is not static. Moreover, because role lies at the centre of professional identity (Chreim et al, 2007; Harmer, 2010; Maranon & Pera, 2015), it should be continually evolving. In the same way leadership is not static or permanently possessed. Instead leadership emerges from the "*interaction between leaders and followers"* (Hartley et al, 2008; Karp & Helgo, 2009, p. 892). Any reformulation of professional identity will have its basis in commonly held

beliefs and values (Harmer, 2010) and in the original role identity of the health visitor (Baldwin, 2012).

"*Rather than viewing leadership as something that is owned, it should be viewed as a dynamic process between people, dependent on context but more importantly on identity and relationships"* (Karp & Helgo, 2009, p. 884). This view of leadership is represented in Figure 8.1. The concept of leadership being understood through relationships was fundamental to how health visitors lead and to the goal i.e. to *making a difference* through leadership and relationships with different groups of people.

With the development of collective leadership in the NHS and social care (NHS Improvement, 2016) organisations must distribute leadership to where the expertise, capability and motivation are situated. This requires the development of social identity, not just individual leadership identities. It requires knowledge of systems leadership skills, not just individual skills that will allow the development of: "*trusting relationships, agree shared system goals, and support collaboration across organisational and professional boundaries"* (NHS Leadership Academy, 2015; NHS Improvement, 2016, p. 2). Therefore, what is required is a new way of conceptualising health visiting leadership development using the conceptual framework developed from this study.

8.4 Existing conceptual frameworks used in leadership education

At the start of the study I was not intending to develop a conceptual framework to explain leadership in health visiting specifically, I was expecting to develop a substantive theory, as is common in grounded theory studies (Strauss & Corbin, 1990). Other than that, I was interested in being able to identify how health visitors understand leadership and from this provide suggestions for how leadership education for pre-qualifying health visitors and those undertaking CPD could be strengthened, in line with requests from government policies (DH, 2011). Therefore, I did not review existing leadership conceptual frameworks in the literature.

In addition, grounded theory methodology is such that an extensive literature review at the beginning of the study is not advised (Charmaz, 2014). Although I have been reflexive to question myself about what I have included in the study and why, in terms of findings from the data, I believe reviewing the conceptual frameworks available once I had developed my conceptual framework was the right decision, as it is difficult, even when being reflexive, not to take on existing ideas.

It is suggested "*that framing post-graduate leadership programmes around a conceptual model can aid identification of the key components required for effective leadership development"* (Leigh et al, 2017, p. 77). There exits several leadership conceptual frameworks (Storey, 2003; Hartley et al, 2008; Storey, 2011; Peppin, Dubois, Girard, Tardiff, & Ha, 2011; VanVactor, 2012) what these models have in common is that they aim to operationalize leadership "*development around a clear set of assumptions that are"* fit for purpose depending on who is delivering the leadership development and why (Leigh et al, 2017, p. 79*). "These suggest that there are core requirements for a healthcare leadership development model to be effective. For example, there is a noticeable global paradigm shift with movement away from the theoretical programme curricula to one that includes work- (practice) based leadership learning"* (Storey, 2011; Leigh et al, 2015; Cunningham, Dawes & Bennett, 2016; Leigh et al, 2017, p. 80).

I have looked at the frameworks relevant to this study in order to situate the emergent conceptual framework in the literature. As I developed the conceptual framework, I came across Hartley et al, (2008) who developed the Warwick *road map for leadership.* Context, purpose and behaviour are part of this framework but are not named the same although they are recognised as important concepts. Hartley et al (2008, p. 159) suggest "*an alignment of leadership development with organisational purposes, practices and people",* as a means of structuring leadership development.

Interestingly, when I reviewed leadership development as part of the literature review conceptual frameworks were found to have a limited evidence base of effectiveness for leadership development in the NHS (West et al, 2015).

After developing my framework, I came across Storey's (2003 & 2011) conceptual framework, which was developed to help organise thinking about leadership issues. Storey's (2011, p. 20) framework is based on four themes, which he states are "*essential in any systematic analysis of organisational leadership*. *These factors are: context; perceived leadership need; behavioural requirements and capabilities; and development methods,"* he describes these interrelated factors as the "*leadership constellation."*

This resonates with the conceptual framework that I have constructed, in that Storey (2011) includes context and behaviour as key components. The conceptual framework developed in this study reflects my philosophical assumptions about leadership and leadership development and the knowledge I have constructed. This is recognized as appropriate for a constructivist grounded theory as Charmaz (2014) advises what is developed cannot stand outside and be separate from the researcher.

The emergent conceptual framework constructed from this study supports the development of leadership from a different perspective to that of theoretical and in this way is similar to other conceptual frameworks being used in health care (Leigh et al, 2017). Leigh et al (2017), in developing a conceptual framework for their leadership development post graduate programmes, used the 'Five Es' of the Leadership Qualities Framework (LQF) (NHS Institute for Innovation and Improvement, 2006) combined with Biggs' (2003) constructive alignment framework to develop the Multidimensional Leadership Conceptual Development Model.

This resonated with me. In my current position as Head of Department, Education and Quality at the iHV, in January 2017 I won a grant from the Burdett Trust for Nursing to implement the conceptual framework that emerged from this study and to evaluate its use in practice (see Chapter 9 for a detailed discussion of this). I did this by designing a leadership development programme around the conceptual framework and the findings from this study. The activities that I embedded in the programme included self-assessment for participants prior to attending the programme; two days delivery by face

to face teaching in which each section of the conceptual framework was discussed and applied to practice.

This leadership development programme was undertaken within three different NHS organizations. Opportunities were offered to try things out in practice and discuss progress in ALSs together with identifying a mentor for each participant.

As part of the programme each participant is completing case studies of their leadership activities and these are being reviewed by me. I decided to introduce case studies because although all participants understood the concept of *making a difference* the core category (see Figure 8.1, p. 223) and could relate to this, some participants wanted a more specific structure to help them think through the conceptual framework. The development of a CoP is part of the overall assessment for this leadership development programme. This process has been shown to develop professional and social identity (Wenger, 1998). These points are discussed further in chapter 9.

All of the activities included in the leadership development programme were taken from the findings of this study. I read the paper by Leigh et al (2017) for the first time recently. It is clear that the design of my programme links directly to the activities suggested by the "Five Es" LQF (NHS Institute for Innovation and Improvement, 2006). All the elements mentioned in the "Five Es" LQF were issues that had arisen from my study, and were embedded in the categories and the core category. The elements that were missing from the LQF (NHS Institute for Innovation and Improvement, 2006) and the combined model suggested by Leigh et al, (2017) are: the importance of identity when building leadership development, and an explicit focus on developing identity. I have explored both of these as a result of the findings from this study.

The findings from my study and how they add to the "Five Es'' LQF (NHS Institute for Innovation and Improvement, 2006) add credibility, originality, usefulness and resonance to the conceptual framework I have developed. As a result of this study all the key evaluation criteria suggested by Charmaz (2014) to test whether a constructivist

grounded theory has contributed to knowledge and practice has been met. The use of the evaluation criteria is discussed further in Chapter 9.

As part of the monies from the Burdett Trust for Nursing I am undertaking an evaluation of the implementation of the conceptual framework through the leadership development programme across the three NHS Trusts using the Kirkpatrick Model: Four Levels of Learning Evaluation (1994).

8.5 Leadership development

This study has demonstrated that historically health visitors have not routinely undertaken formal CPD on leadership training. This is so, even for health visitors who have developed into senior leadership roles (Chapter 5). Despite this, it is recognised that leadership training is a pre-requisite in prequalifying health visitor education. The findings supported this view in that most of the participants in this study who were still in clinical practice only undertook LEO training around 2004. This suggests that leadership is understood in terms of professional experience. Thus, being a good health visitor equates to being a good leader and the former skill set is learned by health visitors doing the job, through observing others and gaining experience. Subsequently, the individual's knowledge of health visiting and their experience are valued as being the most important indicators of being a good leader.

Whilst there is no definitive best way to develop leaders (Hartley et al, 2008; West et al, 2015), nor one best way to train for leadership the findings of this study suggest that the strongest influence for health visitors on leadership is role models. In addition, 'learning from doing' in line with social learning theory (Bandura, 1977) and accumulating experiences that allow a person to test out decision-making skills and responsibility taking are also extremely important. This is in keeping with findings in the literature (Storey, 2011; Zheng & Muir, 2015; West et al, 2015) that suggests that experience, combined with skills and knowledge in leadership with support and guidance provide

the best preparation for leadership. This is supported by Day and Harrison (2007) who recognise the benefits of exposure to opportunities to develop leadership in practice.

It would thus seem pertinent to re-examine what we mean by leadership education for health visitors. Historically leadership modules in many health visitor education programmes have focussed on individual and team leadership skills and styles and been related to the Healthcare Leadership Model (NHS Leadership Academy, 2011 & 2013; Greening & Haydock, 2014). Typically, leadership education has been delivered at the end of the health-visiting programme rather than throughout the programme, although this is changing and more programmes are delivering leadership education in the first semester.

What is unclear however, is how much attention is given to developing a role identity that matches the reality of practice i.e. both health visiting and leadership and social identity. The findings from this study would suggest that this has not been central to leadership development in pre-qualifying health visitor programmes and is not prevalent in CPD leadership programmes.

The data analysis and the subsequent review of the literature highlight the importance of professional identity but also the importance of seeing oneself as a leader: as identity has a significant impact on behaviour (Day & Harrison, 2007). Therefore, it is essential that an introduction to role identify, that incorporates both being a health visitor and a leader, is included early in education programmes for health visitors and opportunities to reflect and apply in practice settings is essential. How this can be undertaken is discussed further in chapter 9.

As discussed above Lord and Hall (2005) and Day and Harrison (2007) suggest a developmental approach to leadership considering, leader, relational and collective levels. The conceptual framework developed from this study enables health visitors at all stages of their professional career to consider: through understanding the context in which they lead; the purpose in why they are leading; and the behaviours they need to

demonstrate to achieve the ultimate of *making a difference.* This will be different for all participants of the health visiting pre-qualifying programme as they arrive with different experiences having accessed health visiting education through different routes e.g. nursing, child, adult, learning disability, mental health or through midwifery (NMC, 2009 & 2010, Malone et al, 2016). The conceptual framework provides an opportunity for all health visitors and health-visiting students, regardless of the route they came in to the profession, to reflect on where they are in their leadership journey.

Moreover, a requirement to focus on "leadership development" as a way of developing leadership is clearly articulated in the literature as identity is central to leadership development as it typically involves behaviours "*in which individuals change their perceived identity as a leader"* (Lord & Hall, 2005, p. 608; Komives et al, 2005). "*Therefore, effective leadership development programmes could be identified as programmes that encourage the development of leadership identity among participants"* (Komives et al, 2005; Zheng & Muir, 2015; Sorensen et al, 2016, p. 41).

It is therefore suggested that education needs to adapt to the changing context, with the provision of support for development of professional and leadership identities. It is equally important to learn about leadership in practice; continuously within a supportive environment (Bawafaa, Wong & Laschinger, 2015) with managers who involve health visitors in service design and delivery.

Communities of Practice (Wenger, 1998) along with ALSs have been found to be beneficial when embedding identity amongst practitioners (Storey, 2011). Opportunities to shadow; mentorship and preceptorship have also been shown to be beneficial (Williamson, 2009; West et al, 2015). Unfortunately, not all leadership development in the past has used the potential for learning from 'on the job' and organisational challenges (Hartley et al, 2008).

This study suggests a different way of educating health visitors to lead. This proposal does not just comprise a course or competency framework, which have been criticised

for just developing the leader (Edmonstone, 2011). It is apparent that leadership development needs to focus on the individual's identity and stage of development together with the health visitor's experience and knowledge of health visiting (Day & Harrison, 2007). Participants' described relationships and role modelling as being key to how health visitors understood leadership. This is not uncommon. Leadership has been recognised as being constructed through relationships (Karp & Helgo, 2009, Wong et al 2013; Laschinger, Cummings, Wong & Grau; 2014).

Therefore, education and development in a relationship-based approach for leadership would seem appropriate. For example, this might include an authentic, distributed, strengths-based approach aiming for inclusive, compassionate and transformative leadership (Cummings et al, 2008; Wong et al, 2010; Regan, Laschinger & Wong, 2016). All of these styles were recognised as valuable within this study and the literature.

8.6 Chapter summary

The concept of *making a difference* was identified from the data and builds on previous studies incorporating this term (Whittaker et al, 2013, Cowley et al, 2013). Understanding the process of leadership involved health visitors making sense of their experiences and identifying how they got to making a difference, which is central to the understanding of this phenomenon. For this to happen professional identity and leadership development need to be part of the professional ideology.

The conceptual framework also builds on previous frameworks on leadership (NHS Institute for Innovation and Improvement, 2006; Hartley et al, 2008; Storey, 2003 & 2011) but expands these frameworks by making explicit the importance of recognising role identity, both professional and leadership, and the specific activities required to build identity.

This research contributes to bridging the gap in the existing knowledge on leadership in health visiting and provides an understanding of leadership for health visitors. It is grounded in the context of health visitors employed in the NHS in England.

Chapter Nine

9. Conclusions and recommendations

9.1 Introduction

This study has explored how health visitors understand leadership within the NHS. This chapter demonstrates how I have made a contribution to academic knowledge and professional practice by undertaking the study. The chapter focuses on the value of the study; how the aims and objectives of the study have been met; the key findings; recommendations that arise from the study and reflections on professional practice. In addition, evaluative criteria for constructivist grounded theory, devised by Charmaz (2014) and applied throughout the study, are discussed.

Prior to this study, the limited research available has been inadequate to describe how health visitors understand leadership. There remains huge scope for work on leadership as a concept, leadership development and how health visitors interact with government policy. The findings of this study identify a conceptual framework for leadership development that can be used as a way of suggesting how health visitors understand leadership and, as a mechanism to structure health visitor education on leadership in academic and clinical practice settings.

9.2 Reviewing the study aims and objectives

This section links the findings from the study including the conceptual framework to the aims and objectives of the study to demonstrate how they have been met. The objectives were mapped to the contributions of the study in section 9.5 and to the recommendations in section 9.6.

9.2.1 Aims of the research

At the beginning of the study the aim was defined as follows: to gain an understanding of how health visitors perceive their leadership role, and how leadership is demonstrated in the delivery of the health visiting service. The aim was to explore underlying assumptions about leadership, in the context of the organisations within which health visitors' work, to enable me to examine how health visitors understand leadership as a social process. The intention was that the findings from the study would inform how health visitors are prepared to undertake leadership during pre-qualifying health visiting training and during CPD.

9.2.2 Research Question

How do health visitors understand leadership?

The conceptual framework explains how health visitors understand leadership discussed in Chapter 8.

9.2.3 Objectives of the research

1. To understand what the term “leadership” means to health visitors.

Leadership for health visitors emerged as an almost unconscious activity that was undertaken based on the knowledge, experience and confidence they had developed through professional practice. How health visitors interpreted and demonstrated leadership came from their understanding of their model of practice and their professional ideology (as defined by Whittaker et al, 2013). This was articulated by the phrase, *making a difference*, which has been incorporated into this study as the core category. This phrase includes an understanding of the *context of leadership, purpose of leadership and leadership behaviour* (this links to contribution to academic knowledge, section 9.5.1 and recommendation 1 section 9.6.2).

2. To identify what leadership activities health visitors, undertake within the organisations they work and to clarify what leadership identity they have.

This study identified that the health visitors' identity is firmly set in being a professional. They recognise that they have a leadership role but they do not automatically see themselves as leaders. They rarely consider themselves to have a leader identity. The study found that health visitors lead in many activities at a local level to bring about the change required for government policies to be implemented. The context of leadership for health visitors is set by strategic leaders/managers. Health visitors then work to deliver the policy by understanding the purpose of leadership and how best to undertake it. This meets the needs of the central health policy that affects health visitors and allows effective delivery of the HCP (DH/DfCSF, 2009a, b). Ultimately, the activities health visitors undertake are governed by health policy. Moreover, changes in government policies affect what leadership health visitors undertake (this links to contribution to professional practice, section 9.5.2 and recommendation 3, section 9.6.1).

3. How do followers make sense of leadership?

Participants' identified leadership as a social process, that involves followers and leaders in a fluid relationship (as discussed in Chapter 6). They felt that individuals could move between the two roles dependent on the nature of the goal of the leadership activity. The notion of shared/distributed leadership was identified in the actions described by the participants however; there was a lack of clarity around how much autonomy was available to enable the sharing of leadership within health visiting teams (this links to contribution to professional practice, section 9.5.2 and recommendation 1 section 9.6.3).

4. To analyse how top down policies, different professional discourses, and cross boundary working affects leadership in health visiting.

Professional discourses and cross boundary working creates problems for health visitors because of a lack of clarity around the health visiting role, arising from continually changing health policy and commissioning of the health visiting service. This impairs their ability to lead and this is reinforced by their lack of a leadership identity. Without a clear role identity and a clear set of expectations health visitors continue to struggle with cross boundary working and understanding their role. Collective leadership, a form of distributed leadership, has been suggested as something that all health professionals should engage in to facilitate working across boundaries (West et al, 2015). At present this skill is under developed and the main stage of leadership development for health visitors is relational (Cummings et al, 2008) (this links to contribution to professional practice, section 9.5.2 and recommendation 3 section 9.6.1).

The findings of this research are in line with other work that highlights the key issues facing health visitors in relation to role identity (Machin et al, 2011; Cowley et al, 2013; Whittaker et al, 2013).

5. To understand the social processes operating within the health visiting service, to generate a theory to explain the phenomenon of health visiting leadership within the NHS.

A conceptual framework has been developed that explains how health visitors understand leadership. This conceptual framework suggests how to give meaning to the phenomenon of leadership in practice. Health visitors understand and engage in leadership through their model of health visiting practice. They also go through the development stages of nurse/midwife to health visitor observing leadership through role modelling. This adds to the theory and practice in the way we understand and deliver education/training on leadership. It is suggested that health visitors are guided by the three categories *leadership in context, purpose of leadership and leadership behaviour* and the core category *making a difference* which together suggest how health

visitors understand and give meaning to leadership (this links to contribution to academic knowledge, section 9.5.1 and recommendation 1 section 9.6.2).

6. To provide recommendations on how leadership education for health visitors might be improved.

Education programmes need to focus on the identity of the health visitor both as a professional and as a leader from the commencement of training. It is suggested that the construction of a leadership development framework for health visitors will support this based on the conceptual framework (this links to contribution to professional practice, section 9.5.2 & recommendations 1 & 2 section 9.6.2).

In Chapters 5, 6 and 7 I interpreted, from the perspective of the participants, how the phenomenon is understood and the processes that were identified that led to concerns. I explored these concerns through the categories *context of leadership*- which identifies the impact of professionalism and changing health policies on health visiting leadership; *purpose of leadership*- defined as understanding the leader/follower relationship and the direction of leadership and *leadership behaviour*- how health visitors understand leadership through role models and how leadership is demonstrated through behaviour and how health visitor leadership identity develops.

Chapter 8 discussed the conceptual framework in the context of health visitors *making a difference*. The conceptual framework was also considered in the context of related literature and theoretical frameworks. *Making a difference* describes what motivates health visitors to undertake leadership and what makes them engage with leadership in their role. The basis for their concerns are explained through the categories *leadership context, purpose of leadership and leadership behaviour.* These elements all need to be considered when developing leadership for health visitors. This theory builds on the work of Lord and Hall (2005) and Day and Harrison (2007) that identifies the need to develop leadership in line with the stage of the individual's leader identity and development. The conceptual framework suggests a process to structure leadership

development so that it enables health visitors at all levels to address their leadership requirements in a flexible manner.

9.3 Value of the study

The literature review highlighted how poor leadership manifesting in the quality of professional care has impacted on patient/client care (Wong & Cummings, 2007). This is most notable in the case of safeguarding of children, where poor leadership was attributed in part to the failings that led to the death of Victoria Climbie from *non-accidental injuries* (Laming, 2003; Hartley et al, 2008). Similar failings in professional leadership, more recently at Mid Staffordshire Hospitals, had a fatal outcome for patients (Francis, 2010 & 2013).

Laming (2009, p. 57) stated *"a robust health visiting service delivered by highly trained skilled professionals who are alert to potentially vulnerable children can save lives".* The findings of this study have the potential to save lives, through providing robust training on leadership for health visitors through the leadership development programme based on the conceptual framework.

It is now well recognised in health care policies that undertaking leadership is not an option but a requirement for all health visitors and all health professionals (DH, 2010a; NHS England, 2014 & 2016). The introduction of the HVIP (DH, 2011) and the renewed focus on leadership in health visiting as an individual responsibility in health policy at every level makes this study both timely and important.

Studies have demonstrated the importance of effective managerial support being in place for leadership to be undertaken successfully by health visitors and nurses (Cummings et al, 2010; Whitaker et al, 2013; ACN, 2015). In addition, the focus on the individual as a leader has been repeatedly reiterated in health policy (NHS England, 2016) and the literature (Parry, 1998; Hartley et al, 2008) however, there was a gap in

the research that explores how health visitors understand leadership and how they undertake it in practice in the NHS.

Review of the literature identified that nurses/health visitors' experience leadership through professional relationships. Moreover, the most frequently used approach to leadership in nursing is the transformational leadership approach (Bass, 1990; Cummings et al, 2010). However, many of the studies undertaken on transformational leadership are on senior nurses in consultant positions or at similar levels in acute hospital settings not on health visitors in a community setting (Cameron et al, 2011; Wong et al, 2013). There is little known about how health visitors experience and undertake leadership (Haycock- Stuart et al, 2010).

9.4 Evaluation of this study and its limitations

To evaluate the study Charmaz's (2014) evaluation criteria for grounded theory studies have been applied; this was used throughout the research process.

Using a constructivist grounded theory methodology, has proved to be beneficial for this study as it suited the aim of the study (as outlined in Chapter 3 & subsequent chapters). As a health visitor, myself it meant I understood the language and none of the participants appeared to find it difficult to discuss issues, even those considered confidential by participants. Although taking this stance did mean that I had a lot of memos to write; as I brought with me a substantial professional knowledge base and subsequently lots of opinions and beliefs about leadership in health visiting. However, acknowledging my bias through memo writing, in supervision with my DBA team and being reflexive about my own beliefs has helped me to apply the methodology appropriately and ensure that I was guided by the data and theoretical sampling in terms of how the theoretical categories developed and were chosen.

The limitations of choosing to use this methodology are that the findings cannot be necessarily generalised. However, this is ameliorated somewhat as the conceptual

framework has been found to be usable and meaningful to practitioners, therefore, meeting the evaluation criteria for a constructivist grounded theory study as worthwhile.

Using constructivist grounded theory suggests that what I have found is one interpretation of multiple possible explanations of what leadership means to health visitors. This is my interpretation; but one that is grounded in the data and my professional expertise and importantly one that has been found to have meaning to health visitors. This has been confirmed by implementing the conceptual framework (see Figure 8.1, p 223) as part of the leadership development programme across three NHS Trusts and the positive evaluations.

9.4.1 Meeting the criteria for grounded theory studies

The criteria for evaluation of grounded theory studies suggested by Charmaz (2014) identifies four key areas to consider as the study is undertaken. These areas are credibility, originality, resonance and usefulness.

Credibility refers to how familiar the researcher is with the setting or topic being studied. This study examined how health visitors understood the concept of leadership in their role. As a health visitor myself, undertaking a constructivist grounded theory allowed me, through the methodology chosen, to understand the professional experiences of the participants across the different levels of health visiting. This allowed data to emerge from the interviews as a result of a co-construction between the participants and me. By constant comparison of the data and the emerging categories it was possible to see the emerging processes that explain how health visitors understand leadership and how health visitors engage in these processes.

This study has extended the idea of providing an evidenced-based approach to leadership development beyond the work of Hartley et al (2008). It builds upon the concept *making a difference,* a term that describes professional aspirations for

undertaking a health visiting/nursing role (Maben & Griffiths, 2008; Whittaker et al, 2013). It develops the work of Lord and Hall (2005) and Day and Harrison (2007) that found that leadership identity was important if individuals were to lead, by recognising the importance of leadership identity development for health visitors. This study supports and develops the professional ideology of health visiting (Whittaker et al, 2013). This is captured in the concept of *making a difference* and extends this to include leadership.

Several studies (Cummings et al, 2008; Wong et al, 2013) have explored the effect of leadership on nursing; however, there has been little consideration of what the impact of leadership is on the role of health visitors and the work that they do with children, families and communities. By exploring the perspectives of health visitors this study has examined how they use their professional background and model of practice to understand leadership. The finding that there is no leadership identity for health visitors is **original**. The study therefore provides a new insight into the phenomenon.

The social and theoretical significance of the study are identified in the conceptual framework, which explains how health visitors understand leadership (Charmaz, 2014). This can explain some of the experiences of being a health visitor. Whilst acknowledging that the conceptual framework builds on previous work, it is also **original** because it is applied to leadership. The use of constructivist grounded theory as a way of examining the phenomenon is also **original.** By using this approach adds to what is known about how to undertake leadership development throughout health visiting education and how to further develop once qualified through CPD training.

The categories provide **resonance** of this study. Charmaz (2014) suggests that resonance means that several points are considered. These are as follows: that the categories present the breadth of the experience described by the participants; that meanings of leadership have been revealed by participants in terms of how they perceive the phenomenon and that links have been drawn between larger collectives of health

visitors and health practitioners and with individual/group perceptions about professional identity and the importance of this to understanding the phenomenon.

The findings of this study have been discussed with other health visitors at all levels of the profession. They have also been discussed with colleagues who work with health visitors. The findings are agreed to make sense and to provide a better understanding of how health visitors struggle to establish a leadership identity (Charmaz, 2014). The notion of *making a difference* has been found, through such discussions with health visitors across the country, to resonate strongly and is recognised as a term that encapsulates what connects health visitors to their practice. This was found to be the case across all three leadership development areas where the programme was delivered.

Usefulness considers whether the study provides interpretations that health visitors can use in their everyday lives. The analytic categories, core category and subsequent conceptual framework provide health visitors with an approach to leadership development based in the data. This allows them to develop a leadership identity and therefore to enhance the leadership they undertake within their role (Charmaz, 2014). It is suggested that other professions, particularly nurses, could also benefit from this approach to leadership development and in the delivery of educational programmes.

This approach would allow integration of theory and practice in leadership using role models in practice environments. This would provide a structure that can be evaluated when delivering leadership education/training and when providing supportive environments in practice i.e. opportunities to experience leadership in a safe environment. The feedback from participants on the leadership development programme have been very positive in terms of how useful the conceptual framework is in order to articulate what, why and how they lead and the outcome they consider to be *making a difference.*

9.5 Contribution of this study to academic knowledge and professional practice

9.5.1 Contribution to academic knowledge

A conceptual framework, (see figure 8.1 p. 223) making a difference: how health visitors understand the social processes of leadership has been constructed to explain how health visitors understand leadership through their professional ideology (Whittaker et al, 2013). This conceptual framework demonstrates how the three categories: *context of leadership, purpose of leadership and leadership behaviour* formed a core category *making a difference* it also identifies the relationships between the categories and how all three relate to the core category.

This research builds on the foundations laid by Whittaker et al (2013) and Cowley et al (2013), to include leadership as an activity driven by the same health visiting professional ideology: *making a difference*. Many scholars consider this as the most frequently cited motivator and outcome for professionals working in healthcare (Maben & Griffiths, 2008; Christmas & Millward, 2011).

According to the literature there is a lack of clarity about how best to develop leaders and leadership in healthcare (West et al, 2015). The concepts: *leadership context*, *purpose and behaviour* have all been discussed in the leadership literature and are included in various frameworks (Storey 2003; Hartley et al, 2008; Storey, 2011; Yukl, 2013); however, they have not been routinely formed into a usable framework to develop an educational curriculum or leadership development programme for health visitors. The conceptual framework developed as part of this study addresses this gap for health visitors.

The contribution to knowledge made by this study is based on the analysis of data drawn from interviews with the participants. Whilst the literature has been effective in identifying an understanding of leadership components, this study has built a larger

picture and provided a broader understanding of how health visitors understand leadership and undertake it in their role. This represents an advance in the understanding of this phenomenon because prior to this study, the literature contained no work specifically examining this area.

This study represents the understanding and meaning given to leadership by the participants co-constructed from the data collected through in-depth interviews and focus groups. Therefore, it is context specific and whilst the findings from this study cannot be generalised in an objective sense, the conceptual framework can be applied to a wider audience whose lived experience and constructed realities are similar.

This study does provide an understanding and recognition of the interesting issues raised in the study that are significant for health professionals when thinking of their leadership role. Therefore, the findings may be significant to other settings and helpful for those who want to research similar issues using different methodologies within nursing/midwifery and other health care professionals e.g. Doctors and Allied Health Professionals. This would support possible refinement of the conceptual framework and provide an understanding of its use in other healthcare settings. Thereby contributing to the development of leadership across other nursing/midwifery specialties and healthcare professionals.

9.5.2 Contribution to professional practice

The findings of this study support a conceptual framework that can be used to design leadership development programmes for educating health visitors both pre- and post-qualifying. This conceptual framework clearly identifies the need to incorporate education on leadership based upon the three categories, culminating in the core category *making a difference*. Furthermore, developing skills for leadership should be a continuous educational process, that is undertaken both in a theoretical and practice context. The findings of this study also clearly recognise the importance of establishing both a health visitor and a leadership identity throughout any period of study (Lord &

Hall, 2005; Day & Harrison, 2007) and developing a social identity (Willetts & Clarke, 2014).

Prior to this study, approaches to leadership did not reflect the experience of the participants at the level of their day-to-day clinical practice. The conceptual framework allows the concerns of the study population to be identified as categories, to be raised through the study and to be constructed into the social process of *making a difference.*

As part of the Burdett Trust for Nursing funded work (see epilogue, section 9.8 for further information about this grant) the conceptual framework was applied to school nursing who share similar experiences both being SCPHN (NMC, 2004). This was used successfully by school nurses who were able to use the framework to articulate and think through their leadership role based on the context of their professional background. As the framework is based on the individual context of the person the framework provides flexibility to apply it to the setting the health professional is working in.

It is therefore, suggested that the conceptual framework also has relevance to how nurses in pre-registration nursing/midwifery education learn about leadership and develop leadership identity. Therefore, I am exploring, through university networks, how this could be implemented into pre- and post-registration nursing, midwifery and SCPHN programmes. For example, I am currently working with Focus Games, an organisation that produces healthcare games for teaching purposes for HEE, healthcare organisations and Universities, etc. We have developed the research findings into a board game to explain the theoretical underpinnings identified through each category that makes up the conceptual framework. This innovation has been funded by the Burdett Trust for Nursing. I believe this will be attractive to a wider audience of healthcare practitioners.

The conceptual framework shares elements with other frameworks that have been used to support the development of leadership through targeted educational/training

programmes for example Storey (2011 & 2013) and Hartley et al, (2008) specifically around recognising the importance of context in leadership something that many authors in this subject area consider to be essential (Yukle, 2013; West et al, 2015).

Further work is recommended to apply the framework to a wider range of health professionals to understand if it is a valuable way of providing meaning to leadership for health care professionals.

9.6 Recommendations

The recommendations from the study are linked to the academic and professional contributions noted in section 9.5 and to the objectives listed in section 9.2.3 and the literature and are aimed at clinical practice settings, education and further research.

9.6.1 Recommendations for practice

1. The key recommendation from this study was a conceptual framework that can be used for designing leadership programmes for health visiting education e.g. *context of leadership, purpose of leadership and leadership behaviour,* culminating in *making a difference.* This suggests how health visitors understand leadership and builds on existing knowledge (Storey, 2003; Hartley et al, 2008; Storey, 2011; Whittaker et al, 2013). (This links to contribution to professional practice, section 9.5.2).

2. Professional experience was central to how health visitors' leadership role evolved. What is noteworthy is the lack of formal leadership development currently undertaken by health visitors. Consideration should be given to support leadership development (this links to contribution to professional practice, section 9.5.2). This should not just be seen as training events as this has not been shown to be effective in terms of impact on improving client/patient

care. Instead training coupled with other development activities e.g. ALSs and shadowing opportunities should be considered (West et al, 2015).

3. Health visitors' express that they have a leadership role however, this does not include a leadership identity. Leadership development programmes should focus on developing a leadership identity for health visitors in the context of their organisation; this builds on existing knowledge (Lord & Hall, 2005; Day & Harrison 2007). (This links to contribution to professional practice, section 9.5.2).

9.6.2 Recommendations for education

1. The findings from this study i.e. the conceptual framework should be used to implement changes to the structure of leadership development for health visitors on pre-qualification health visiting programmes to ensure programmes are evidenced based (West et al, 2015). (This links to contribution to academic knowledge, section 9.5.1).

2. Planned structured activities should be included in pre-qualification health visiting programmes to teach leadership. This should include doing and observing in practice settings, role models, mentors and practice teachers as well as other appropriate leaders- as supported in the literature (West et al, 2015). (This links to contribution to academic knowledge, section 9.5.1).

3. Emphasis should be placed upon development of professional and leadership identity in pre-qualification health visiting programmes and CPD programmes in order to build in both from the commencement of the programme (Maben & Griffiths, 2008). (This links to contribution to academic knowledge, section 9.5.1.).

9.6.3 Recommendations for future research

1. Further research could focus on how health visitors experience leadership, in a shared/distributed capacity and if role and social identity contribute to this. As this approach to leadership is very dominant in health policy at present (West et al, 2014; West et al, 2015; NHS Improvement, 2016). This warrants further exploration using different methodologies which would provide a different slant to these issues.

9.7 Conclusion

This study has extended understanding of how health visitors make sense of leadership. The study supports the development of a conceptual framework to explain this. This study sheds light on the importance of building and reformulating health visitor identity and developing leadership identity when delivering health visitor education. It provides an interpretive perspective instead of the more common positivist approach to leadership research reported in the literature (Parry, 1998; Lidster, 2014).

During the study, several concerns emerged around the phenomenon of leadership in health visiting. These have been discussed under the categories *understanding the context of leadership; understanding the purpose of leadership; and recognising the relevance of leadership behaviour.* From analysis of these three categories *making a difference* emerged as a core category. Participants repeatedly referred to *making a difference* as something that compelled them to undertake activities that they believed would improve practice. They felt that change, through leadership, could share good practice and allow health visitors to feel engaged and motivated when such changes occurred. A further benefit in engaging health visitors with leadership was that even when the environment was challenging and unsupportive, they still saw leadership as beneficial. *Making a difference* therefore, became a very relevant process for participants/health visitors; as it has done previously for other health professionals. This

is recognised in the literature (Maben & Griffiths, 2008; Whittaker et al, 2013). Through the emergence of the three categories and core category a conceptual framework was developed that suggests how health visitors understand leadership.

As a result of this study two key contributions have emerged from the data.

- A conceptual framework making a difference: how health visitors understand the social processes of leadership has been constructed to explain how health visitors understand leadership through their professional ideology (Whittaker et al, 2013).

- The findings support the construction of a leadership development programme based on the conceptual framework for health visitors. This should focus leadership development as a continuous approach to leadership and recognise the importance of establishing both a health visitor and leadership identity (Lord & Hall, 2005; Day & Harrison, 2007).

9.8 Epilogue

9.8.1 Personal reflexions on professional practice

It has been a privilege to have had focussed time to explore the intriguing subject of leadership with a range of health visitors from front-line practitioners, to middle managers to national leaders in health visiting.

This research has completely revised my views on the role of leadership in health visiting and, as a consequence, I have made changes to my professional practice (highlighted throughout Chapters 5, 6 & 7). I initially thought that health visitors did not take the opportunities to be the leaders of health policies such as the HCP (DfCFS/DH, 2009a, b) because they were not clear about the difference between leadership and management

and the reason they did not optimise leadership opportunities was because they didn't have the skills. What I found is completely different.

Many different professionals (including health visitors), both within the study and in my professional context, had commented to me that health visitors didn't understand what leadership was. It was repeatedly suggested to me that not only did health visitors not understand leadership but also, they were not clear on their role either. What I found was that health visitors have a very good understanding of what leadership means, despite, in most cases, the lack of any formal leadership development after qualifying.

Whilst recognising that it is a common criticism of health visitors that they cannot articulate their role, I had always thought this was the 'fault' of the health visitor. However, undertaking the research identified the amount of change that has occurred in health policy and the organisation of the health visiting services since early 2000, which has had a direct impact on what is expected from the health visitor role. This, to some extent, is out of the health visitors' control. Targets that are set by commissioners that, in essence control, the work that health visitors are able to undertake and thus lead on, is not routinely decided on in discussion with health visitors.

What I found from the analysis of the data and review of the literature was complex. The rhetoric of health policy is that all health professionals, including health visitors, are leaders at different levels and need to do so to improve patient/client care (DH, 2008 & 2010a, NHS England, 2014). Health policy purports to encourage dynamic leadership that develops new ways of working (NHS Improvement, 2016) that requires practitioners to make decisions and be autonomous. However, the reality is that the government sets targets in health and social care often without consultation with practitioners. This approach can prevent dynamic leadership and restrict professional practice. There is an eternal dichotomy in health policy between those who ask who cannot deliver and those who can deliver but are not asked. This questions whether autonomous practitioners are really wanted by health policy makers and commissioners. By definition autonomous practitioner implies they can use their

professional judgement to make decisions on healthcare not be led purely by a government target.

Through reflection on the data analysis it made sense that if health visitors are not clear on their own role nor have control over their emerging role then how can they lead across professional boundaries. Moreover, I realised my perspective of how health visitors undertake leadership, or not as the case may be, was very much based at an individual health visitor level rather than an organisational level: I was expecting individual health visitors to show leadership almost as if I was viewing them as separate to the context that they worked in i.e. their organisation. I realised, through undertaking the study, that it is not just about how well a health visitor can articulate their role but that if both elements of their role, community public health and individualised care, are not endorsed by management then that role identity will not be 'real' for the health visitor.

I was surprised by how leadership theories were not seen as valuable to professional practice by nearly all the participants in the study. In view of the amount of time I had devoted as the SCPHN (Health Visiting) course leader to covering leadership theories in health visiting pre-qualifying programmes I expected participants to see them as beneficial as a way of understanding and explaining leadership. Yet nearly all struggled to identify any leadership theories used in practice. In this way, there did appear to be a gap between theory and practice. In addition, some of the 'wicked problems' (Ham, 2014) expressed by participants, in terms of how do you engage with staff and empower them when you have to meet deadlines and targets in short turnaround time, were recurrent issues in relation to engagement. The answers to such problems are not easy to glean from the literature. What appears to happen is that everybody knew about change management theories although nobody had time to implement them.

The data analysis and the literature review provided a new understanding of the importance of identity in terms of not only professional roles but that of leader. This has been my key learning. The importance of health visitors developing a leader identity has

not been previously recognised in the literature or in practice. This has been completely overshadowed by the fact that they are, first and foremost, professional health visitors and it is that identity that is most important. The leadership development programme developed from the findings of this study provides a way of addressing this issue of identity.

Having made this revelation, I shall now discuss how this learning has changed the way I practice in my job as Head of Department (Education & Quality) at the iHV and will demonstrate how I have used the findings from the study and the wider learning from undertaking a DBA.

To support health visitors with leadership and to pilot the use of the conceptual framework developed through this study I applied to the Burdett Trust for Nursing for funding to rollout a leadership development programme in three NHS Trusts across England. In January 2017, I was awarded a grant to implement my conceptual framework as part of the leadership development programme.

Whilst designing and delivering the leadership development programme It became apparent to me that the conceptual framework could also be used as a diagnostic assessment tool to establish the level health visitors are undertaking leadership i.e. leader, relational or collective (Lord & Hall, 2005; Day & Harrison, 2007). I developed behaviour statements taken from the categories to support understanding of what the three categories meant e.g. context, purpose and behaviour and how this resulted in making a difference i.e. undertaking leadership activities that impact on improving children and families' health outcomes. I applied and was successful in receiving additional funding from the Burdett Trust for Nursing to test the framework as a diagnostic tool and have started discussions with the NHS Leadership Academy with a view to the leadership development programme being accredited and endorsed by the academy. It is already endorsed by the iHV.

What transpired from delivering the leadership development programme was the importance of ALSs as a means of embedding leadership and developing role and social identity in practice settings. This has been a key learning point and made me consider how the focus historically is always on the training element of a programme, which is usually more expensive than delivering ALSs, yet it is the ALSs that allow practitioners to consider how they are implementing knowledge and skills into practice: in this case leadership and therefore develop an identity. This model of delivery has been so positively evaluated that I am now considering all our training programmes at the iHV incorporating an element of ALSs as a way of making learning more sustainable and as a way of developing identity. This approach to leadership development is supported in the literature review (Storey, 2011; Yukle, 2013; West et al, 2015).

In addition, providing leadership opportunities for participants on the programme, through mentors and support from managers, has proven to be effective in developing the health visitors' leadership capacity and identity. Delivering the leadership programme within the context of a specific organisation has been highly effective in gaining an understanding of the individual within the organisation as oppose to them being seen as separate identities. Developing and implementing the leadership development programme in this way has followed the findings of the study and the literature on how best to implement leadership development and build identity (as discussed in Chapter 2 & 8).

Due to the strategic national position that I work in I have had the opportunity to talk to several national leaders in PHE, HEE and NHS England. As a result, I have shared my learning around the conceptual framework and the importance of identity. Time and again senior leaders have had a light bulb moment when discussing identity with them. It is something that all discuss initially in terms of professional identity, but not leadership, and when discussing the need to develop leader identity it resonates

I have discussed with NHS England how the leadership development programme could support the Leading Change, Adding Value (LCAV) strategy initiative and how important

the concept of *making a difference* is to practitioners. In order to strengthen the outcome *making a difference* through leadership I have suggested using the NHS England evidence template as a way of capturing how health visitors undertake leadership. This will be facilitated through the ALSs on the leadership development programme and NHS England will then promote these case studies as evidence of best practice in leadership if they meet the criteria. This is important as I have learnt from doing the study that valuing the contribution and reinforcing the leadership role of health visitors is important to build leader identity, this is supported in the literature (Day & Harrison, 2007; Machin et al, 2011).

I am currently leading a project group to develop a national recommended curriculum for health visitors and school nurses (0-19). The intention is that universities offering these programmes adopt it. This curriculum development project consists of the following partners: RCN, CPHVA/Unite, School and Public Health Nurses Association (SAPHNA), National Forum of School Health Educators and United Kingdom Standing Conference on SCPHN Education. I have disseminated the findings of this research into this group and I have discussed including the conceptual framework in the recommended national curriculum programme, which I am currently involved in writing.

I presented the findings from this research at the iHV national Leadership conference in London in December 2016 and the implementation of the leadership development programme in 2017. I had positive feedback in terms of how useful practitioners felt the conceptual framework would be in relation to academic and clinical practice, as the following quote highlights:

"Very interesting and something I am currently trying to develop with my health visitors- helping them to make sense of their leadership roles within our current service".

I have also presented the findings to the SCPHN Northern Community of Practice, which includes the Trust where I undertook the study. The results were received positively and

all participants at the meeting agreed on how relevant the conceptual framework is for leadership development in academic and clinical practice.

Recently I have been approached by SAPHNA to include my leadership conceptual framework into an e-learning module on leadership for school nurses and health visitors, funded by PHE.

In general, the whole of my learning from undertaking the DBA has contributed to my professional practice. There is an overwhelming need to be able to formulate a link between policy and practice. One of the key findings from delivering the leadership development programme was the lack of appreciation of health policy by both junior and senior health visitors. There is a huge gap between policy and how practitioners understand and interpret it in relation to their roles. Whilst they recognise it is important, as found in the study, they have little understanding of what it means to them in practice. I have raised this with the nursing directorate in PHE as an area that needs addressing. I have also included a section on policy implementation in the leadership development programme as it forms part of the context of leadership category.

Thus, undertaking the DBA has enabled me to apply my learning around health policy, leadership literature, strategic working as well as implementing the findings of the study directly into practice. This reinforces my findings as I am making a difference myself, through leadership by being aware of my own context, purpose, and behaviour. Thus, reinforcing my own leadership identity.

WORD COUNT – 86,183

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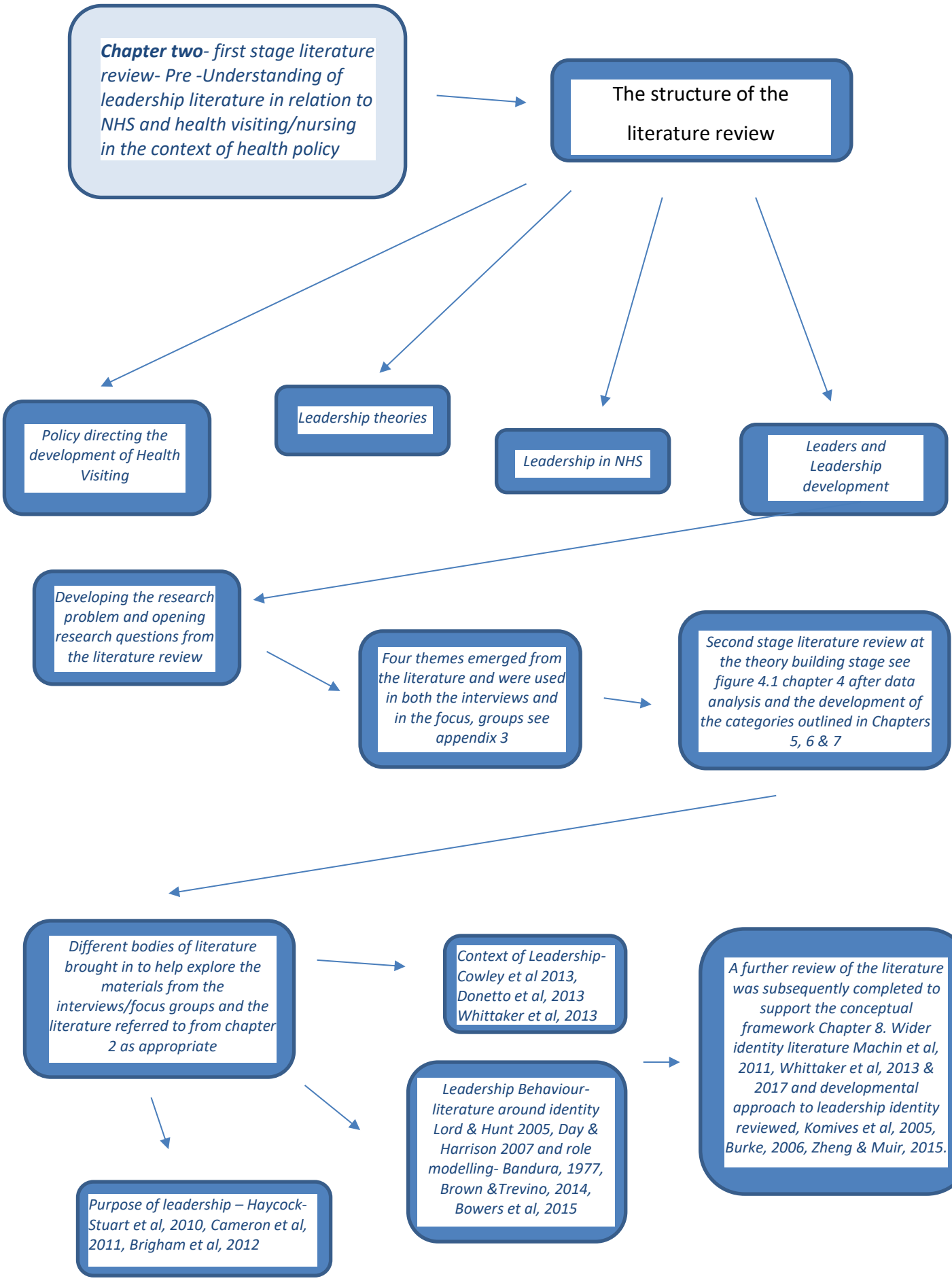
Appendix 1

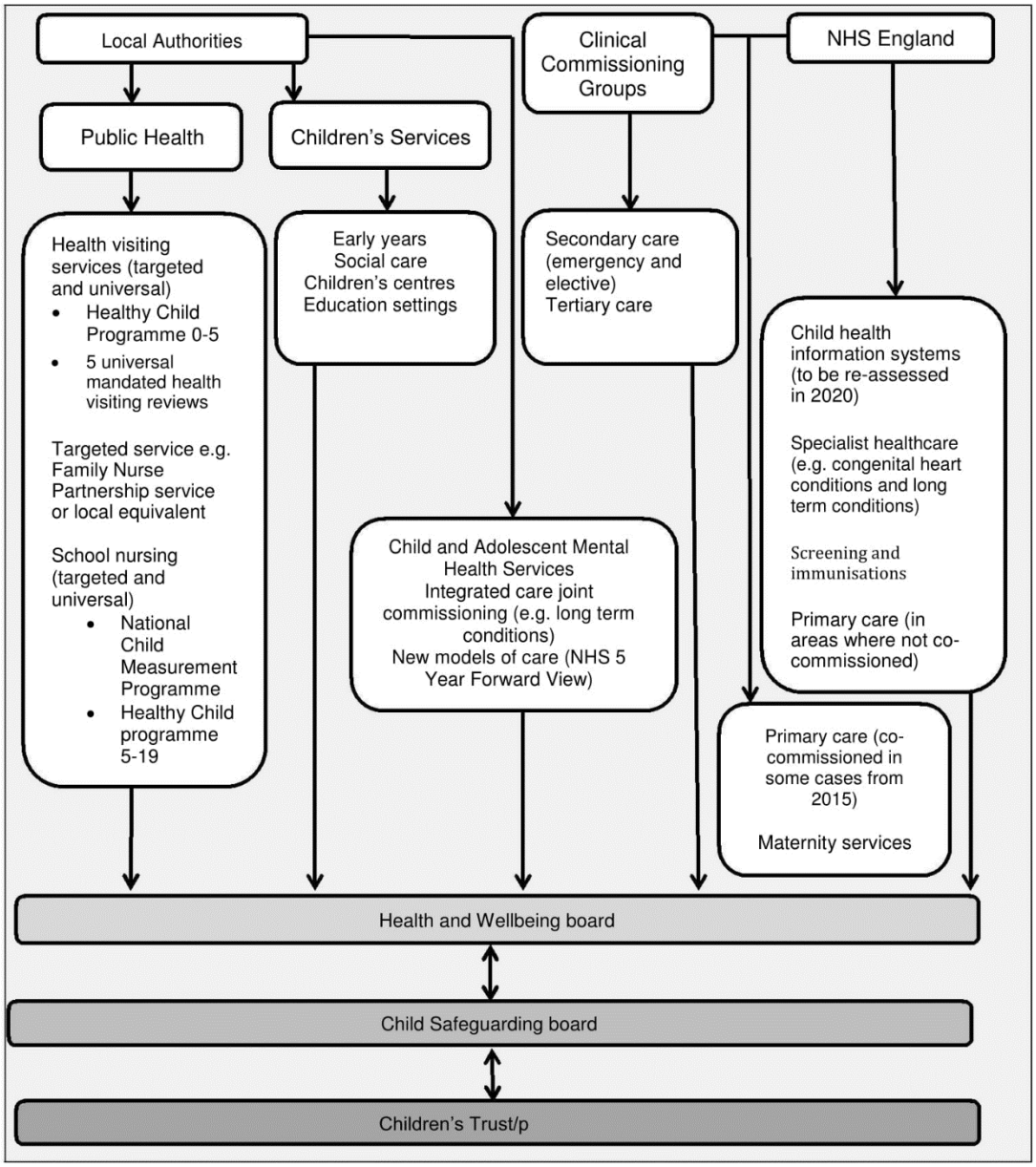
Literature Flowchart



Appendix 2

Commissioning responsibilities of local authorities, clinical commissioning groups and NHS England for the health and wellbeing of children aged 0-19.

Local commissioners should also consider the links and interface with mental health, sexual health, smoking and substance misuse services.



Appendix 3

Outline Interview Guide/Focus Group Guide

Experience of leaders

- Can you provide examples of leadership that you have experienced?
- Can you think of a time when leadership was not effective and how that felt?

Your experience of leadership

- What does leadership mean to you?
- What does management mean to you?
- Is leadership important to you/health visitors? Probe: If so why?
- Are there theories about leadership that have influenced your thinking and or actions? Probe: If Yes what?
- What leadership activities do health visitors undertake?
- What is the relationship between leadership and followership?
- If you were running a leadership course in this organisation, what content would you include?

Structure of Leadership within the NHS

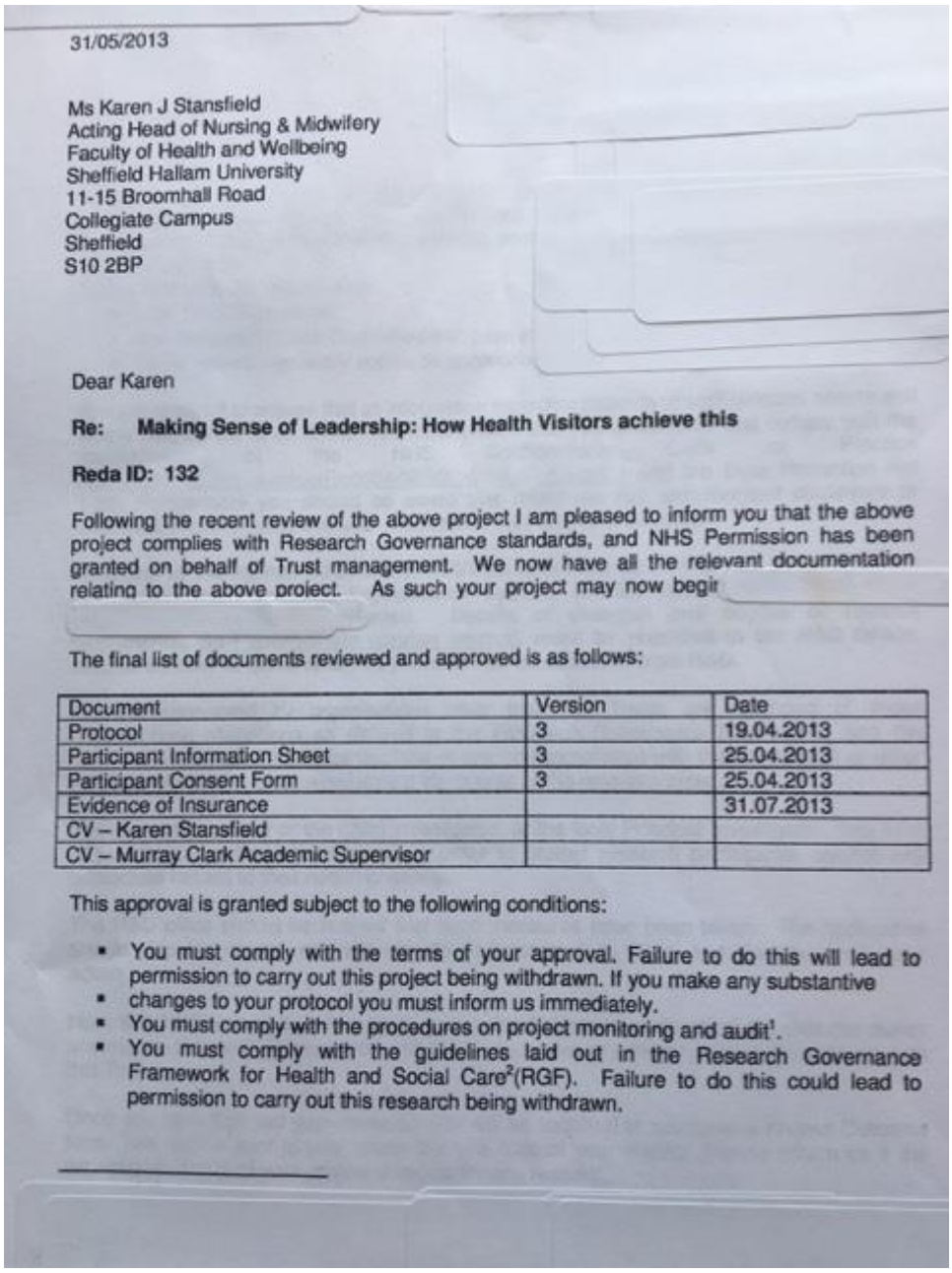
- How is leadership facilitated and supported within the Health Visiting service?
- What leadership skills are required to lead on the delivery of the Healthy Child Programme?
- In what way do you think the Health Visitor Implementation Plan (DH, 2011) has had an impact on the leadership role of health visitors?
- What leadership training have you undertaken?

What would you do if you were in charge?

- What concerns/issues do you have about leadership?
- How do health visitors act to resolve these concerns about leadership?
- What prohibits leadership within the health visiting role?
- What sort of leadership would you wish for yourself/health visiting in the future?

Appendix 4

Ethical approval –Research and Development Department, NHS Trust



31/05/2013

Ms Karen J Stansfield
Acting Head of Nursing & Midwifery
Faculty of Health and Wellbeing
Sheffield Hallam University
11-15 Broomhall Road
Collegiate Campus
Sheffield
S10 2BP

Dear Karen

Re: Making Sense of Leadership: How Health Visitors achieve this

Reda ID: 132

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begi

The final list of documents reviewed and approved is as follows:

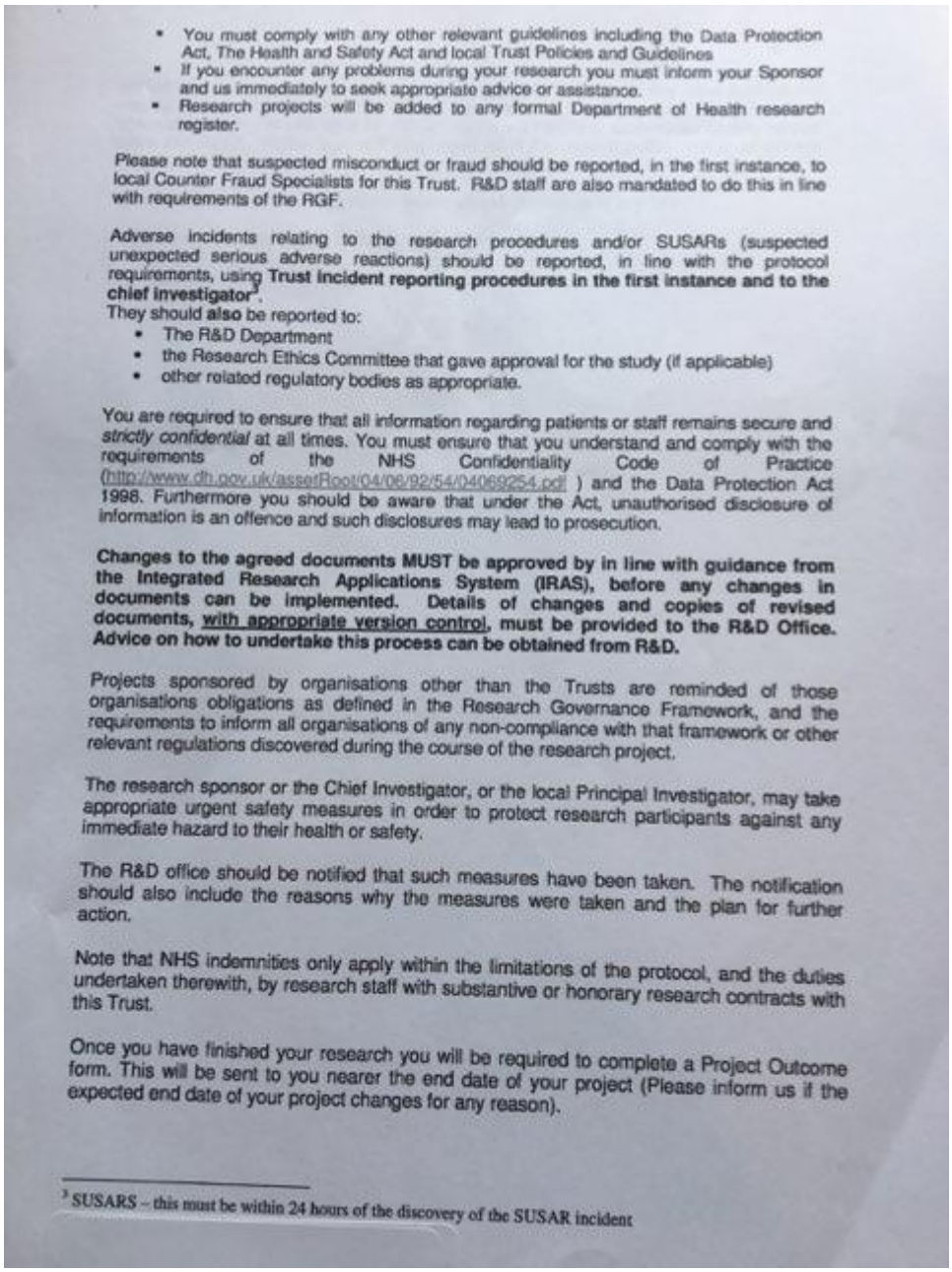
Document	Version	Date
Protocol	3	19.04.2013
Participant Information Sheet	3	25.04.2013
Participant Consent Form	3	25.04.2013
Evidence of Insurance		31.07.2013
CV – Karen Stansfield		
CV – Murray Clark Academic Supervisor		

This approval is granted subject to the following conditions:

- You must comply with the terms of your approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive
- changes to your protocol you must inform us immediately.
- You must comply with the procedures on project monitoring and audit[1].
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care[2](RGF). Failure to do this could lead to permission to carry out this research being withdrawn.

Ethical approval –Research and Development Department, NHS Trust

Continued



- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator**[3].
They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study (if applicable)
- other related regulatory bodies as appropriate.

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.

Changes to the agreed documents MUST be approved by in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

Projects sponsored by organisations other than the Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

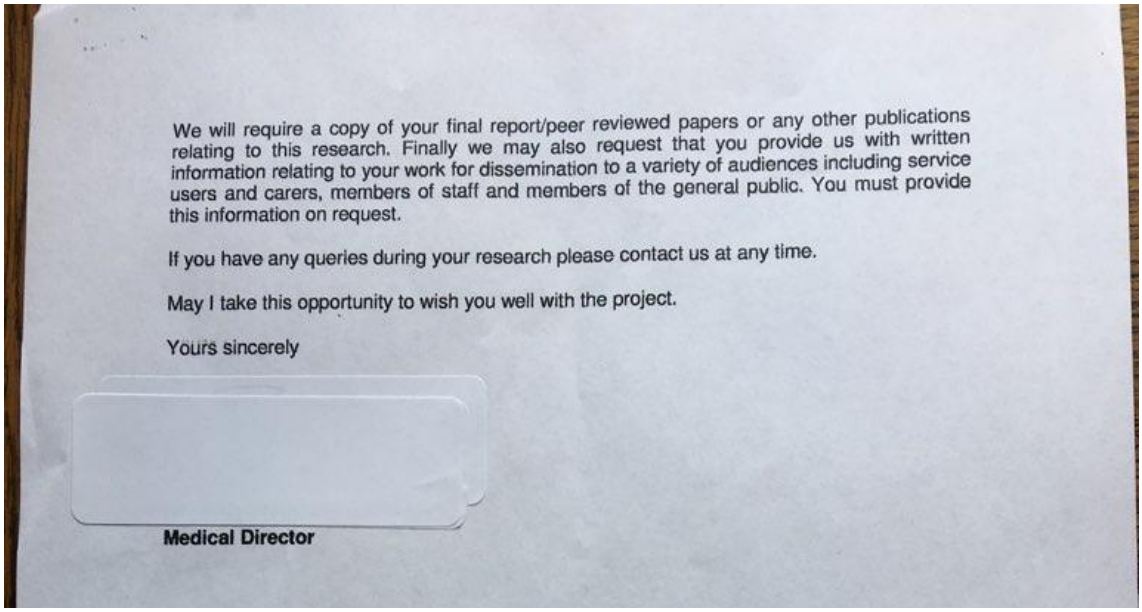
Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

[3] SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

Ethical approval –Research and Development Department, NHS Trust

Continued



We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely

[redacted]

Medical Director

Appendix 5

Ethical approval – University Research Ethics Committee

FORM 1

SHEFFIELD BUSINESS SCHOOL

RESEARCH ETHICS FORM: PART A
ETHICS CHECKLIST

This form is designed to help students and staff complete an ethical scrutiny of their proposed research. It also enables the University and SBS to keep a record of research conducted that has been subjected to ethical scrutiny.

Name of student or principal investigator	Karen Stansfield
Name of supervisor (if applicable)	Murray Clark
Title of research proposal	Making sense of leadership within the NHS: How health visitors achieve this
Outline of methodology[1]	The methodology for the study is grounded theory, and will therefore, involve the use of specific methods which are, coding, memo writing, theoretical sampling and the use of the constant comparative approach to direct the simultaneous collection and construct analysis of the data, thus progressing the development of the theory at each stage of the data collection and analysis. These methods will be used concurrently to undertake the study. Data collection will be undertaken using focus groups and semi- structured interviews.
What are the anticipated outcomes, impacts and benefits of the research? What are the plans for dissemination, and feedback to participants in the research/project?	Outcomes - There is a dearth of literature about leadership in health visiting. Therefore, the research will provide an understanding of how leadership is enacted throughout the health visiting service; and how health policy is implemented in practice; which will be beneficial both from a professional practice and academic perspective. Impacts – The overall findings of the study will influence and support the advancement of education programmes about leadership, within the subject areas of Nursing, Business and Healthcare Leadership at Sheffield Hallam University. Benefits - Using distributed leadership theory within the research provides a different way of conceptualising leadership in healthcare; thus, this will provide further evidence for what is known about distributed leadership and how it is enacted in healthcare; therefore, contributing to the academic literature on post heroic leadership.

[1] If the research has a number of distinctive phases where the full methodology or research subjects are not clear at the outset, a separate ethical approval may needed for each phase. In this case, the outline of methodology should make clear if approval is only being sought for an initial phase of work. Normally this requirement would only relate to Doctoral Students at the RF1 and RF2 / DB2 stages of their research.

	Dissemination - written informed consent will be received from the participants involved in the research. All participants will be given written information about the study and informed that they can withdraw their participation at any time. The information will contain the aim of the study, the methods, what confidentiality means in relation to anonymity. Feedback- the preliminary findings of the research will be shared with the participants, throughout the analysis, and the participants will be able to discuss them with the researcher. All quotations will be shown to and approved by the participants involved

	Question	Yes/No
1.	Does the research involve human participants?	Yes

If NO please go to question 7.
If YES, then please answer the following questions 2 - 6:

2.	Will any of the participants be vulnerable? (E.g. Young people under 18, people with learning disabilities, people who may be limited by age or sickness or disability from understanding the research, people who are limited by knowledge of language, and people whose livelihood may be in jeopardy as a result of the research etc.)	No
3.	Will anyone be taking part without giving their informed consent? (E.g. Research involving covert study, coercion of subjects, where subjects have not properly understood the research etc.)	No
4.	Will the research output allow identification of any individual who has not given express consent to be identified?	No

If the answer to any of the questions 2 - 4 is YES then Part B - Application for Research Ethics Approval (Form 2) should be completed and then the research proposal should be submitted to the SBS REC for approval *unless* it falls into a category/programme of research that has already received **category approval. (See Appendix 3 of the SBS Research Ethics Procedures.)**

5.	Is there any reasonable and foreseeable risk of physical or emotional harm to any of the participants? (E.g. Distressing interview questions, experiments involving participants, asking participants to consume samples etc. In answering this question it may be helpful to consider whether the risk is any greater than that which the participant may experience in their normal workplace or similar life situation.)	No
6.	Is there any reasonable or foreseeable risk of harm to the researcher or the University? (Physical, emotional or professional)	No

If the answer to question 5 or 6 is YES then the University's Standard Risk Assessment form (Form 3) should be completed.
If the research involves laboratory or kitchen work with chemical or biological hazards then the SBS Risk Assessment form (Form 4) should be completed as appropriate.

7.	Does the research require approval from any external ethics committee, e.g. the NHS? For NHS research, this includes any work using NHS Patients (including tissues, organs, or data), NHS staff, volunteers, carers, NHS premises or facilities.	Yes

If the answer to question 7 is YES then the research proposal should be submitted to the relevant external body. For NHS Research Ethics Committees please refer to http://www.corec.org.uk

If the research proposal does not require submission to either the SBS REC or an NHS or other external REC then **standard approval** applies.

If the research proposal requires submission to the SBS REC please refer to the SBS Research Ethics Policy, or contact the secretary of the committee (currently Vicky Walton) for more information. **Approval awaited** applies until the proposal has been considered by the SBS REC.

ETHICAL APPROVAL (please tick):

X *(Standard approval)* This project does not require specific ethical approval.

☐ *(Category approval)* In my opinion this work falls within **Category 1 / 2 / 3** (please circle as appropriate) which has been previously approved by the SBS REC and it does not therefore need individual approval. (See Appendix 3 of the SBS Research Ethics Procedures for full details.)

☐ *(Approval awaited)* This project should be referred to the SBS REC for individual consideration – the work should not proceed unless and until the SBS REC gives approval.

I can confirm that I have read the Sheffield Business School Research Ethics Policy and Procedures document and agree to abide by its principles (please tick).

Signed..Karen Stansfield.. Name .Karen Stansfield.....Date [redacted] 19.02.13
Student / Researcher / Principal Investigator (as applicable)

Signed ..... Name Murray Clark.....Date 18 Feb 2013
Supervisor or other person giving ethical sign-off (as defined by SBS Research Ethics Procedures)

Note: SBS Research Ethics Policy available from the following web link:
https://staff.shu.ac.uk/Organisation_and_Management/research_centres.asp

The approved Categories of Research

- *The research involves direct access to subjects, through interview, questionnaire, focus groups or other group sessions.* All subjects know the purpose of the research and give their consent both to their participation and to use by the researcher(s) of the output.
- *The research involves participant or non-participant observation of subjects.* All subjects know that they are being observed as part of research activity, and give their consent both to their participation and to use by the researcher(s) of the output.
- *The research involves participant or non-participant observation of subjects.* Some or all subjects may not know that they are being observed as part of research activity. Full anonymity of both subjects and organisations is guaranteed.
- *The research makes full or partial use of primary data, information and/or analysis originally obtained outside the research project.* Full anonymity of both subjects and organisations is guaranteed.

Students - If standard approval applies, please return this form at the same time you submit your research project proposal form to your supervisor.

Staff - If standard approval applies, please keep this form for your own records.

Faculty Research Ethics Committee

For proposals requiring FREC attention

- Proposal accepted by Chair

  Chair's Action

  Signed S. Tietze Name. Prof Susanne Tietze Date. 18.02.2013

- Proposal accepted by FREC

  Signed..... Name..... Date.....

- Proposal approved subject to conditions

  Signed..... Name..... Date.....

Conditions

Request for further information:

- Not approved

  Feedback

Appendix 6

Participant information sheet

Making sense of leadership: How health visitors achieve this

Version 3

25.04.13

Sheffield Hallam University

Participant information sheet

Study title:	**Making sense of leadership: How health visitors achieve this.**
Chief investigator	Karen Stansfield
Telephone number	0114 225 5980

Study Sponsor: Sheffield Hallam University

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

I am undertaking this study as part of my Doctorate in Business Administration at Sheffield Hallam University.

The purpose of this study is, to investigate what constitutes effective leadership in Health Visiting, in order to consider leadership development, in terms of the skills and knowledge required for inclusion in health visitor education programmes and continuous professional development for health visitors.

Participant name:

You will be given a copy of this information sheet to keep

Making sense of leadership: How health visitors achieve this

Version 3

25.04.13

1. What is the purpose of this study?

The purpose of this study is to understand how health visitors make sense of leadership. I aim to explore, from the health visitor's perspective, their experiences of leadership within their role. How they engage in the process of leadership with other professionals. What their concerns are and how they act to resolve these concerns, within the context of the National Health Service (NHS) and Social Care Organisations within England.

2. Why have I been invited?

You have been chosen as a possible participant in the study as I am interested in exploring what leadership in health visiting means to you as a strategic leader/manager/educationalist involved in the professional development of health visiting.

OR

You have been chosen as a possible participant in the study as I am interested in exploring what leadership means to you as a Health Visiting Manager/Leader/Practice Teacher and your experiences of leadership in your role.

OR

You have been chosen as a possible participant in the study as I am interested in exploring what leadership means to you as a health visitor and your experiences of leadership in your role.

3. Do I have to take part?

Your decision to take part in this study is entirely voluntary. You may refuse to participate or you can withdraw from the study at any time. Your refusal to participate or wish to withdraw would not influence in any way your current role.

4. What will happen to me if I take part?

If you participate in the study it will involve undertaking one semi-structured interview with me that will last for one hour, in a convenient location within the NHS Trust that you work or at Sheffield Hallam University in your normal working hour. In the interview a selection of questions relating to leadership and health visiting will be asked by myself and discussed with you. The interview will be recorded via audio taping for data collection purposes.

OR

If you choose to take part in this study it will involve attending one focus group which will take approximately 90 minutes, which will be undertaken in a convenient location within the NHS Trust in your normal working hours. In the focus groups a selection of questions relating to leadership and health visiting will be asked by me and discussed with you and four other health visitors who will also be part of the focus group. The focus group will be recorded via audio taping for data collection purposes.

5. Expenses and payments

You will not be paid for taking part in this study.

6. What are the possible disadvantages and risks of taking part?

There are no apparent risks of taking part in the study.

7. What are the possible benefits of taking part?

There are no specific benefits of taking part in the study. However, the development of effective leadership is one of the National drivers required by the Department of Health in line with government health and social care policies. The outcomes of this study will support these developments.

11. What if there is a problem or I want to complain?

If you have any queries or questions please contact:

Principal investigator: Karen Stansfield email k.j.stansfield@shu.ac.uk and phone 0114 225 5980

Sheffield Hallam University, Faculty of Health and Wellbeing

Alternatively, you can contact my supervisor: Murray Clark email m.clark@shu.ac.uk and phone 0114 225 5555

If you would rather contact an independent person, you can contact Peter Allmark (Chair Faculty Research Ethics Committee) p.allmark@shu.ac.uk; 0114 225 5727

12. Will my taking part in this study be kept confidential?

The interviews and focus groups will be recorded and then written up word for word. I will check that the recording and the written transcript are the same. I will then erase the recording. The transcript will be kept on a password-protected computer. Anonymous codes will be used for participants when data is analysed. I will ensure that any identifying details are taken out of any final report and any publication so people reading these will not be able to identify you. The written transcripts will have all links to you removed at the end of the study and will be kept for 3 years after the project and then destroyed.

It might be that in the interviews something of concern arises relating to patient/client care. If that happens, I will consult with my supervisor to discuss what to do. I will act in accordance with my Professional Code of Conduct.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder called a site file. This is locked away securely. The folder might be checked by people in authority who want to make sure that researchers are following the correct procedures. These people will not pass on your details to anyone else. The documents will be destroyed seven years after the end of the study.

13. What will happen to the results of the research study?

The results of the study will be disseminated through peer reviewed scientific journals and conference presentations. A copy of the study will be available from the Learning centre at the University. A summary sheet of the findings will be provided for you at the end of the study.

14. Who is sponsoring the study?

The sponsor of the study is Sheffield Hallam University.

15. Who has reviewed this study?

All research based at Sheffield Hallam University is looked at by a group of people called a Research Ethics Committee. This Committee is run by Sheffield Hallam University but its members are not connected to the research they examine. The Research Ethics Committee has reviewed this study and given a favourable opinion.

16. Further information and contact details

If you have any queries or questions please contact:

Principal investigator: Karen Stansfield email k.j.stansfield@shu.ac.uk and phone 0114 225 5980

Sheffield Hallam University, Faculty of Health and Wellbeing

Alternatively, you can contact my supervisor: Murray Clark email m.clark@shu.ac.uk and phone 0114 225 5555

If you would rather contact an independent person, you can contact Peter Allmark (Chair Faculty Research Ethics Committee) p.allmark@shu.ac.uk; 0114 225 5727

Appendix 7

Consent Form

Making sense of leadership: How health visitors achieve this

Version 3

25.04.13

Sheffield Hallam University

Participant consent form

Study title:	Making sense of leadership: How health visitors achieve this
Chief investigator	Karen Stansfield
Telephone number	0114 225 5980

Participant name	

	Please read the following statements and put your initials in the box to show that you have read and understood them and that you agree with them	**Please initial each box**
1	I confirm that I have read and understood the information sheet dated **25.04.13** for the above study. I have had the opportunity to consider the information, and ask questions.	
2	I understand that my involvement in this study is voluntary and that I am free to withdraw at any time, without giving any reason.	
3	I understand that the focus group/semi structured interviews will be recorded via audio taping for data collection purposes.	
4	I understand that members of the research team may look at my data.	
5	I would like to receive a copy of the results at the end of the study	

Making sense of leadership: How health visitors achieve this

Version 3

25.04.13

To be filled in by the participant

I agree to take part in the above study

Your name	Date	Signature

To be filled in by the person obtaining consent

I confirm that I have explained the nature, purposes and possible effects of this research study to the person whose name is printed above.

Name of investigator	Date	Signature

Filing instructions

1 copy to the participant
1 original in the Project or Site file