Does Professional Identity impact on the Credibility of Leaders of Integrated Health and Social Care Services?

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LIST OF ABBREVIATIONS

Allied Health Professionals (AHPs)

Clinical Commissioning Group (CCG)

Children and Young People Service (CYPS)

Commission for Health Improvement (CHI)

Connexions (Cx)

Department of Health (DH)

Department of Health and Social Care (DHSC)

District Health Authority (DHA)

Educational Welfare Officer (EWO)

General Practitioners (GPs)

Health Visitor (HV)

Integrated Care Systems (ICS)

Learning and Development (L&D)

Local Authority (LA)

Multi-Agency Teams (MATs)

Pennine Care NHS Foundation Trust (PCFT)

Social Worker (SW)

Social Care Institute for Excellence (SCIE)

Trafford Children and Young People Service (TCYPS)

Trafford Healthcare NHS Trust (THT)

Trafford Metropolitan Borough Council (TMBC)

Youth Offending Service (YOS)

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Abstract

The last two decades has seen a range of government reforms that have involved major changes in the provision of health and social care. The drive towards integration continues with the recent publication of The Health Care Bill (2021). This research has been conducted in an integrated children and young people service but is relevant to any integrated health and social care public sector service model.

The services in this research are provided through area based multi-professional teams consisting of Health, Social Care and Learning and Development professionals. When the service was initially established all Service and Team Leaders had to have a registered professional qualification. This research explores through a mixed methods approach whether professional identity influences the credibility of leaders working in integrated services.

Using a Mixed Methods Convergent design, data was collected and analysed from a stratified sample of (n=116) questionnaires and (n=25) semi-structured interviews, generating themes that informed the findings.

The research found that Leaders managing multi-agency services do not have to be professionally qualified to gain credibility, it is a leader's qualities and behaviours that gain them credibility when leading multi-professional teams in an integrated service.

This research will assist and inform recruitment and selection processes of future service and team leaders working in integrated services.

Several recommendations for future practice emerged from the research. These include the recommendation that if a non-professionally qualified service or team leader is appointed, arrangements must be in place to give presence to the professional voice at an operational, strategic and executive level. A further recommendation is to ensure that multi-professional staff receive continual training and development, to enable them to understand the different leadership qualities brought by non-professional and professional leaders so as to improve a leader's self-belief and credibility.

Chapter One: Context and Background

1.1 Introduction

This D. Prof research study is set in the context of one of the early pathfinders for integrated health and social care services (National Evaluation of Childrens Trust Pathfinders, 2007). The aim of the thesis was to gain a deeper understanding of professional identity as a concept, and whether it has an influence on the credibility of leaders working in integrated health and social care services. The research also aims to determine what the specific 'inter-professional' challenges are for staff who originate from different professional and non-professional backgrounds and who work in the service and to expose any specific factors that influence the credibility of service leaders of integrated services.

This first chapter provides context to the study, offering an insight into the plethora of National Health Service (NHS) policies spanning decades, which have reformed organisational structures and have influenced the range of leadership practice and approaches that we observe today. The study is set within Trafford Children and Young People Service (TCYPS), one of the first successfully integrated health and social care models, in the country. The integrated service of TCYPS presents a professional leadership model within a team structure. Finally, the chapter offers a personal reflection of the practitioner/researcher's professional experiences of policy application within the context of the study and how their personal perspective informed the research topic and enquiry. There is tension that the worlds of policy and practice are 'two communities' (Furlong & Oancea, 2005, p.5), but this study brings together policy, practice and research (Groundwater-Smith & Mockler, 2007) to inform the future leadership of integrated teams.

1.2 Study Background

Successive governments have introduced policies over the last few decades with an ambition to integrate health and social care services. The Five Year Forward View (2014), The Long-Term Plan (2019) and the most recent Health and Care Bill (2021), have all outlined a vision to transform health and social care services by placing an emphasis on service integration. The policy drivers for service and systems integration have increased exponentially over the past two decades, this is in response to the increasing demands and the rising costs of care. These ambitions are driving

significant changes in health and social care services, from a commissioning and delivery perspective (Appleby, 2013), but the progress and success of achieving integration has been slow and limited (Humphries, 2015). Kozlowska et.al., (2018), suggests that some of the barriers to successful integration have been mainly due to conflicting organisational interests, insufficient resources to develop the integrated service and a lack of commitment by the organisations involved.

I have worked in the NHS and the Local Authority (LA) as a nurse for over 35 years, progressing through the clinical and managerial ranks to become a Director in the NHS and the last 12 years I have held the position of Joint Director across both health and social services. During this time, I have observed and experienced seismic shifts in leadership models ranging from traditional bureaucratic leadership styles to more contemporary distributive leadership models, where decision making is distributed across the workforce rather than the adoption of a hierarchical approach to leadership (Currie et al., 2009). As a Health Director working with colleagues in Trafford Children and Young People Service (TCYPS), on behalf of the local Healthcare Trust and CCG, I had lead responsibility for developing one of the first national large scale integrated partnerships. This new approach to service delivery required a strategic and structural reorganisation of the health and social care services. This was achieved by bringing together disparate groups of professionals from the health and social care sectors under the same organisational structure. The aim of the transformational programme was to co-locate professional groups of staff (social workers, nurses, youth workers, teachers, early year staff, psychologists, paediatricians, psychiatrists and AHPs) into a single team under the leadership of a manager who may (or may not) have possessed a relevant professional qualification.

This strategic and organisational change was extremely challenging as it required a complete culture shift for some individuals (Petch, 2013). The new organisational structure was to be led by Directors with strategic leadership portfolios (I held the portfolio for healthcare leadership governance) There was three multi-agency area-based teams and district wide multi- agency service teams e.g., Looked after Children, Children Centres etc. Each area-based client facing multi-agency team will be led by a Head of Service with direct line management of an Operational Manager who in turn will manage/supervise the Team Leaders/Senior Practitioners, who will all hold relevant professional qualifications in health or social care. The other non-direct client

facing multi-agency teams such as commissioning has the same management structure but there was not a requirement for these managers to be professionally qualified, despite managing staff who possessed professional qualifications but had responsibility for strategic commissioning, e.g., Public Health Clinicians, School Improvement Staff etc.

At the time of developing the integrated service, there was significant resistance to the proposed organisational changes, with criticism being overwhelmingly focused on the proposal that the Heads of Service and Operational Managers, may not possess the same professional qualification as the staff in the teams that they will be managing.

If the objections to the proposals had been accepted, this would have meant that each professional group of staff would have been led by someone from their own professional background, whilst they may have been co- located in the same base as other client related professional groups, they would have continued to operate as single professional teams and not integrated multi- professional teams.

It was this level of unrest from the professional groups that triggered my interest in the research topic of professional identity and leadership credibility in integrated services.

Since the conception of this research, successive governments have expressed a continual drive to develop integrated services the most recent being The Health and Care Act (2022), which established Integrated Care Systems (ICS) as formal statutory bodies that control NHS commission and spending in local areas. These ICSs are made up of NHS organisations and local councils in England and have a statutory duty to develop 'place-based plans' (Kings Fund, 2017) and form Sustainable and Transformation Partnerships (STPs). ICSs, are now seen by NHS leaders as being the future model of health and social care integration.

The unique findings from this research in respect to the factors that influence leadership credibility within an integrated service are important to inform professional staff integration in future ICS's and for systems leadership models generally.

1.3 The Aims and Objectives

The overarching aim of the study was to expose factors that influence the credibility of an integrated service leader, with a particular focus on professional identity, from the

perspective of the different multi-professional staff groups, within the integrated health and social care service.

Four key study objectives unfolded:

- To gain insight into the qualities that makes a leader credible, from the perspectives of different professionally qualified and unqualified staff.
- To identify and understand the key factors that contribute to a leader's credibility in a multi-agency integrated health and social care service.
- To determine if the professional identity of a leader influences their credibility.
- To extend the theoretical knowledge of the interplay of credibility, professional identity, and leadership, to inform the selection of appropriate leaders for integrated health and social care services.

It is important to review the origins of integrated teams and services through the critical synthesis of successive governmental structural reforms of the NHS. This chapter provides a context and background to the introduction of integrated services with specific reference to the development of Trafford Children and Young People Services (TCYPS), which is the location of the study. Alongside key policy junctures, the researcher/practitioner, as a senior manager in the NHS at the time of the research, also provides a reflective commentary of key practice and professional challenges.

1.4 NHS Policy that influenced service integration and leadership through the decades

There has been an overwhelming amount of research and discussion in respect to health and social care service transformation and leadership since the inception of the NHS in 1947 (Hunter, 2008). Successive governments have introduced policies to transform and reshape health provision and social care services over the decades. The policies have been launched in the spirit of improving service provision for patients and service users, but to date none have offered any supporting guidance as to the types of leaders and what leadership styles are best suited to achieving successful implementation of new legislation, guidance or service reforms.

Leadership in the public sector, has been influenced by policy development stretching back to the inception of the NHS (NHS Act, 1947). In essence, the introduction of the NHS reduced competition and helped to reduce inequity of access for patients, with healthcare being administered centrally by the government, thus reflecting a traditional 'command and control' management approach, with instructions being cascaded down from central government to regions and districts.

Many significant policy changes have emerged in recent decades, mainly as a result of failings of organisations, systems and processes- such as the *Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary (Kennedy Report)*, in 2001 and the later report of the *Mid Staffordshire NHS Foundation Trust Public Inquiry (The Francis Report)*, in 2013. The next section of the chapter guides the reader through key policy changes which influenced the structure and leadership of the NHS, over the decades with a particular focus on:

- Structures and medical management
- The emergence of general management in the NHS
- GP fund holders and internal markets
- Performance management challenges
- Modernising healthcare and leadership sustainability
- Policy influencing strategic change in Trafford

1.4.1 Structures and medical management

As the NHS developed, legislation and policies in the 50's and 60's were plentiful, especially with the election of a Conservative government in the 50's. History informs us that the Conservative party were not signed up to the founding principles of the NHS and it was not aligned to their ideological beliefs, therefore, when they came into power there was a far greater level of scrutiny of services evident along with the introduction of several reformative pieces of legislation and policies (Greener et al., 2014).

The new government policies focused on GP services, medical training and the promotion of health through education and the prevention of disease to improve the health of the nation. One of the key features of primary care in the 50's was the

successful introduction of polio and diphtheria vaccination programmes, resulting in a dramatic reduction in the number of cases for both illnesses thus improving health outcomes and freeing up GP resources impacting on cost efficiency.

The publication of The Cogwheel Report (1967), in the late 60's recommended greater involvement of doctors in medical management, with the intention that these new medical leadership roles would include financial management of health resources. Cogwheel (1967), also proposed structural change of health provision, with clinical specialisms being organised into medical divisions, as this was considered to be the best method of achieving improved medical care and financial management. The drive to achieve cost efficiency in health care continued, with the publication of the Seebohm Committee Report (1968), which recommended that children, elderly and mental welfare services should be integrated and community based.

Further health policies emerged with the intention to reform council and health services, a key green paper, The National Health Service: Future Structure (1970), was published, but it received strong objections, as a contentious recommendation was for Local Authorities to take the lead and manage health service provision. A review of the proposals followed and an alternative model was presented, that led to the establishment of Area Health Authorities (AHA). These AHA's would match the local authority footprint so provide some level of co-terminosity. The newly elected Conservative government brought further structural changes, which saw the creation of a further tier of health beauracracy through the creation of Regional Health Authorities (RHA). The role of these new RHA's was to plan and allocate resources to Area health Authorities, with a view to promoting a '*new opportunity for a partnership with the Local Authorities.'* (Sir Keith Joseph, Secretary of State for Social Services; House of Commons Debate 1st July 1971).

The introduction of the NHS Reorganisation Act (1973), was to improve co-operation and co-ordination between the NHS and Councils, in essence this was an early attempt towards integrating preventive and follow-up care services but the organisations remained linear in their form. Despite, the aspiration for policy development in the 70's to lead to reforming leadership and service integration, it had instead been considered to be a decade of disruption, with administrative restructuring resulting in disillusionment for many (Gorsky, 2008). Some of the barriers to achieving successful

implementation of policy guidance for service integration, has been predominately due to the differing institutional rules, the contrasting funding streams and the issues of organisational and professional cultural (Kodner & Spreeuwenberg, 2002).

Historically, from the inception of the NHS until the 1980's, medical doctors practiced autonomously with minimal managerial control, creating their own fiefdoms, (Greener et al., 2014), but this lack of managerial oversight became more concerning in the 1970's. There was increasing dissatisfaction from patient groups, expressing their concerns that Health services were being organised around clinicians and not focused on patients (Southon & Braithwaite, 1998). The continuing under resourcing of NHS manager positions in the UK in the 1970's, was an issue to attract the right people into posts that could innovate and reform services, as these positions were regarded as having very little status, low paid and seen as facilitator roles to doctors and not NHS leaders in their own right (Greener et al., 2014). Davies and Harrison (2003), suggested that many of the issues in the doctor/manager relationship became more apparent with rise of the NHS manager in the 1980s. This coincided with the newly elected Conservative government and their continual drive to achieve cost containment, with the frequent publication of health policies, increasing the notion of consumerism by proposing the reform of services that influenced the leadership models in the NHS. Spurgeon, Clarke and Ham (2011) argued that prior to the return of a Conservative Government in 1979, health reform had steadily followed an incremental path.

The new policy changes to integrate services over the decades appeared to have had minimal impact on leadership or service integration (Bruce & Hill, 1994). The policy recommendations in the 60's and 70's to integrate health and local authority services only served to reinforce the uneven power relationships among competing interests, with a bias towards hospital based medical specialisation always having priority (Battistella & Chester, 1973).

1.4.2 The emergence of general management in the NHS

Thatcher's Conservative government in the early 1980's was determined to bring about NHS reform, continuing with the frequent publication of health service reorganisation policies, with the aim to manage the public spending pressures, to increase efficiency and to revolutionise leadership to create a more business-like environment.

In the late 70's the Labour government had commissioned research to investigate the variation in health outcomes across all the social classes, to consider the causes and

identify any policy implications, The Black Report: Inequalities in Health (1980). The investigation found a widening gap of the nation's health. The circulation of this report was limited, and the recommendations never fully implemented (Levitas & Guy, 1996). The report was rejected, mainly because the proposals were deemed to be too costly and because of the political antipathy towards the NHS from the now newly elected Conservative government (Berridge & Blume, 2003).

The Health Services Act (1980) established District Health Authorities (DHA), and AHAs were now abolished, it was decided that Regional Health Authorities (RHA) did not need to be configured around AHAs. The reform was to achieve structural simplification to bring structures closer to local populations to increase understanding of local needs. The other objective was to simplify governance (Nuffield Trust, 2010).

This reform received criticism from a number of sceptical observers, indeed even from a Conservative government backbencher who expressed during a House of Commons debate: -

> "…*we were advised by a previous Conservative Government, who reorganised the NHS, that they would make it more efficient so that it would cost less. They said the same about local government. We know that both statements were untrue. Not only has the NHS become more inefficient it costs a lot more as well…."*
>
> Rt. Hon. Nicholas Winterton M.P. (HC Deb.,18th February 1982)

The NHS management revolution began with the publication of The NHS Inquiry (1983), more commonly referred to as the Griffiths Report. This review of the NHS was commissioned by the Conservative government seeking recommendations on how to strengthen NHS management. The review clearly identified that the main weakness of the NHS was the lack of a defined general management function (Spurgeon, Clarke & Ham, 2011), in addition to the added failure of management to use resources efficiently or effectively to meet patient's needs. The report was endorsed by the government, which recommended that new posts of General Managers be appointed to provide the necessary strength of leadership to ensure the delivery of cost-effective services, and to introduce change initiatives to drive efficiency savings (Spurgeon, Clarke & Ham, 2011). A key recommendation was that doctors should now become actively involved and responsible for fiscal management, indeed the report stated that medical staff:

> *"… must accept the management responsibility which goes with clinical freedom... and participate in decisions about priorities…"*
>
> The NHS Inquiry (1983, p18).

Interestingly, when discussing the impact of the Griffiths report recommendations in relation to the comparative management styles between the NHS and local authority leaders, Hunter (1984), argues that there is a marked difference between the two sectors. He suggested that this was due to the NHS being more densely populated by professionals, with the NHS attempting to combine professional and public accountability, whereas this is less evident as a governance approach in local government. Pre- Griffiths, there was a 'consensus management' approach in the NHS, which has been described as making decisions on a consensus basis (Harrison, 1988). Ham (2012), argued that a consensus approach would not fit with the strategic aim of achieving effective, quality and efficient health services as recommended by Griffiths (1983).

This new model of leadership that Griffiths (1983), was recommending was being drawn from the private sector and business management theories .At the time there was evidence to suggest that clinicians viewed the Griffiths recommendations negatively, viewing them as a way to exclude them, some clinicians described feeling distanced from the leadership of the health service (Read, 2014), but the converse was thought to be the case, it was argued that the intent of Griffiths (1983) was to bind clinicians to corporate decisions, to limit their professional vetoing of change (Lewis, 2014). Key General Manager positions were no longer being selected from the traditional pool of candidates (Read, 2014), there was now a drive for general manager posts to be filled by the best person for the job, 'regardless of discipline' (Griffiths, 1983, S8.2). These recommendations were an attempt to create an environment that encouraged quality and efficiency improvements (Enthoven, 1985). At the time of the Griffiths implementation, from a practice perspective, I experienced an increase in accountability for the achievement of performance e.g., the number of patients waiting for elective surgery; the number of home visits made by community nurses. There were also regular budgetary management meetings with finance officers, with a definite shift in role for corporate services now holding clinicians accountable for healthcare expenditure. At times the leadership style within the healthcare

organisation felt akin to a commercial business as opposed to a delivering a patient centred service within a health sector environment (Lewis, 2014). Whilst, the perceived commercialisation of healthcare services could be viewed as negative it has been suggested that clinicians working in management felt more productive and innovative (Lewis, 2014). This was my experience as a relatively young nurse manager at the time of the introduction of the Griffiths model of leadership, I personally benefitted developmentally through increasing my knowledge and understanding of business systems and processes and how this could link to benefit patient care and lead to better quality outcomes. This enabled me to consider the services from a 'whole systems' perspective, enabling me to consider how the organisational models of service delivery impacted on the patient's experience. By the mid 1990's I was offered an opportunity to take up a role as an integrated service leader 'Joint Business Manager' across the local health and social care, a unique position at this time. Lewis (2014), which I believe my newly honed business skills enabled me to secure the position, as I was now viewing services from a strategic perspective and no longer from a narrow viewpoint. There is no doubt that the most influencing effect of the Griffiths recommendations was the change in the health service environment culturally, these changes laid the foundations for the introduction of internal markets. A significant change was the active recruitment of Board Chairs from external business environments and chief officers from within the health sector, who were receptive to the new policies of driving service efficiencies through adopting lean management processes (Spurgeon, Clarke & Ham, 2011).

1.4.3 GP fund holders and internal markets

The 1990's saw The NHS and Community Care Act (1990) introduced, it was the most ground-breaking of all reforms to date, as it was the first-time legislation that fractured the link between provision and purchasing of health care, by creating commissioners (Ham et al., 2016). Health Authorities in their role as commissioners, received central government funding and powers to freely buy healthcare for their resident populations from the public or private sector. This, therefore, required public sector providers (hospitals and community health services) to compete for health business and the NHS began to operate like a market (Calovski et al., 2019). General Practitioner Fund Holders (GPFH), were established, thus bestowing powers on GPs to become budget holders, now with the authority to purchase hospital and community health care from

a range of providers. Some GPs chose not to be GPFHs and their health services continued to be purchased by the Health Authorities, whereas a number of GPFH came together to form a consortium, to share resources and the risks (Timmins, 2015). Criticism of the reform suggested the government had created a two-tier system with patients of GPFH's having quicker access to health treatment than those patients registered with non-fundholding GPs (Petchey, 1995). As a Joint Business Manager during this period, I recollect there was a build-up of resentment towards some GPFHs with some provider managers and clinicians feeling that there was a set of power dynamics at play- with providers being the subordinates. In practice relationships sometimes could be fraught between local providers and commissioners but this didn't influence the contractual relationships as there is evidence that GPFH demonstrated loyalty to local providers (Glennerster et al., 1994). GPFH and non-fundholders believed they should have key leadership roles in the NHS, and they should be involved in strategic decisions and influencing the future shape of health services (Fischbacher & Francis, 1998). GPFH schemes were abolished and replaced by Primary Care Trusts (PCT), with the commissioner and provider split remaining (Turner & Powell, 2016), with PCTs being encouraged to include private sector providers in their future commissioning plans (Klein, 2013).

The concept of quasi-markets (DH,1997; 1998; 1980; Griffiths,1983) in the NHS, had a major impact on the NHS, with the major organisational changes that had occurred to facilitate the implementation of the policies; structuring, restructuring, setting up different forms of service delivery, establishing commissioners and providers with the intent to improve patient care. The evidence offered by Grand, Mays and Mulligan (1998), suggests otherwise, they conducted an in-depth systematic analysis, reviewing the findings of many researchers who had conducted research into the impact the reforms had on patient outcomes. They concluded that overall internal market policy reforms had made very little change and there was no evidence of to support that the reforms had any significant positive or negative impact on healthcare. Fournier (2000) however argued that a positive effect was the introduction of competition into healthcare environments, had increased managerialism, bringing with it a level of consumerism that challenged professional autonomy and roles.

Having had the opportunity and experience of working across organisational boundaries in acute and community health settings, I found that the need to motivate health staff to become action and performance focused became more important during this period of reform (Ham, 2012). The overall impact of competition market policies on care quality was limited, mixed and inconclusive, (Glenister,1998; Grand, Mays & Mulligan, 1998; Brereton & Vasoodaven, 2010), although it remained a core thread of the NHS reforms throughout 1990's and beyond.

1.4.4 Performance management challenges

The 90's saw a plethora of health policies being introduced; the launch of The Health of the Nation (1991) (HOTN) was significant. This policy was the first time that a strategic approach towards service planning to improve the health of the population had been published. This was quickly followed by the publication of the Patients Charter (1991), outlining patients' rights to receive a quality health service, by placing an emphasis on target setting for waiting times for treatment. Performance Indicators (PI) was now part of the NHS common vocabulary and had to be embedded into the organisations culture to ensure the linkage between delivery of patient care was aligned to the overall mission of the organisation.

Tony Blair (Labour Prime Minister), won the election in 1997 with a manifesto that promised a commitment to abolishing the internal markets in the NHS. The new labour government initially focused on setting patient targets e.g., reduction in waiting lists, but the currency of performance indicators remained despite the manifesto declarations. The Labour government introduced National Service Frameworks (NSF) ten -year programmes to improve high priority clinical areas, this was to be achieved by setting measurable goals within set time frames. They were initially received favourably by leaders and clinicians within the NHS provider services as investment was aligned to the achievement of the targets. The aim of the NSFs was to improve quality of access and consistency of service standards across the NHS to reduce the 'post code lottery' effect and ensure parity of care (Spurgeon, Clarke & Ham, 2011). Despite, the initial positive reception to these initiatives and the additional financial investment to support the implementation of policies recommendations, with the aspiration to increase capacity and reduce waiting times, clinicians became very critical of performance tables. These tables rating the performance of hospitals and

clinical specialisms were having a negative impact on the public's trust and staff morale (Adab et al., 2002), therefore clinicians were feeling dissatisfied with them as the resources were insufficient to meet the demands. Not all performance indicator outcomes were valued by society nor were they always measurable or meaningful. As a practitioner, I recall colleagues and senior clinical staff expressing their concerns about the burden of bureaucracy, the increasing number of reports, documents, data collection forms to complete, to measure quality outcomes, these were creating stress and challenges for staff (Lomas et al., 2018).

The publication of policies by New Labour seemed to be relentless with more aspirational white papers being released. The first being the Primary Care: Delivering the Future (1996), this white paper comprised of 70 initiatives which included the requirement to consider the inter-relationships between primary care, acute services and the local authorities, but from a financial perspective but it failed to consider integrating services. A second white paper followed soon after in November 1996, The NHS: A Service with Ambitions (1996). These two papers were heralded to be the solution to transforming health services by adopting a more efficient and effective approach to managing resources but the department of health failed to issue guidance to take this forward. The problem in practice was it was left to local organisations to translate and develop guidance to implement the recommendations.

The NHS Primary Care Act (1997), was the next paper, promoting more flexible GP services and increasing patient choice, whilst these were viewed as positive steps none of the policies supported any real reform from an integration perspective. The New NHS: Modern and Dependable (1997), offered some hope, as the legislation clearly indicated the need to improve local partnerships and move towards the integration of services through strengthening joint commissioning and strategic planning arrangements. This policy gave leaders an opportunity to flex their knowledge and drive change towards greater integration and more robust development of shared and federated services which had linked funding.

In the earlier section with the Griffiths reforms leaders focusing on performance management tended to adopt more of a transactional leadership approach, but with the speed of policy changes throughout the 90's this became challenging as a leader, as in practice, leaders had to become extremely flexible and adaptable to meet the demands and expectations therefore a transformational approach was more

compatible with the leadership required during this political period. The transformational leadership approach has been criticised, because it emphasises the 'heroic leader' and by having a one-way direction between leader to follower as it limits the influence of followers in the change processes (Lo et al., 2018).

1.4.5 Modernising Healthcare and Leadership sustainability

The late 90s saw an influx of policies promoting interprofessional working, (Kenny, 2002). The intent was to modernise the NHS, but there was an acknowledgement by the Labour government, that to achieve this, then leadership capacity would need to be central to any reformation of healthcare (Ham, 2012). The New NHS: Modern, Dependable (1997). the GPFH were abolished, and replaced with Primary Care Groups (PCGs). Mannion (2011), suggested that the GP commissioners should adopt a strong directive leadership approach but also nurture a culture of collaboration, especially with the evangelical launch of The NHS Plan (2000) by the Labour Health Secretary Alan Milburn. The plan saw the abolition of PCGs but replaced by PCTs with a shift away from contracting and more emphasis being placed on quality outcomes as opposed to cost. A First-Class Service: Quality in the New NHS (1998) and Clinical Governance: Quality in the New NHS (NHSE 1999), saw District Nurses and GPs now working closer together and PCTs were strengthening their partnership working with local authorities (Campbell et al., 2007). The plans that New Labour had produced for Health Care reform in respect to competition and choice were creating a level of challenge ideologically for some clinicians and managers as the reforms being introduced were considered to be far more radical than Thatcher's government, removing barriers for NHS providers and Commissioners to work with the independent sector (Spurgeon, Clarke & Ham, 2011).

The introduction of the Health and Social Care Act (2001) led to the eventual establishment of NHS Foundation Trusts as legally independent organisations but they failed to deliver as expected, as many leaders of these new Trusts continued to seek direction from central government rather than leading innovative change through looking at garnering better ways of working in partnership with staff and local communities (Collins, 2016).

Patient Choice, Our Health, Our Care, Our Say: A new direction for community services (2006), was the seventh paper published by the Labour government since taking office, with aspirations for better service coordination across health and social

care to reduce acute hospital admissions and improving efficiency (Dickson, 2008). There was little evidence of improved partnership working despite the numerous training initiatives commissioned following the establishment in 2001, of the National Centre for Leadership as part of the NHS Modernisation Agency (McAreavey et al., 2001).

High Quality Care for All: NHS Next Stage Review Report (2007) more commonly, referred to as the Darzi Report, recommended a quality driven major reconfiguration of hospital services, placing a strong emphasis on clinical leadership, mainly for medical staff to take forward the reforms. This has been re-emphasised time and again in particular when there have been failures in standards of care that have led to major enquiries, the lack of strong clinical and corporate leadership has been found to have contributed to these organisational failings (Keogh, 2013; Francis, 2013; Christie 2015).

The Care Act (2015) was launched and considered to be ground-breaking in that it introduces partner organisations to strategically plan and deliver services in a more coherent manner. There was now a drive to focus on strategic thinking, planning, identifying priorities, efficiencies and delivering a joined-up service. This of course brings with it a leadership challenge to successfully engage people from different organisations, cultures, professional backgrounds to share the same ambition and a common purpose to achieve better outcomes for service users- whilst delivering service efficiencies is no mean feat.

There is a plethora of scholarly articles in relation to the concept of 'new managerialism' demonstrating a move towards a new business culture and new ways of working in the public sector (Deem et al., 2007; Ackroyd et al., 2007; Klikauer, 2013; Shafritz et al., 2016; Exworthy et al., 2017). This theory is sometimes referred to as 'new public management' (Hood,1995), suggesting the type of managers and leadership needed in the NHS has changed over the decades.

Key leadership skills required in public sector services are about making sense of change and being able to relate to people whilst creating a vision and developing new ways of working (Hood, 1995). The challenges faced by leaders, in particular managers who are also clinicians are having to consider the tensions between professional and public service values and how these align with managerial structural

reforms (McGivern et al., 2015). Despite evidence from Grand, Mays and Mulligan (1998), that the quasi- market reforms had made no significant impact on health care, the labour government received credit from the Audit Commission and the Healthcare Commission in 2008. This was in recognition for the progress they had made with the implementing the market focused reforms as there was now a significant improvement with the reduction of waiting times and lists. This was not thought to be as a result of the impact of the market-orientated reforms but more to do with the increased investment in building capacity in the NHS (Spurgeon, Clarke & Ham, 2011). The authors concluded that the despite the reforms, commissioners remained weak, and the establishment of NHS Foundation Trusts had little impact nor did patient choice on achieving service reform.

1.4.6 Policy influencing strategic change in Trafford

Specific legislation and policy guidance supported the integration of children and young people services (Every Child Matters: Department of Child and Family Services (2003) (ECM) a precursor to the amended Childrens' Act (2004). The key aim of ECM was for every child, whatever their background or circumstances, to have the support they need to: *'*Stay Safe; Healthy; Enjoy and Achieve; Economic Well- Being; Positive Contribution' (ECM, 2003: p18). Each of these themes had a detailed framework requiring multi-agency partnerships to work together to achieve better outcomes for children. Ofsted developed and adopted a thematic inspection framework to grade the local social services and health providers against the five thematic outcomes. Although the inspection framework has now since been revised when the coalition government discarded ECM strategy, the themes remain and are still considered good practice (Ofsted Excellence Gateway Treasury Website, 2015). The revised framework had little impact on the model of service delivery for TCYPS, with only some small refinements to the governance systems and processes to reflect the new inspection framework. The Childrens Act (1989), was amended to the Children Act (2004), largely as a consequence of the Victoria Climbie Inquiry *(*2003). The rationale behind the Childrens Act (2004) amendments was the need to improve a co-ordinated response between statutory and non-statutory organisations to improve the overall well-being of children. This legislation was the basis for most childcare proceedings, and it notably facilitated the bringing together of all local government functions of children's social

care and education under the statutory authority of local Directors of Children's Services (2004) and remains the same today.

The same year saw the launch of the National Service Framework for Children, Young People and Maternity Services (NSF), (2004), a policy that set out the standards for child-centred services which was reinforced again in the ‘Choosing Health’ (2004), policy paper which promoted improved patient choice, personalisation and working together. The establishment of NHS England in 2013 saw the discontinuation of the NSF. The NSF had been helpful from a provider perspective as it offered the Trafford Childrens Services an opportunity as providers to clearly identify service gaps to meet needs and agree with commissioners the resources required for NSF compliance to reduce fragmentation, strengthen integrated pathways and achieve quality outcomes. There had been previous attempts by the Labour government with the launch of ‘Our Health, Our Care Our Say’ (2006) to set a new direction for the health and social care system by emphasising a client centred approach through the concept of personalisation. Following on from ‘Our Health, Our Care Our Say’ (2006)., came a further white paper ‘Putting People First’ (2007), the proposals within this policy highlighted yet again the need for Local Authorities to undertake partnership working with the local NHS, and other statutory agencies, third and private sector providers. This was with the intent to create a new, high quality, fair, accessible and responsive care system.

The partnership paradigm continued with the publication of ‘High Quality Care for All: NHS Next Stage Review Report (2008), advocating previously fragmented services to be better co-ordinated and integrated. This report clearly recommended plans for Local Health commissioners and partners to work together to create new Integrated Care Organisations (ICOs), designed to bring together health and social care professionals from a range of organisations. Locally in Trafford, the PCT outlined plans in 2008, to bring together the adult acute trust and adult community services into a single health provider with the intention to establish an integrated care trust by October 2010. The plan was rejected by the Strategic Health Authority in November 2010 based on the instability of the long-term financial viability. The importance of leadership when championing change for integration is to be mindful of not adopting a fortress mentality and for leaders not to focus on their own organisation at the exclusion of

leading change across sectors (Curry & Ham, 2010). This leadership approach was notable when a joint proposal was submitted to the SHA from Trafford Community Health, the Acute Hospital and Social Care to establish an Adult Integrated Care Trust – the SHA responded rejecting the proposal. They were concerned the Trust would not meet the efficiency savings target and the proposed Integrated Care Trust would be unable to reduce the acute health Trust's financial deficits at the pace expected without significantly affecting the quality of patient care (Shaw & Levinson, 2011).

This was disappointing for all partners and the direct care staff who had spent a lot of time and effort visioning, engaging and training in preparation. The staff attended Leadership Quality Improvement work streams based on *The Intermountain Healthcare Advanced Training Programme* on service improvement methodologies, leadership style, teamwork and multi-disciplinary/ multi-agency working (Shaw & Levinson, 2011; Gregory, 2015). As a senior leader with acute and community health responsibilities, I attended the training, it was theory based and on reflection, whilst the theory was helpful as professionals, need to understand the rationale for integration, the training may have been more meaningful if it had included some discussions around the issues that affect interprofessional team working (Hudson, 2002). The Care Act (2015), promotes the need to transform adult social care to promote a seamless service through better partnership working – this act in essence replicated the drivers for change that supported the rationale to reconfigure the Trafford Children Services.

There hasn't been a shortage of legislation and guidance to support the integration of services (Griffiths, 1983; NHS Community Care Act, 1990; High Quality Care for All: NHS Next Stage Review Report, 2008; The Care Act, 2015). The endeavour for integration seemed to be relentless and in 2015 another piece of legislation was published by the Conservative government the Better Care Fund (BCF) (2015) with the intention to consolidate the various funding streams into one pooled budget hosted by the Clinical Commissioning Groups (CCG). To achieve this the focus was now firmly on a wholesale adult services transformation to promote better integration of health and social services for individuals and deliver cost benefits across the whole system. To facilitate closer meaningful collaborative relationships the BCF (Section 75) agreement would provide formalities to facilitate collaborating bodies to agree joint commissioning arrangements with a view to establishing a framework for the provision

of health and social care services. This approach was a replica of the earlier work that had been achieved successfully in 2007, by TCYPS – 8 years earlier.

After Trafford's proposals to form an Integrated Care Organisation were rejected in 2010 by the SHA, Trafford Community Health Services began developing a new multi-specialty adult community based ICO. Trafford was successfully established as a Local Care Organisation (TLCO) in 2019, working in partnership but independently across Trafford and Manchester community health conurbations providing integrated community and social care services under a Section 75 Better Care Fund arrangement. In 2021, TCYPS, remains an integrated service model and is now governed by the TLCO (S75) agreement.

The mission of consecutive governments to achieve health and social care service integration has been relentless and as recently as September 2021, The Health and Care Bill (2021) was published, again proposing recommendations for reform to the Health and Social care organisations with the model of delivery being through integrated structures, systems and processes. The Bill places a focus on improving health outcomes rather than providing services by introducing two statutory elements, one being an Integrated Care Board (ICB) for NHS strategic planning and decisions and the second element, being an Integrated Care partnership (ICP) being responsible for developing a partnership plan that meets the broader health, public health and social care needs of the local population. This has similarities to the strategic governance arrangements established by Trafford Children and Young People Strategic Partnership Agreement 2007.

The proposals in the Health and Care Bill (2021) allows for different approaches to integration according to local circumstances, thus allowing a departure from previous top-down approaches to NHS reform (Thorstense-Woll & Bottery, 2021). Interestingly, the day following the publication of the Health and Care Bill (2021), a policy paper was announced to review the leadership requirements to support those who will be leading and managing integrated services, given the establishment of ICBs in April 2022. The policy paper: Review of Health and Social care Leadership in England: Terms of Reference (2021), scopes the review and includes ten key areas, many of the areas pertinent to this research study, as the policy paper review seeks to consider the

findings of previous reports on leadership and their impact on delivering quality efficient and effective integrated services.

Kenyon (2021), reported in the Local Government Chronicle, that the Health Secretary would be looking at more transferable joint roles across both the health and social care sectors. Whilst the Secretary of State was predominantly referring to adults in his speech at the National Children's and Adult Services Conference (NCAS, 25.11.21), it was intimated that this leadership approach would be applicable to those working with children in particular those with learning disabilities and autism (Kenyon, 2021).

It was this interest as a practitioner /researcher that provided the motivation to reach deeper into the area of leadership credibility and the influence that professional identity may play in their success in delivering integrated services. The researcher had previously examined the credibility of non-clinical leaders in the NHS (Longshaw ,1999 MBA Award). During the development of TCYPS, a literature search was conducted and a paucity of evidence existed, in relation to identifying if leadership credibility was reliant upon a person's professional identity with a particular focus on integrated health and social services.

The motivation to conduct research into the area of leadership credibility and professional identity became stronger during the staff engagement period of the consultation to establish an integrated childrens health and social care service under a single management structure. As the strategic leader with responsibility for leading the organisational change on behalf of the health partners, to establish an integrated service with multi-agency teams consisting of multi-professional staff- much of the feedback received was negative, with staff expressing their fears and anxieties of being accountable to someone other than someone originating from their own professional background.

It is evident from the everchanging political landscape in terms of policy influence on strategic development of health and social care services, that there has been an impact on public sector leadership roles and their influence on the success of multi-agency working, and although this study began seven years ago the foresight of how leadership styles needs to change to meet the policy challenges, it is fortuitous that it continue to align with the current political strategic thinking, hence the call for papers

to inform the development of future leaders of Integrated Care Systems and Services (Review of Health and Social care Leadership in England: Terms of Reference, 2021)

1.5 Towards an integrated model of service provision

Integration can be defined as 'the act of combining or adding parts to make a unified whole' (Collins, English Web Dictionary, 2019), but defining integrated care is somewhat of a challenge, with over 175 definitions (Armitage et al., 2009; Robertson, 2011). Within the current evidence base there are many descriptions available that define different forms of integration such as joined up working partnerships, joint ventures, strategic alliances, collaborations, managed care, shared care (Brown & White, 2006; Robertson, 2011). Expressions which only serve to continue to add to the opaqueness of what integration means (Freeman et al., 2000; Coxon, 2005). Indeed, many forms of integration can only be understood when examined in context as there are a range of meanings and approaches that offer different understandings of how integration can occur (Kodner & Spreeuwenberg, 2002). Integration can occur within autonomous organisations through to full integration of services between and across organisational boundaries (Brown, 2006; Williams, 2012). Within the NHS health and social care integration is often when organisations merge their services, combining all the relevant service components to form a single service, different to virtual integration, where providers work together strategically to form networks, partnerships and alliances (Curry & Ham 2010; Murphy et al.,2016). The definition of integration varies according to the political, social, and organisational context, although there is often commonality in the drivers which leads to the establishment of integrated organisations (Van Raak et al., 2001; Nies & Berman, 2004; Ramsay, Fulop & Edwards 2009; Williams 2012). Table 1, below shows the common drivers to establishing integrated organisations.

Table 1: *Common drivers to establishing integrated organisations*

• Lead to improved efficiency of resources
• Lead to improved efficacy through collaboration between organisations and professionals with the common purpose to manage complex policy challenges
• Lead to improved communication and interaction between service users, professionals, providers and commissioners.

Integrated Care Network's (ICN) Guide to Integrated Working (2004), suggests that integration can be designed at an organisational, service, or professional team level, it can be small or large, and there are no size fits all model. This proposition was relevant to the transformational change that took place in Trafford when establishing TCYPS. There are other definitions of integration which suggest the need to be more flexible and creative, to enable the achievement of the key drivers such as reducing waste and duplication, improving quality care, and delivering more preventative care (Rand Europe & Ernst Young, 2012: p10). The World Health Organisation, presents an amalgam of descriptions of integration as a common definition:

A definition proffered by the World Health Organisation is: *The management and delivery of health services so that clients receive a continuum of preventive and curative services according to their needs over time and across different levels of the health system* (WHO, 2008 p5). Nuffield Trust (2021), offers an alternative perspective, they describe integration in terms of an aim rather than a definition. They suggest the aim of integration, is to join up health and social care services that are required by individuals so as to deliver care that meets personal needs in an efficient way.

Many of the definitions are levelled at adult services but can equally apply to childrens services too. The key driver for change in Trafford children services was originally the aim to improve quality standards and life outcomes for children and young people by reducing inefficiencies and duplication of effort (Williams, 2012). Whilst, integration can be creative in the development of service forms (ICN, 2004), from a patient's perspective integration is often found to provide a coordinated and smooth progression of care (Freeman et al., 2000). Integration in Trafford was predominantly related to the combining of systems and processes at a team and service level which supports better inputs and outcomes for patients (Freeman et al., 2000).

Table 2: *Combining Definitions of Integration*

	Autonomy	**Co-ordination**	**Integration**	**TCYPS**
Vision of System	Individual perspective	Shared commitment to improve system	Common values all accountable	Common values and shared commitment
Partnership Type	Own rules occasional partnership	Time limited or similar cooperative projects	Formal mission statements legislation	S75 NHS Act formal legislation
Resource Utilisation	To meet self-determined objectives	To meet complimentary objectives, mutual reinforcements	Used according to common framework	Used according to common strategic and business plan service framework
Decision Making	Independent	Consultative	Authority delegated single process	Delegated authority via single process supported by the S75 arrangements
Information	Used independently	Circulates amongst partners	Orients partners work towards agreed needs	Information sharing protocols in place for partners to target highest risks and areas of need

Note. From ICN,2004, World Health Organisation [WHO], 2008, RAND, Europe & Ernst Young, 2012 p34

The setting up of TCYPS involved negotiations between different people from different agencies who were committed to working together, this relationship required a degree of trust, equality or reciprocity (Sullivan & Skelcher, 2002). TCYPS as an organisational entity was underpinned by a Strategic Partnership Agreement (SPA), (S75, NHS Act, 2006) and this agreement facilitated a full health and social care service provider integration with the associated governance arrangements Often full integration includes a formal system of pooling resources with agencies/professionals (Leutz, 2005) but TCYPS's organisational form stopped short of pooling financial resources, and these remained separate. TCYPS reflected an interdisciplinary and holistic approach, bringing together fragmented services in a more comprehensive and co-ordinated way, subject to legal, clinical and professional requirements (Pratt, 2016).

Table 2, above compares Trafford CYPS with a model of autonomous integration, a single organisation with integrated functions; the second model presented is one of co-ordinated integration, which is an aligned complimentary model of integration; the final model is of full integration, providing a formal merging of separate organisations to become a single integrated service across organisational boundaries (Brown, 2006; Williams 2012).

Integration of TCYPS, was horizontal at each level of the multi-agency structure, but vertical at an organisational level (Glendinning, 2003; Reed et al., 2005). Horizontal models are when services are arranged across primary and secondary health care organisations for specific groups of patients or service users around clinical pathways, (Goodwin et al., 2011). Vertical integration tends to be arranged around functions such as finance and contracting. It has been suggested that vertical integration could actually be a be a route to better integration of patient care – if integration was to be across the same care sector -primary and secondary health care (Sidhu et al., 2022),

Van Raak et al., (2001), formulated a sociological system that brings together a collection of providers and the relations that exist between them, thus creating a system that is shaped like an interorganisational network. This model sounds very similar to the Integrated Care Systems that are currently being developed across England as per the Health Care Bill (2021).

This systems approach and the importance of relationships horizontally and vertically across each layer is considered be the key to achieving optimum quality of healthcare (Chaung & Inder, 2009). Figure 1, shows their 4-layer model, illustrating the healthcare systems hierarchy (Chaung & Inder, 2009, p3).

Figure 1: *Hierarchy of Healthcare Systems*

Note. From Chaung & Inder, 2009, p3.

Integration is at the heart of systems theory and is central to organisational design and performance (Thompson,1967), providing organisations with the ability to achieve common goals and optimal results (Kodner & Spreeuwenberg, 2002). Systems thinking is looking at and understanding the whole environment in which the organisation exists (Pratt, 2016 p84), this assists with service design to avoid services being fragmented and operating in silos and becoming unsustainable.

1.5.1 Evaluating success of integration

TCYPS as an integrated organisation shared a vision to improve outcomes for children, young people and their families by ensuring safeguarding children underpinned all services. This common purpose created a strong and open culture that led to improved professional practice, and recognition of how the integration of services led to an 'outstanding leadership' judgement following a rigorous safeguarding quality inspection by Ofsted (Ofsted, 2015).

Interestingly, there is a limited evidence base of the impact of integrated working in practice (Leichsenring, 2004), and where evidence does exist there is a lack of understanding about the aims and objectives of integration, which requires more work (Cameron et al., 2014). Available research does indicate that without integration at various levels, all aspects of health care performance suffer, patients get overlooked, much needed services fail to be delivered, or are delayed, quality and patient satisfaction declines and the potential for cost-effectiveness diminishes (Berwick 1991; Anderson & Karlberg, 2000). The evidence throughout the last two decades has failed to offer an understanding of what quality impact integrated care has offered to the service user (Baxter et al., 2018). There is an absence of research that evaluate the outcomes for integrated services, other than tangible financial ones, and the research evaluation is focused towards adult services. (Baxter et al., 2018).

In Trafford, the fluidity of the term integration presented a challenge for leaders whilst government strategies and policies encouraged service providers to integrate and be creative (Ouwens et al., 2005).

***Table 3**: Criteria for recognising success in integrated working*

Type of outcome	Specific characteristics
Soft outcomes	• Respectful and acceptable work relationships • A more trusting, supportive, and less stressed culture • A valuing of unique individual contributions • Staff that are more open to ongoing change
Process outcomes	• Sustainable work relationships • Increased informal communication flow • Enhanced coordination • Better decision making as staff share diverse ideas • Thinking outside the box - a holistic perspective • Increased involvement/participation/ownership
Hard outcomes	• Increased individual staff capacity through • informal training, multi-skilling, shadowing, mentoring and integrated working • Faster induction of new staff members • Less duplication, permitting increased productivity • Fewer staff seeing the patient/client; fewer steps • New unilateral joint initiatives impossible • Increased flexibility, reducing pressure on one professional group; enhanced cross over

Note. From Rushmer & Pallis, 2002: p60.

Criteria exists from which to measure the success of integrated working as described in Table 3, (Rushmer & Pallis, 2002, p60.) but offers limited insight as to whether multi-professionals based together deliver better outcomes for their clients. Crocker et al., (2020, concluded that the challenges of measuring the benefits of health and social care integration remains to be a challenge. The absence of research makes it therefore difficult to draw any firm conclusions about the effectiveness of UK based integrated health and social care services (Cameron et al., 2014). Indeed, the evidence base for joint working was found to be less than compelling (Glasby et al., 2011). A study in Northern Ireland found structural integration of health and social services was more

conducive towards integrated working but did not necessarily lead to better service outcomes (Reilly et al., 2007). The National Audit Office (2017) recently reported that progress with integration of health and social care had been less successful than envisaged and they reported that the integration to date had not delivered all the expected benefits for patients, the NHS or local authorities.

Indeed, previous sections providing an overview of NHS policies highlighted a plethora of policies in favour of integrated services than examples of actual implementation (WHO, 2008). It is a challenge to evaluate how successful integrated service models have been in achieving the original aims, to reduce duplication and improve access to services to achieve improved health and well-being outcomes for patients, and for patients to gain better self-management of their health conditions (Harris & Bermingham, 2020). There continues to be a need to evaluate clinical outcomes in those receiving care from integrated health and social care programmes, but complex of multiple interventions makes evaluation complicated (Cronin et al., 2017; Harris & Bermingham, 2020). There are no specifically designed measures that reliably provide an evidence base of quality, or efficiency outcomes (Harris & Bermingham, 2020). The indicators used currently to measure success of integrated services fail to consider patient experience or outcomes (Crocker et al., 2020) therefore the benefits are not multi-dimensional.

1.5.2 Trafford CYPS Journey of Integration

The motivation to drive the integration of services forward in Trafford stemmed from the need to share information across professional staff groups and other public sector organisations which were co-terminus. This was to improve safeguarding standards for children, young people and their families, in particular those with children with complex needs who were being supported by several agencies. Each agency delivering care that was uncoordinated, duplicated and fragmented. (Trafford's CYPP Report, 2006.) Statutory and voluntary agencies working in Trafford, identified this fragmentation as being a major barrier to meeting the needs of service users (Local Visioning Workshop feedback, TCYPS, 2001). Seeking to co-ordinate the efforts of these professional services consumed substantial resources, particularly staff time involved in meetings and planning, often with little value being added for the patients/service user(s) (Scott & Caress, 2005). The agency leaders were enthusiastic

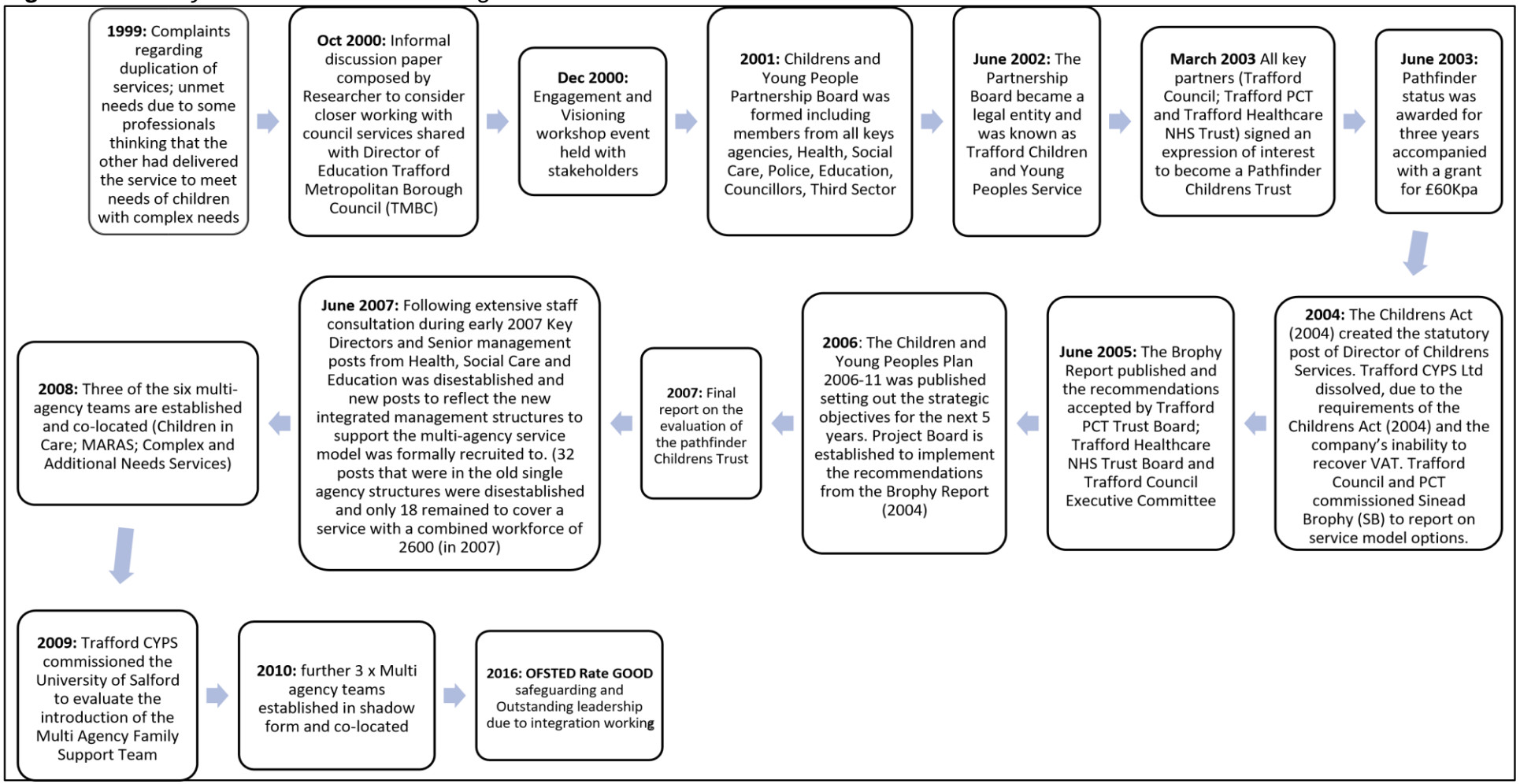
to deliver more coherent and integrated services it was necessary to agree number of legal and strategic formalities. The leaders needed the skills and strategies to understand, influence and lead the local integration design (Ham & Walsh, 2011). The Council, NHS Trust and PCT (the PCT was later replaced by Clinical Commissioning Group (CCG). Leaders in Trafford came together agreeing a shared vision and set about enthusiastically promoting the benefits of integration to their respective Boards/Committees. This co-ordinated approach with consistent messaging was important as a barrier to achieving integration can be due to the fortress mentality adopted by some leaders who focus solely on the survival of their own organisations. (Ham & Walsh, 2011).

The introduction of The Children Act 2004, placed a statutory duty on Local authorities to have a designated Directors of Childrens Services (DCS) role, as in Trafford many councils created a joint post by merging the Director of Children Social Services and Director of Education posts. This new role facilitated a vertical integration within the council, bringing together under one management umbrella Education, Youth Service, Children Social Services, Early Years, Children's Fund and the Youth Offending Team. Figure 2 below, shows TCYPS progression over time to full integration (see Appendix 12), for Researcher/Practitioner reflections of the process). Eventually health services would be integrated with social care and education in the council, but the PCT required assurance as to the professional governance arrangements before the next phase. This next phase required comprehensive staff engagement and building commitment, therefore as leaders it was essential to offer staff clarity of vision, and develop a shared culture underpinned by strong professional relationships (Shaw et al., 2011). A poor understanding of the vision and the absence of a common purpose can reduce the success of integrating services (Mathieson 2011, Cameron et al., 2014), whereas leadership commitment to a shared purpose and a clear vision are key to successful integrated services (Mathieson, 2011).

In June 2002, the Council and Health organisations legally established Trafford Children and Young People Service Limited, a company limited by guarantee, owned and managed by all the different partners, including the statutory agencies but also young people and parent representatives, voluntary sector, schools and colleges. The intention was for this Company to act as the organisational vehicle within which the

integrated multi-agency service would be delivered, however, because of the requirements of the Children Act (2004) and the inability of the Company to recover VAT, the Company was dissolved in 2004. The new business arrangement between the key statutory partners, Health Trust, PCT and Council was now to be underpinned by a Strategic Partnership Agreement (SPA) and in 2005 a Childrens Trust Board was established. The Childrens Trust Board had two arms, one being the Joint Commissioning Board (PCT and Council) and a Strategic Partnership Board (Commissioners, Council, Health and Voluntary Sector providers). This phase was testing the credibility of leaders, as the vision was not being realised due to bureaucratic interference, but to minimise the risk of staff disengagement leaders strengthened the communication with all multi-professionals through being transparent about the interruptions. In addition, they held workshops to increase their participation in developing the systems and processes that would support joint team working. The change challenged the leaders' skills in terms of retaining engagement and trust from the employees (Sinkkonen & Wallin, 2018). Figure 2, sets out a progressive summary of the journey towards the establishment of the integrated children's services in Trafford.

***Figure 2**: Journey to establish TCYPS integrated* services



A key feature of the Strategic Partnership Agreement was a governance framework that offered commissioners assurance in relation to professional and clinical governance, in line with local government and NHS requirements. For the first time, all children and young people services including health, education and children's social services were now comprehensively specified with expected outcomes with associated service level agreements and contracts in place. All the different professional groups were involved in developing the professional governance framework, with specific responsibility for developing the professional and clinical supervision structures for decision making and personal development. As the strategic and professional lead for health services, this was the most personally challenging aspect of the change management process. There was much contention from some professional health groups who objected to being managed operationally by someone from a different profession despite there being assurance in respect to having access to professional and clinical supervision at all times. A professional group of staff wrote to all three chief officers of the partner organisations and to the local MP, raising concerns regarding establishing multi-agency teams. This resulted in a senior lead professional who was dissatisfied with the new proposals resigning as a protest to the change. This was unfortunate but they believed that the integrated structures and systems would compromise patient safety, despite a commissioned report into safety and governance by the CCG that gave assurance that the integration of the Trust and Council services would be safe with the proposed governance and management structures in place.

The Local Strategic Partnership (LSP), was the umbrella body for all businesses, public and voluntary organisations in the Borough, identified in its Community Strategy. The Vision for 2021 (Trafford LSP, 2006), set out the priorities in the Children and Young People Plan (CYPP, 2006) within a single, strategic, overarching plan for all services affecting children and young people. This plan was instrumental in reforming services to children and young people in Trafford, by setting out the strategy, priorities, structures and processes for how the different statutory and non-statutory agencies and groups should work together. The establishment of multi-agency teams was key to the successful achievement of these priorities and staff were involved throughout the process. A strategic

direction that comes solely from the top layer of leadership will fail (Pratt, 2016 p128). The systems and processes to support services for children and young people and their families were organised through a single integrated process, integrated information and referral assessment systems, underpinning the integrated working model. This merged multiple referral and assessment systems in practice and in-line with the Government's Common Assessment Framework (CAF) (Department for Education and Skills, DfES, 2004). This integrated working model promoted the development of easier and co-ordinated access to services through a single referral point. Indeed, there was now multi-agency collection, sharing and use of information and single case management for each child/young person and family with complex needs (including a lead professional, co-ordinated services, a single assessment, and support plan). This was welcomed by the multi -professional groups and a series of training workshops were held to ensure all staff were familiar with the new ways of working. The leadership approach was distributive as we wanted to achieve systems level integration across the organisations (Salmon et al., 2020).

The final phase of the integration of services in Trafford was establishing the systems and process changes to support better access and co-ordinated care. This required a major staff consultation change programme. The aim was to establish an integrated service delivery model through Multi-Agency Teams (MATs) made up of multi-professional staff from health, social care and education services. All of the teams were to be co-located with three being based in geographical areas within the borough, based on population need. The proposals for change to form an integrated service (to be known as Trafford CYPS) through multi-agency teams was met with various levels of resistance from a number of professional groups. Resistance to the proposed changes was more subtle than others, ranging from staff attempting to influence the shape of the service model to retain old structures by ignoring requests to attend meetings and non-attendance at training and consultation events, then expressing their lack of involvement in the change programme. Change can be disruptive and distressing, and as leaders, it was important to maintain a culture that welcomed challenge (Scobie, 2021).

A major reorganisation and restructuring took place and in line with the governance and financial arrangements all the new job descriptions, personal specifications and the recruitment process was consulted on over a period of three months. Key professional lead positions were disestablished and replaced with multi-agency Heads of Service, Operation Managers and Team Leaders with all having to hold professional qualifications from (health, social care and education), these posts were ringfenced for staff at similar pay grades to the new positions. In the spirit of 'we are all in this together' to harness commitment and trust from all staff, all the Directors posts were disestablished too (mine included) and were subject to formal recruitment processes and appointments made by Trust Board Chair, Lead Council Member, Council CEO and CCG Chair and CEO, a truly integrated interview panel. Once Strategic Directors were appointed, the recruitment process was cascaded through the structures. They appointed Heads of Service and the responsibility for appointment was cascaded down until all Team Leaders were in post. It was a harrowing time for some staff, especially for those displaced but with personal development plans and professional coaching support, all staff received positions within the newly established TCYPS.

1.6 Structure of the Thesis

The Professional Doctorate thesis is presented in six chapters. This chapter has focused on setting the scene for the study, providing an overview of NHS policy development that impacts on NHS leadership and service integration. The journey of integration is mapped for TCYPS, one of the first operationalised integrated services for health and social care in the UK. As a senior leader in the service, I played a key role in progressing the service, team, and agency integration. The dissatisfaction of staff being allocated to teams led by a manager who was not the same professional background was an interesting situation. I searched the literature at the time of the pre -engagement phase, and discovered there was a glaring evidence gap to inform any understanding of how professional identity influenced the credibility of integrated service team leaders, which became the focus of the study.

Chapter Two sets out the search strategy to bring together literature to provide a deeper understanding of the concepts of professional identity and how this

influences credibility. A focus on interrogating the theories of leadership to consider how the different styles align with the successful delivery of integrated services is provided with an in-depth examination of the relevance of professional identity and its relationship to the theories leadership and credibility in an integrated service context.

Chapter Three provides a comprehensive rationale for the selection of the methodology and the adoption a mixed methods approach for this study. The chapter also demonstrates the ethical approach to the research.

Chapter Four provides a detailed insight into the demographic information relating to the research study participants

Chapter Five presents the rich findings gained from the thematic analysis of (n=116) questionnaires and the insightful perspectives of (n=25) semi-structured interview participants.

Chapter Six discusses the key findings from the thematic analysis identifying the evidential gaps and revealing he unique knowledge that has been discovered in relation to professional identity and leadership credibility. This chapter also makes recommendations that will influence leadership practice and also concludes with identifying any issues that may have limited the study and offers options to extend the research.

1.7 Summary

This chapter provided a history of NHS policy development over the last five decades that shaped the provision of health services from traditional command and control structures to integrated healthcare and social care systems that require leaders to be adaptable and transformative. The overabundance of health policies introduced, in the 90's and the early 2000's was ground-breaking because they facilitated the devolution of commissioning, from general administrative structures such as Strategic Health Authorities (SHA) to GPs. The introduction of the internal market in the NHS was now being influenced by Primary Care providers who had knowledge of local health need. In respect to integration of childrens services the most seminal legislation was the Childrens Act (2004), as this charged local authorities with the statutory responsibility to adopt a co-ordinated approach across agencies and partners to safeguard

children and young people. The need to reshape and restructure childrens services was to reduce risk of harm, as safeguarding is the thread that runs through all services.

The introduction of the Better Care Fund (2015) which expressly identified the need for resource flexibility and placing an expectation on CCGs and other partners to consider pooling budgets to facilitate integration of services, influenced services to refine pathways between services to ensure that the patient/client is at the centre of all service provision. This has facilitated the development of Integrated care Systems (ICS) which will be established across England by July 2022. The development of integrated services continues despite there being an absence of evidence that confirms that integration works from a patient quality outcome perspective notwithstanding there is research to support efficiency benefits (Crocker et al., 2020).

The chapter offered an insight into the journey to establishing an integrated children and young people service in Trafford, sharing the strategic formalities that underpinned the transition and also the change management challenges from a leader/practitioner perspective.

The chapter also identified the motivation behind the research subject and how the interest grew, and policy changes influenced the development of integrated health and social care services. The researcher also identified the need for further understanding and knowledge of what factors influenced the credibility of integrated service leaders and if professional identity was a key influencer. The nature of this enquiry is located in a multi-professional integrated service. This is to gain a deeper understanding of what is already known regarding leadership credibility and professional identity in an integrated service setting and how service leaders of the future can develop to deliver high quality services. It is necessary therefore to interrogate the current evidence available in the areas of leadership credibility and professional identity to find the evidential gaps to develop the theory and practice, to inform future leaders of integrated services. The next chapter will examine the literature relating to leadership credibility and the relationship with professional identity

Chapter Two: Professional Identity and Leadership Credibility

2.1 Introduction

The first chapter provided a historical chronology spanning four decades, presenting a y contributed to the major reorganisation of the health and social care economy, and the drive towards health and social care services integration. The leadership changes over the years were captured, ranging from general managers, medical consultants as leaders, and now an increasing number of multi-professional leaders within integrated teams (Edmonstone, 2020; Lewis, 2014). As a result, professional identity and the credibility of leaders is being questioned (Andrew, 2012; Webb, 2017), an experience I've managed in practice as a senior leader of multi-agency teams in an integrated health and social care service.

Credibility of leaders has been researched authoritatively and is considered to be important as it enables organisations to be successful, this is critical during organisational change (Kouzes & Posner 2007, 2011). Indeed, change is challenging for any organisation but particularly when multi-professionals in teams fear losing their professional identity and values (Wain, 2020). The decisions of senior management in Trafford to appoint team leaders who had professional and health care qualifications to manage multi-professional groups of staff was not guided by robust evidence but more from continuing traditional employment practices commonly used in health and care services.

This Chapter focuses on the current evidence base to examine the concepts of professional identity and leader credibility. The literature was searched using a comprehensive search strategy, relevant papers and grey literature was critically appraised to expose current research surrounding leadership theories and integrated professional teams, A summary of the synthesis of the themes extracted from the literature review highlights evidential gaps and a lack of understanding that this thesis will address.

2.2 Key Research Questions

The key questions that emerged from my practice as a senior leader that needed to consider were:

a) What is known about leadership theory in the context of integrated services?

b) What do leaders need, to gain credibility when establishing multi-professional teams within integrated services?
c) How important is it for leaders to be professionally qualified to lead integrated services?

The objectives of the literature review were fourfold:

- To critically review key literature on leadership, its development over the decades and application within the context of the public sector
- To interrogate literature on professional identity with a particular emphasis on professionals working within integrated health and social care services
- To identify emerging theoretical constructs in relation to leadership to inform the study.
- To examine the concept of 'credibility' in current research and how these interplays with leadership and professional identity within the context of an integrated service or interprofessional working.

2.3 Search Strategy

The review of the literature was carried out at the commencement of the research study, this was considered appropriate as there was a need to consolidate the research questions and the review focused on identifying what we currently know and understand regarding concepts of leadership, credibility, and professional identity and how they interface within the context of integrated services. The timeframe selected was from 1999 to 2021, this time period allowed the capture of early relevant literature that reflected the limited materials regarding credibility theory, but it offers context to the theories that may have influenced the shape of health and social care service provision.

The search strategy identifies the lists of the search terms, the combinations of the terms and word to be used, the databases to be searched and any other forms of searches to be undertaken (e.g., handsearching) and the inclusion/exclusion criteria.

To ensure comprehensiveness and bias reduction in the searches the research question was broken into 'concepts' which developed search terms to locate relevant or related literature (Centre for Reviews Dissemination, 2009). The search strategy identified keywords and terms to generate relevant publications, using Boolean operators (And, Or Not) and truncation (*) and using subheadings.

This enabled key terms as listed in Table 4, to be searched separately and simultaneously and acted as filters to refine the results to avoid the retrieval of unlimited materials.

The terms identified were compared with concepts and terminology that were prominent within current policy documents on health and social care integration/integrated care.

***Table 4**: Search Terms and Rationale*

Search Term	Rationale
Integrated Care	Policy and Think Tank term used to describe the development of services Term
Integrated Services	The service delivery model for integrated care
Health and Social Care	The Location of the research study
Integrated Service Leaders	A term to describe an individual or group of people directing towards shared goals
Leadership Credibility	A term to describe the qualities of someone who can instil trust and belied in followers
Professional credibility	A term which relates to knowledge and insight into the particular area or sphere of health sector activity in which the organisation operates.
Professional identity	Knowledge, training, and/or education that is relevant to an industry and a particular job
Mult- professional working	The term multi-professional working denotes cooperation of a group of professionals from three or more different professions

The reference lists of identified reports and articles were examined to identify further research studies appertaining to the research topic and concepts. The key words were then combined and cross-referenced offering different permutations for further searches as follows:

Credibility and Leadership and Health and Social Care

- Credibility and Professional Identity and Health and Social Care
- Credibility and Integrated Services
- Integrated Services and Professional Identity
- Integrated Services and Leadership Credibility
- Integrated Services and Professional Credibility
- Integrated Services and Multi-Professional Working
- Professional Credibility and Leadership

2.3.1 Selection of Literature

The selection of the relevant studies was extracted from a range of sources, including electronic databases, internets searches. journals, books, reference lists. In addition, hand searches were used to check reference lists, journals and books and the internet, this involved scanning abstracts, reference lists, and conference documentation and Think Tank advisory papers from sites such as the Kings Fund, Nuffield Trust and SCIE, which are producing relevant papers that are influencing policy development in the areas of health and social care strategy and service provision. This manual method of searching can reveal studies that maybe missed (Centre of Reviews and Dissemination, 2009). A search of the available databases through the NHS Trust, Local Government Association and the University, Google Scholar was also used to search for any online articles or materials that were unavailable through other sources. Repeated searches were conducted to reduce the omission of relevant documents. A diverse range of study designs were included in the search. Grey literature published and unpublished was generally excluded such as conference papers, notwithstanding that statutory and government policies,

reports, white papers and guidance were gathered and used to inform the context of the study and background to the development of new business models in particular the integration of health and social care services.
The databases included in the search are listed in Table 5 below.

Table 5**:** *Databases Searched*

The Cumulative Index to Nursing and Allied Health Literature (CINAHL)	Cochrane Library
Univ of Salford Library (SOLAR)	British Library for Online Thesis (EThOS)
Kings Fund (Independent Research Publications)	Harvard Business Review (HBR)
National Institute of Health Research (NIHR)	Local Government Associations (LGA) Knowledge Hub (KHUB)
NHS Networks	NHS Confederation
Social Care Institute for Excellence (SCIE)	Department of Health (DH)
the University of Salford thesis repository (USIR)	Office for Standards in Education, Children's Services and Skills (OFSTED)
Nursing and Midwifery Council (NMC)	Office of Public management (OPM)
Nuffield Trust (Independent Research Publications)	Google Scholar

2.3.2 Series of Searches

The search was first conducted in 2013 as part of the initial exploration of the identifying the research question. The research study faltered due to lack of supervision capacity and personal challenges, therefore on re-establishing the research study a further literature review and research was repeated in October 2021 as part of the preparation for this thesis as it ensured that any contemporary or updated knowledge could be captured, this is important as integrated service leadership is a progressing theory. A further three papers

have been incorporated into the literature review. The presentation of the results in this thesis is the final review of the literature.

2.4 Inclusion Criteria

It was necessary to develop a framework to assist with the final selection of the papers or sources of evidence, this is to inform the decision of whether to include or exclude them in preparation for the next stage in the process which is the critical analysis of the literature selected. The inclusion and exclusion process are illustrated below in Figure 2. Narrowly defined inclusion criteria could omit potentially relevant studies and generalisability but too broad can be challenging to synthesise as over complicated and laborious to review (Centre of Reviews and Dissemination, 2009). The creation of inclusion and exclusion criteria, Table 6, enabled the review to remain both focused and manageable (McNally & Alborz, 2004). The framework was adapted from the Population Intervention Comparators Study design (PICOS) Tool, although PICOS is used to frame research questions the elements can be adapted to determine the inclusion criteria, all elements may not be relevant, but they are useful when selecting studies for review in preparation for critical analysis. (Centre for Reviews and Dissemination, 2009). Inclusion criteria also supports the need to reduce bias in making decisions about which papers to include or exclude (Paterson et al., 2001). The inclusion criteria and rationale are outlined in Table 6. Each paper was reviewed against the inclusion criteria and those that satisfied the criterion and none of the exclusion criteria were retained for critical analysis.

Table 6: *Inclusion Criteria*

Inclusion Criteria	Rationale
Population Studies and evaluations that focused on leaders and staff in community or primary care, and Social Care settings	Studies that identified settings in large corporate commercial organisations due to the need to draw on contextual similarities The research relates to public sector services: Health and Social Care
Location International and national	This research study is located in UK but accessing international research papers enables the capture of leadership and credibility research that has an international location, otherwise materials may have been missed
Comparators Integration; Inter-professional. Multi-agency partnerships. Multi-agency Teams. Leadership Qualities. Professional Identity Leadership Credibility; System Leaders, Sector Leaders	Allows for a broader scope to retrieve informative research that reflects current Integrated service leadership agenda.
Outcomes Studies and evaluations that present evidence of success or failure of Service Leaders, (including systems, processes and outcomes that maybe challenging to measure e.g., service user quality outcomes	Identify knowledge of what challenges exist or what influencing factors make leaders successful
Study Design a) Theoretical Papers relating to leadership, credibility, integrated care services, professional Identity, interprofessional workforce. Peer reviewed, qualitative and quantitative research studies	a) To identify current knowledge • What is already known? • Where are the gaps in evidence?
b) Credible Think Tank, policy advisory and conference papers	b) To inform policy and practice
Timeframe (1999-2021)	This time frame was selected to consider historical leadership and credibility theories and approaches in line with the emergence of legislation and policy in respect to Integrated Services

Note. Adapted from PICOS Centre of Reviews Dissemination, 2009

2.5 Exclusion Criteria

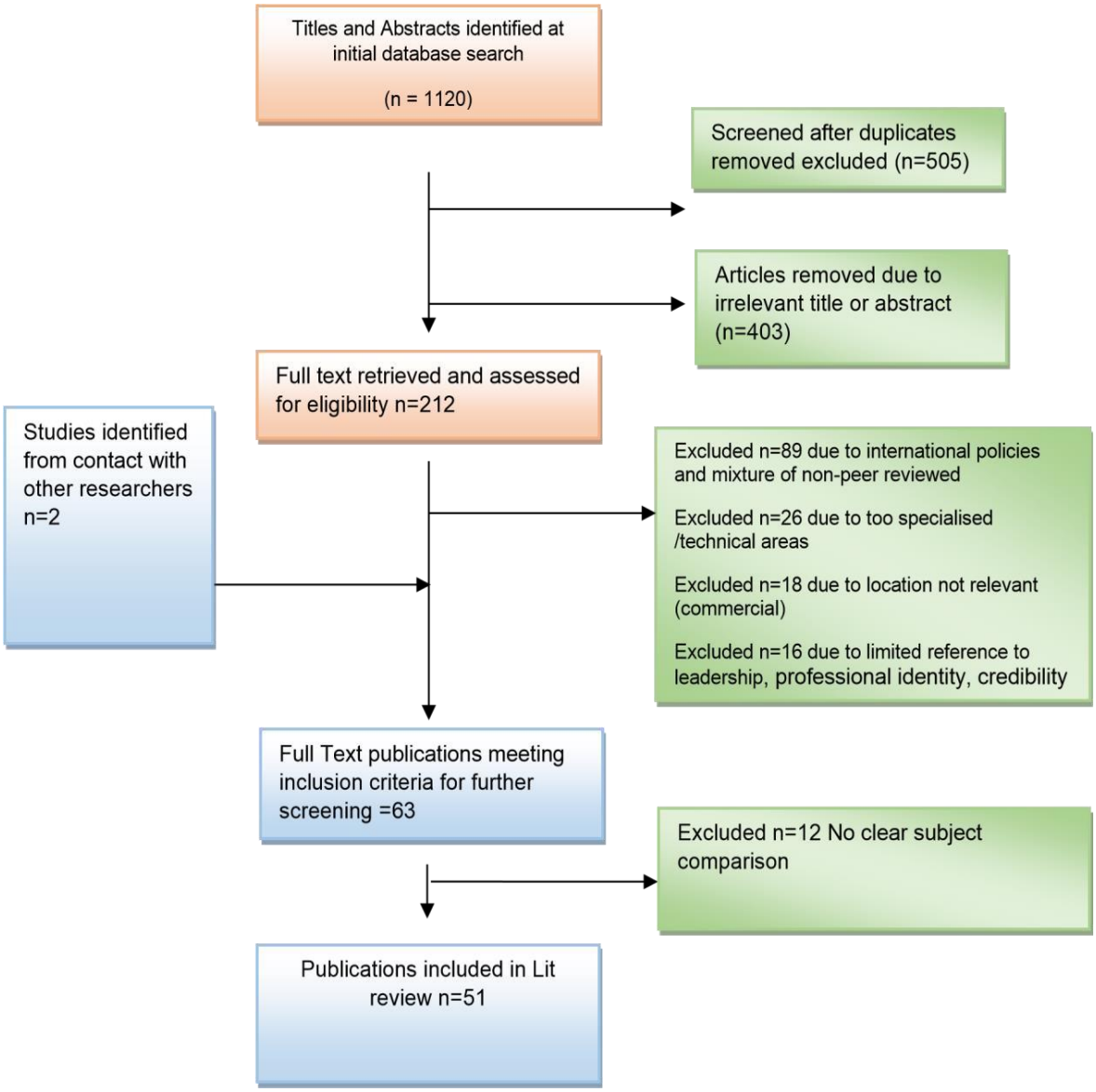
Articles that failed to satisfy the one or more of the inclusion criteria and met exclusion criteria were not retained and excluded from the study. The exclusion criteria are identified below in Table 7.

Table 7: *Exclusion Criteria*

Exclusion	Rationale
Population Studies that are focused on highly specialised or technical services	Doesn't reflect the public sector population of the research study
Comparators Studies relating to public/ private mergers Integration Commercial Business integration	These environments are outside the scope of the research.
Outcomes Research studies focused on single sector structures – in respect to transformation of functions e.g., financial services, IT, Transport	Study findings deemed to be too narrow and limits exploration of challenges across sectors.
Study Design Non-peer reviewed papers, editorials and comment papers Think Tank papers and policies that are not applicable to UK Health and social care	Reduces bias and maintains quality of the research study Research study is being conducted in UK
Foreign Language papers that require translation	Researcher no access to translator services or facilities

Note. Adapted from PICOS Centre of Reviews Dissemination, 2009.

***Figure 3**: Diagram of Inclusion and Exclusion of Publications*



2.6 Search Results

A final search was conducted in October 2021. At the first stage of retrieval (n=1120) articles, duplicates and articles with irrelevant abstracts and titles (n=908) were excluded. A further (n=161) were scanned and excluded. The remaining (n=51) abstracts were screened, and the full text of remaining articles scanned against the inclusion criteria as can be seen in Table 6. Each paper was scanned to identify any characteristics that may be appropriate to the study review with the potential of addressing the research question. Each article was

assessed against the inclusion criteria and the articles that met the criteria were retained and included in the review.

The exclusion criteria were not applicable to these remaining papers. The type of methodologies and number of the retained articles were as follows:

- Literature Reviews (including 1 Think-tank paper) (n=38)
- Qualitative Studies (including 1 Think Tank paper) (n=9)
- Mixed Methods (n=2)
- Cross- Sectional Study (n=1)
- Case Study (n=1)

The aim of the review was to develop a theoretical understanding of the influence that professional identity has on the credibility of leaders of integrated health and social care services. There was therefore a need to consider the diversity of management and social science literature, distinguishing between sources that had no empirical evidence, and those of applied robust research of practice and experience. The strengths and limitations of each paper were critically appraised to determine their research methodology quality (Long et al., 2020). This was done by using a systematic review tool, Critical Appraisal Skills Programme (CASP, 2018), to assess the rigor, quality and scientific integrity of each piece of literature (Fink, 2005). The (n=51) research or literature review focused papers that were retained following appraisal (see Appendix 2).

2.7 Synthesis of the Review Findings

The remainder of the chapter focuses on the synthesis and critical discussion of the evidence uncovered, although this is not an exhaustive summary, it does provide a deeper understanding of the key concepts and study influences. Key themes emerged from the review of the literature, and these are presented below, the themes are not distinct they are inter-related but to offer a level of coherence and clarity they are presented separately.

The themes that were generated as follows:

- Leadership
- Credibility

The synthesis considers leadership theories to provide a contextual understanding to the development of theoretical knowledge surrounding leadership. The critical analysis of the theories adds richness to the connectivity between policy and practice from a leadership perspective (chapter one) and provides a platform to support the research study to determine if professional identity is a key influencing feature in producing credible leaders.

It is helpful to consider the various perspectives on leadership theory, to determine whether there is any evidence to suggest that professional identity influences the credibility of leaders. The concept of leadership can be tracked throughout time and has been discussed for over a century and it's been estimated that there are more than 200 definitions of leadership (Turner, 2019), and this is because there is no universal theory of leadership (Scully, 2015).

2.7.1 Leadership

The public sector has been undergoing significant transformational change for more than four decades, with the introduction of the most recent policy driver, The Health and Care Bill (2021), places a greater impetus for local authorities and health partners to establish integrated health and social care services. These ambitious whole systems change plans to deliver integrated services across England is expected to be in place by July,2022. This statutory requirement has placed increasing demands on organisations to produce leaders who can adapt and meet the challenges (Daly et al., 2014, Timmins, 2015). It is therefore, critical for the success of future health and social care service transformation and delivery, that leaders possess the ability to lead (Timmins, 2015).

It is important therefore, to consider what type of leaders are required to meet these challenges, what traits and approaches should be adopted to deliver successful organisation outcomes. Leadership styles and approaches are plentiful and can be open to interpretation, it is this that creates a fascination with the subject area (Turner, 2019). Leadership consists of different dimensions, but it is mainly concerned with values, actions, behaviour and

relationships (Northouse, 2016). It is key to this research study, therefore, to consider the factors which may influence leadership credibility and examine the different theories around these dimensions

I. Trait Theories

The theory of leadership styles and traits has evolved over the years, from being interpreted as a form of dominance to achieve goals to now being one of influence to achieve outcomes, relying upon a leader's personality and character (Turner,2019). Leadership has been associated with personal traits, the qualities and skills that leaders possess, or they have been aligned with process, which reflects the interaction between leaders and follower (Barr & Dowding, 2019; Northouse, 2016). It is considered that leadership is a series of relationships between people as they move with a common purpose to achieving an organisation's objective (Turner, 2019). This definition will be relevant to the research study, in particular when considering the interplay between leader and follower and to understand whether relationships have any influence on leadership credibility.

Trait theory as an approach, is consistent with the philosophy that defines leadership as being in a sense 'a person' rather than a role, (Roe, 2020), therefore offering an understanding into leadership behaviours which are grounded in psychological assessments of personalities (Judge et al., 2009; Northouse, 2016). This is important from a trait theory perspective as this approach may help organisations to progress leadership development and recruitment strategies, enabling organisations to employ individuals who have the attributes to fulfil roles (Northouse, 2016; Roe, 2013).

The need to understand what type of leaders are required to lead these new complex integrated organisations, is challenging. This is because of time pressures to deliver a new integrated care system and the need to recruit to these new leader positions (Timmins, 2015; Sims et al., 2007). Early theorists have promoted the idea that traits are innate and leaders are born (Northouse, 2016). This idea was considered by the participants in qualitative research conducted by Timmins (2015) as they debated whether systems leadership (a contemporary leadership theory) for integrated health and social care could be taught or learnt by those with the inherent skills and personality traits. The

consensus from the debate was that systems leadership could be learnt and is not reliant on a leader's personal characteristics and qualities. This belief conflicts with Northouse (2016), who argues that personality traits are fixed and cannot be learnt, but skills and competencies can. This position also supports the notion that leaders can positively influence others because they possess particular naturally determined traits (Judge et al., 2009; Northouse, 2016). This is an interesting perspective with respect to leadership credibility and what factors may act as influencers- in respect to this research study, whether it is traits or skills, competencies or qualifications that contribute to a leader's credibility and success. The opinion that traits are the key influencers is at odds with the opinion of Avolio (2004), who suggests that traits do not offer much of a promise in understanding the most important variables that act as influencers (Avolio, 2004 p136).

Kouzes and Posner (2007), who have conducted a comprehensive qualitative study over a 5-year period with 15,000 respondents investigating the concept of leadership credibility, fundamentally disagree with the trait theory approach to leadership. The idea that traits are predetermined, and potential leaders are unable to learn to be effective leaders is relevant to this research study as it will be looking at factors which influence leadership credibility. The idea of not being able to learn may affect a leader's ability to develop particular traits which may influence followers.

A further perspective of personality traits is the view that they can act as an indicator of leadership performance, this assertion has been considered to be unhelpful and has received much criticism (Northouse, 2016; Scully, 2015). This is because it is centred on the traits and motives of leaders being exclusive, without any credence being paid to other potentially underlying and objective organisational, social and economic factors that could influence the success of leaders (Kaiser et al., 2008). A key strength of trait theory is that it is not gender specific so offers a level playing field, but the universality of the theory is undermined because of different organisational cultures. (Roe, 2013). In respect to leadership credibility, it is suggested that theories based on traits or styles only work well at a middle management level as followers need to be inspired

and more senior leaders don't have the opportunity to personally interact with the whole workforce (Leavy, 2003).

II. Behavioural Theory approach

If trait theory offers an understanding that a leader's characteristics and personality are key to this approach, then behavioural leadership theory presents a different theoretical approach, one that purports that a leader isn't born but they are made. This theory contains different assumptions from trait theory, as it assumes a leader can learn specific traits to improve, as actions define the leader's ability (Grint, 2011).

If a leader is successful in one organisation there is no guarantee that their traits will influence a leader's success in another (Matuson, 2011). The relevance of trait theory to the research study is to understand if traits alone act as an influencer to gain credibility or are there other factors that may contribute to the perception of the followers.

The theory of charismatic leadership is the most researched concept (Dinh et al., 2014). This trait remains the most significant of all traits for recruiters, in their desire to appoint charismatic leaders with the hope that they can resolve the insurmountable organisational challenges (Grint, 2011). This expectation of traits creates an overreliance on the leader and not the abilities of the followers to achieve a resolution (Northouse, 2016). Charismatic leadership draws on personality traits, with the charismatic leader's attributes and behaviours often manifested by leader types (Grint, 2011). Key attributes of charismatic leaders include a high level of self-belief, self-confidence and desire for power (Northouse, 2016). As leaders, they espouse goals and a vision that resonate with the values of group members, communicate confidence that the group can achieve their goals and become role models behaving in line with these values (Kouzes & Posner, 2011; Northouse, 2016). There is plenty of evidence to suggest that charismatic leaders are confident communicators and can captivate audiences (Avolio, 2004). The term charismatic is overused, misused and thought to be useless a descriptor of leaders (Kouzes & Posner, 2007). An interesting perspective that may require further exploration in the context of leadership credibility research is the notion that leaders are given charisma by

their followers rather than it be solely down to personality traits. The research study will build on the knowledge surrounding this theory.

Interestingly, the contemporary theory of 'living leadership' offers a converse perspective to the charismatic type of leadership theory as it is suggesting that 'living leadership' is 'anti charismatic' (Binney et al., 2012), with some contingency elements such as the belief that leadership happens between people and is shaped by the context of the organisation (Yukl, 2009). Living leaders are at their most effective when they match their strengths and weaknesses to the organisation (Binney et al., 2012). The leader here is not expected to live up to the charismatic hero model but is an experimenter who is not always the dominant visionary who manages the organisational reality (Binney et al., 2012). These ideas are based on a longitudinal case study of actual leaders who were found to be struggling in the real world to live up to the ideals of transformational leadership (Binney et al., 2012). It would be challenging as a leader of integrated services to adopt this style of leadership as the nature of the health and social care population need leaders to have the ability to transform and reshape services across complex systems. This would require them to be in touch with reality and to face challenges head on at times, living leadership would maybe a bit too challenging to align with the organisation's objectives. There is no discussion in this longitudinal study that considers leadership credibility in respect to influencing multi-professional staff or the requirement for 'living leaders' to be aware of their professional identity as a key influence for engagement or change.

III. Contingency / Situational Leadership Theory

Another traditional leadership theory is contingency theory (also referred to as situational theory), which moves away from traits and personalities and considers the view that leadership style should match the situation whereas situational leaders adapt their style to each situation that arises to meet the needs of their followers (Avolio, 2004; Northouse, 2016). In this context followers are referred to as a group of people who follow guidance, direction from organisational leaders.

Contingency leadership theory promotes the notion that the most effective leadership style is dependent on the relationship between the leader and the group (Northouse, 2016). This is pertinent to the leadership model currently employed in many public sector organisations but has not been fully tested in an integrated health and social care services environment. The evidence suggests that promoting positive working relationships can result in performance compliance, requiring an exchange process, with employees exchanging effort to gain reward (Avolio, 2004). A process of clarifying goals and objectives offers clarity in relation to mutual expectations, if goals are achieved it is more likely to result in individuals and groups achieving expected levels of performance, thus the reward is contingent upon achievement (Mullins, 2008).

This basic behavioural principle of positive reinforcement suggests it is an effective management approach to adopt to achieve the required outcomes of an organisation (Yukl, 2009). When considering this theoretical approach in the context of Trafford CYPS (this thesis research study location), a quasi-contingency leadership style was adopted, the relationship between leaders and 'followers' motivated them to increase productivity through achieving targets which contributed to better quality outcomes for children and their families (Ofsted, 2015). For example, within the childrens school health service, the team worked together to complete child and family assessments (tasks), which resulted in a reduction of the number of children on child protection plans. This motivation to achieve serves as an intrinsic reward, but if applying the theory of contingent rewards in this scenario, the drive to achieve service improvement and to safeguard children from harm would be the reward and the contingent would be the professional's behaviour.

Situational theories do not consider the leader's perceptions of situations and how these might differ, for example, the same leader may not operate successfully in radically different situations (Yukl, 2009). If a situation is highly unfavourable then a relationship leader would be preferred, compared to a favourable situation, where a task orientated leader would be more appropriate (Yukl, 2009). The validity of this notion is uncertain and not evidenced (Grint, 2011). The issue of professional identity and leadership credibility doesn't

feature in situational leadership theory nor the need to possess professional expertise or experience to be successful in any given situation. Yet, there will be integrated service leaders who will adopt a situational leadership approach but no evidence that the adoption of such an approach adds to their leadership credibility.

It could be argued that contingency, trait and behavioural leadership theories have helped to provide a more comprehensive understanding of leadership (Northouse, 2016). This may be due to the limited research available in respect to the new leadership roles that are emerging to lead integrated services, as these new service models are still in their infancy.

Value-based leadership models such as transformational leadership seems to have had a significant impact on leadership studies, affording researchers to build and expand the model of leadership, which considers elements of trait, charismatic, and behavioural approaches to leadership, particularly with a bespoke 'individual' approach towards transformational leadership. From the examination of the available literature, it would appear that the adoption of a 'bespoke' approach would allow for the strengths and qualities of individuals to be nurtured through experience and development of competencies and confidence to position themselves as strong leaders.

IV. Contemporary Leadership Theories

Contemporary leadership theory attempts to consider how leadership operates within complex and dynamic situations from a wider organisational level through to the individual (McKimm & Phillips, 2009). Leadership and communications are inextricably linked and the need to ensure leaders have strong communication skills is important since the focus is now on the importance of networking and collaboration in a contemporary society. A collective leadership approach will enable the transformation of the delivery of health and care services (Van Wart, 2013; West, 2014). This would suggest that the development of networks presents a new leadership challenge in respect to ensuring the strategic and important messages don't get lost in translation when dealing with a population that sit outside the direct control of a leader. It is the intention of this study to discover if working across different organisational boundaries, in multi-agency teams alters or affects the ability of leaders to

communicate clearer or if indeed there are any implications that need to be considered for future leaders to adopt different methods of communication.

The emerging changes emanating from policies can impact on leaders, with the new situational leadership influences placing demands and possible constraints d on leaders (Van Wart, 2013). It is critical to consider the impact of leadership approaches on followers too, especially during turbulent times, as retention of a stable workforce is fundamental to achieve sustainable change (Van Wart, 2013).

Transactional Leadership Theory focuses on the frequent interactions between leaders and followers. To achieve retention of followers, leaders need to adopt an approach that is encouraging and supportive, to facilitate the followers to have a belief that they will succeed (McKimm & Phillips, 2009; Van Wart, 2013; Northouse, 2016). Followers need to be developed therefore leaders may need to adopt a coaching style (Van Wart, 2013). Fulfilling the transactions can be challenging especially when faced with resource deficits, this is why it is important to invest in high level exchanges with followers, promoting participation and delegation (Van Wart, 2013). The relevance of transactional theory in the context of an integrated service is important, as leaders will need to be cognisant of staff morale and their response to the continuous churn in the system because of constant change. This will be a feature of the research study when considering leadership credibility as the methods should uncover any particular issues that leaders of integrated services need to be mindful of during times of change to ensure follower retention and commitment.

The Theory of Emotional Intelligence based leadership may be worth considering in relation to supporting followers during challenging organisational changes. There is a suggestion that existing competency-based models of leadership consist of 80% to 100% Emotional Intelligence (EI) abilities (Goleman, 2020). The Emotional Intelligence based theory raises the issue of the ‘passive– avoidant’ dimension which is featured in the Full-Range Leadership Theory (FRLT) model developed by Avolio (2004). As a general theory it focuses on the behaviours of leaders towards the staff in different work situations. What a leader doesn’t do, is just as important in their success, as

what they actually do (Goleman, 2020). This is an interesting phenomenon, in respect to how followers may perceive leaders from a credibility standpoint in the public sector. Culturally, leaders in public sector organisations tend to follow a mandate and sometimes followers may not always be aware of what underpins some of the harsher decisions. This returns to the earlier issue of strong communication being intertwined with leadership.

Transformational Leadership approaches require commitment and insight. Having poor insight can lead to poor follower perceptions of the leader (McKimm & Phillips 2009; Van Wart, 2013). From a research study perspective this lack of insight could impact on leadership credibility and will be worth considering for future integrated service leaders as it could have implications for the successful delivery of organisational objectives if follower engagement is weakened. The lack of insight issue is a concern as self-confidence is a helpful trait for leaders to possess too much of it can lead to narcissism (Van Wart, 2009).

Interestingly, (Goleman, 2020) refers to “dark side” characteristics of leadership, such as arrogance, insensitivity, untrustworthiness and selfishness which can exist alongside the constructive leadership qualities. Having any of these ‘dark side’ characteristics can negatively impact on career progression and are negatively related to team performance (Goleman, 2020). They are also out of kilter with the theory of distributive and collaborative leadership theory (McKimm & Phillips 2009; Van Wart, 2009). The horizontal or distributive leadership theory model is considered to be a highly effective leadership model as it reduces the need for formal leaders through adopting a more facilitative approach by creating development and learning opportunities to retain follower commitment (West, 2014). It is recognised that models that view management and leadership as intertwined roles remains both current and appropriate in health and social care services, as transactional and transformational tasks are important aspects of the overall manager role in integrated services. (Elliot et al., 2020).

The research study investigating credibility of leaders will offer an insight into the traits and the qualities that leaders may display that will impact on follower

perception, the issue of professional identity in respect to possessing professional qualifications and if these have any bearing on increasing someone's self-confidence to the point of being hubristic, therefore the thesis research may provide an understanding of how these leaders are perceived.

The Distributive Leadership model is synonymous with collective leadership as a conceptual theory. It is an approach that promotes the idea that achieving successful outcomes is everyone's responsibility (West et al., 2014). This collective leadership is a significant contrast to the more traditional approaches to leadership, as it allows for an approach which develops the collective capability of an organisation as opposed to developing individual capability (West et al., 2014). They go onto suggest that a collective leadership approach could lead to a shift in organisational culture, where all staff adopt leadership roles, and the focus is on continual learning which leads to better patient care (West et al., 2014). The author does advice that this leadership approach requires a high level of engagement and discussion and a heavy investment in nurturing leadership. Distributive leadership is the preferred model of leadership for integrated services, as it is one that relies upon interactive relationships with shared responsibility (Edgren & Barnard, 2012). This model removes barriers to achieve greater participation, consistent commitment through empowerment of staff at the delivery levels (Edgren & Barnard, 2012).

Authentic Leadership, as a contemporary theory, defines leaders as having the ability to demonstrate a passion for their purpose and they practice their values consistently. (George et al., 2007). Leaders who are authentic have the ability to establish long-term, meaningful relationships and have the self-discipline to get results (George et al., 2007). This was demonstrated in a longitudinal study of 125 participants through a qualitative approach which found that none of the characteristics, traits, skills, or styles influenced their success as leaders (George et al., 2007). However, reframing their life stories which were based on personal experiences helped them to understand their values and by being more authentic they became more effective leaders.

This authentic style of leadership in the public sector maybe career limiting and high risk, because there is a balance between being authentic and sharing your thoughts as a leader based on your personal values and those of politically lead organisations such as councils. There is evidence to suggest that it is important for there to be an alignment of values between the leader, their followers (Matuson, 2011). This is an interesting contention to consider in relation to the research into leadership credibility and professional identity. Working across two organisations with quite different governance structures for accountability, one being politically led by elected members and the other being an appointed Board with no formal political party alignment, authentic leaders would possibly have to consider their leadership strategy to persuade the chief officers that maybe their strategic decisions need to be adjusted.

The life-story concept provides followers with a major source of information on which to base their judgments about the leader's authenticity, serving as role models to their followers (George et al., 2007). This methodology has been challenged as to its veracity as life stores maybe fabricated to fit in with authentic models (Shamir & Eilam, 2005). The authentication of authentic leaders by their followers is based on trust, a quality which aligns with several leadership theorists (Avolio 2004; Shamir & Eilam, 2005). The more the follower's life stories reflect that of their leader's life stories in relation to values and characteristics, the leaders are judged to be authentic (Shamir et al., 1993). This may be relevant to explore in relation to the research, in essence to determine if leaders are identified to be credible by followers from the same professional or occupation origin. There is no reference in the literature or research studies of authentic leaders or leadership theory that considers the professional identity of leaders influencing either their authenticity or whether authenticity equates to credibility.

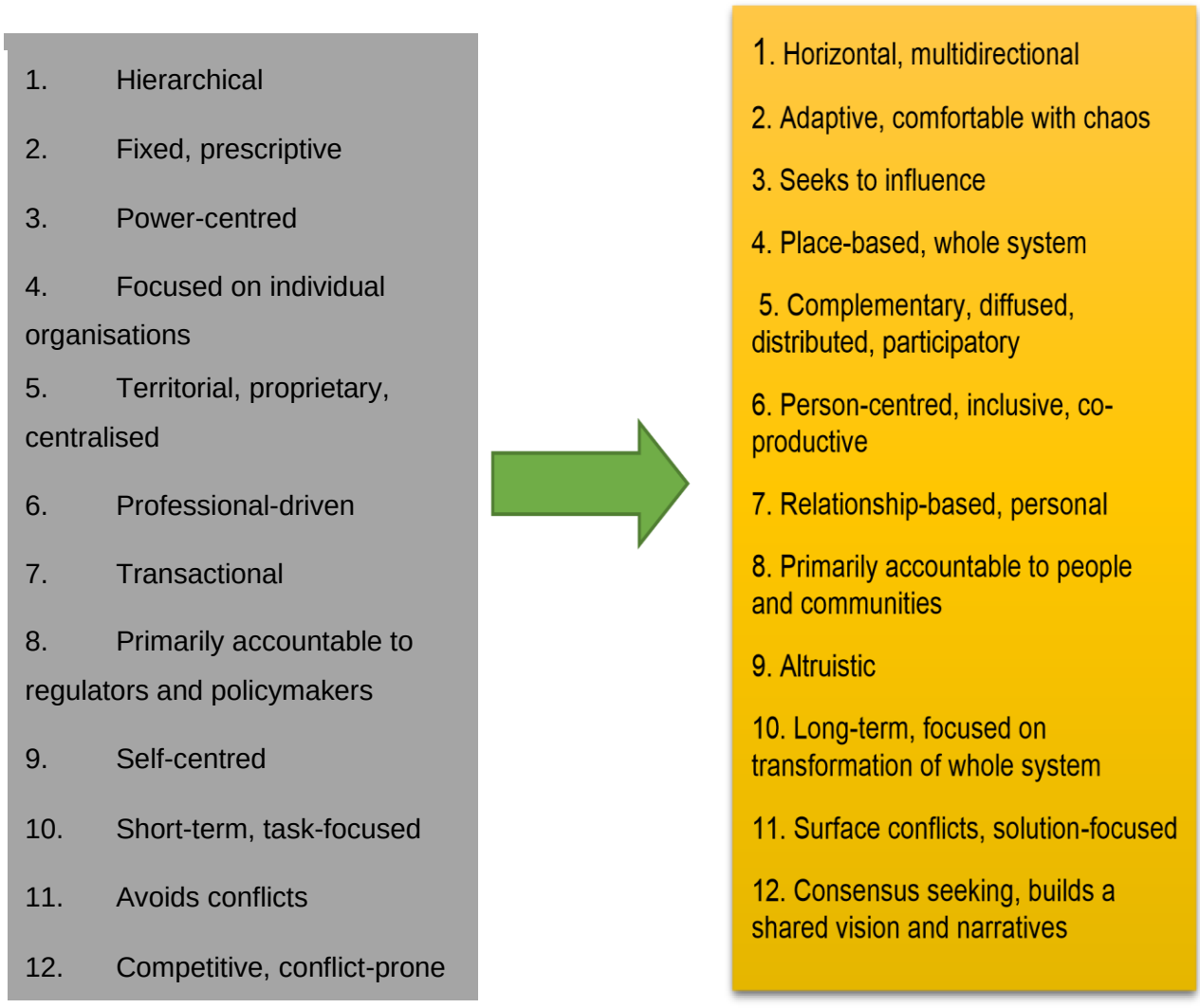
Systems Leadership Theory is becoming the preferred model for leaders delivering health and social care services through an integrated systems model (Timmins, 2015). Edmonstone (2020) proposes that systems leadership is more than working inter-organisationally as it involves a co-evolved agenda and practice. He suggests that traditional leadership

development with a focus on competencies does not prepare system leaders for the challenging health and social care agenda that lies ahead and is concerned that individuals and their employers continue to resolve complex situations by:

> "…finding the "right" people with the "right" qualifications, rather than building the more collaborative efforts required…"
>
> (Edmonstone, 2020, p.360.)

A model for future leaders of Health and Social Care, emphasises the need to shift from a traditional hierarchical leadership approach that uses management direction to one that influences and leads change across organisations and systems (SCIE, 2018).

Figure 4 *Leadership Model for Health and Care*



Note. SCIE, Future of Care, 9, 2018

The challenge for the future selection of leaders of evolving integrated services needs to be revolutionised, with new approaches, new theories to reform recruitment and the future identification of successful leaders. This is becoming a more pressing issue, as there is an impending loss of a pool of experienced and knowledgeable leaders, who may have been contenders for senior leader positions in these new Integrated Care organisations are now reaching retirement age (Timmins, 2015). Another consideration that may need to be taken, is that future leaders for these integrated models may have only ever worked in a single sector organisation and the challenges of working across two or more organisations is in a very embryonic stage, with no evaluation as yet to determine which leadership model is the most successful. This is notable by the recent call for leadership research papers by the incumbent Secretary of State for Health and Social Care, Sajid Javid (*NHS Confederation Integrated Care Systems Leaders Conference,10th November, 2021*). There exists a volume of contemporary leadership theories but little time to test their place and worth, certainly not within integrated settings (Turner, 2015).

The relevance of this leadership theory to this research study is the need to identify the influencing factors that contribute to leadership credibility of managing across organisational boundaries. The research study being conducted will contribute to further knowledge of leadership theory by providing evidence of what leadership qualities or attributes are important to achieving successful outcomes. There is no prescriptive evidence that offers a template to suggest what is required for leaders of these new delivery service models and no available evidence to suggest if professional qualifications are influential to gain credibility.

2.8 Credibility, Professional Identity and multi-professional perspectives

It is appropriate at this juncture to reassert the context for this research study, to ensure that there is an understanding of the need to review particular research areas, which will add value to the context of this study. Earlier in the chapter the different leadership theories were considered to ascertain if any emerging theories or approaches would:

a) enhance the professional credibility of leaders of integrated services, per se and/or

b) consider if any of the theories would be strengthened by the leaders being professionally qualified or having expertise in particular areas.

This section of the chapter, therefore, will consider the literature in relation to credibility in leadership sense but also referencing the concept of professional credibility and if there is a distinction, and if there are does it reduce or add anything to the evidence that already exists. This latter part of this chapter offers a review of the literature to gain a deeper understanding of professional identity as a concept and how it links with leadership credibility to determine if there is evidence that leaders of integrated services need to possess relevant professional qualifications to influence their credibility to lead change and transform organisations. The relevance of professional identity and where professional qualifications is positioned within this concept needs to be exposed, the contextual location is considered within an integrated service with the need for leaders to influence teams of multi-professionals from different professional backgrounds and agencies.

2.8.1 Credibility a perspective for leaders

From the outset it is worth noting that there is a significant lack of research from a public-sector leadership perspective in relation to credibility influencers for leaders of integrated services. Leadership styles may work successfully in a single health agency, or a local authority social care service may not necessary be as effective in a complex, challenging health and social care organisational system (Turner, 2019).

It is helpful to review the origin of credibility to understand the concept of credibility as a term, it is derived from the Latin ‘credere’, and is defined in the Oxford English Dictionary (2011), as *‘the quality of being convincing or believable’*, this research, therefore, needs to consider how the credibility of leaders is gained and if an individual’s professional identity is an influencing factor on their leadership prowess.

Credibility is frequently attached to objects of assessment, as in source credibility, media credibility, and message credibility and they are fundamentally interlinked (Kouzes, 2011), Credible sources are seen as likely to produce credible messages and credible messages are seen as likely to have originated from credible sources (Fragale & Heath, 2004). A credibility conceptual framework, Table 8 was developed to evaluate credibility of information technology (Tseng & Fogg, 1999), but it can be applied to other products or situations to evaluate credibility.

Table 8: *A Conceptual Framework for Credibility Evaluation*

Type of Credibility	**Example**
Presumed credibility describes how much the perceiver believes someone or something because of general assumptions in the perceiver's mind.	People presume that most people tell the truth, but we also presume car sales people may not be totally honest. Presumed credibility relies on the assumptions and stereotypes of our culture
Reputed credibility describes how much the perceiver believes someone or something because of what third parties have reported.	If a professional body (Royal College of Medicine) reported that a BP machine made by DOA Ltd was a highly accurate medical device. This third-party report would give DOA Ltd products a high level of reputed credibility.
Surface credibility refers to believability based on simple inspection, such as looking at the cover of a book or relying on the type of language people use as an indicator of credibility.	A web page may appear credible just because of its visual design or the solid feel of a handheld computing device can make users perceive it as credible
Experienced credibility refers to believability based on first-hand experience as people interact over time, their expertise and trustworthiness can be assessed.	Over a period of time a fitness enthusiast may determine that her computerised heart rate monitor is highly accurate.

Note. Tseng & Fogg, 1999**.**

Reputed credibility maybe relevant to the research study to ascertain if any perceptions exist from multi-professionals as there maybe perceptions that the communication strategies used to consult on the case for change didn't deliver the outcomes they were expecting.

There is no shortage of literature referring to credibility, as it has been examined across a number of fields ranging from communication, information science, psychology, marketing, and the management sciences to interdisciplinary efforts in human-computer interaction (Tseng & Fogg, 1999; Marsh & Dibben, 2003). The most relevant evidence relating to this research study is the literature is linking credibility and leadership. There is a limited number of authors who have researched this subject area, but the key authorities are (Kouzes & Posner 2011; Quist, 2009). As discussed earlier these authorities have conducted several research studies within different organisations at an international level and have discovered that a leader's qualities influence their credibility but there has been no examination of a leader's credibility and the affect professional identity as an influencing factor plays in their success. There is a need to distinguish between credibility and its most recognisable outcome, persuasion, as operationalised by message acceptance (Fragale & Heath, 2004). The most obvious of these is that credibility is intimately tied to persuasion, which suggests that credibility is an ascribed characteristic that it is multidimensional and subject to the perception of the observer. Unfortunately, this idea cannot be taken further as much of the literature around persuasion is non comparative with this research study. The subject area of credibility in relation to persuasion lies in the realms of Information credibility (Tseng & Fogg, 2019) and legal research literature which discusses using persuasion to strengthen and convince courts of credible evidence and legal arguments. Here lies an area that may need to be explored further to achieve a deeper understanding of how leaders can credibly persuade the followers, i.e., multi-professionals to deliver successful outcomes.

Leadership theory as discussed earlier, offers an array of traditional models of leadership, (McKimm & Phillips, 2009; Northouse, 2016; Turner, 2019), in the context of credibility, there is a focus on charismatic leaders, who offer a type of leadership that is transformational in process. This dimension of leadership

provides vision and a sense of mission, instilling pride, respect and trust. (McKimm & Phillips, 2009; West, 2014; Northouse, 2016). Leadership is observable, a learnable set of practices, but the number one factor at the heart of the relationship with subordinates is trust (Avolio, 2004; Kouzes & Posner, 2011).

It would be remiss to discuss the concept of credibility without referring to trust or trusting behaviours, as trustworthy interfaces become enabling because they lead the user to want to interact with them, increasing productivity (Marsh & Dibben, 2003). The notion of trust in information itself is also critical when one considers content, source, intent, and meaning, in view of leaders being the message givers to the followers. Often credibility and trust have sometimes been used interchangeably, but they should not be considered synonymous (Tseng & Fogg, 1999). Trust is different from credibility because *"trust indicates a positive belief about the perceived reliability of, dependability of, and confidence in a person, object, or process*" (Tseng & Fogg, 1999, p41). Trust frequently refers to a set of beliefs, dispositions and behaviours associated with the acceptance of risk and vulnerability. As an emerging key leadership quality in relation to credibility, trust is central and unquestionably the most important factor in establishing leadership credibility (Kouzes & Posner, 2007; 2011). Those leaders who connect with followers through trust have been found to be more effective (Penny, 2017). Trust as a quality or characteristic of leadership may serve as a more powerful influencing factor than that of professional identity or professional qualifications or professional identity.

The qualities of a credible leader are to be knowledgeable and to demonstrate competency and honourable intent (Quisi, 2009). An additional factor of professional credibility to be considered, in the context of healthcare organisations, is the issue of the overlap of professional knowledge and skills with generic leadership attributes (Turner, 2019). This is the crux of this research study, whether professional qualifications feed into the concept of professional identity, and if it does, does it have any influence on leadership credibility.

For leaders to engage followers, it is critical for them "*to have professional credibility, gained often from leaders possessing a professional insight into their*

organisational environments", (Turner, 2019, p12). Leadership in healthcare is considered distinctive from leadership in other sectors (McKimm & Phillips 2009), with the requirement for leaders to be professionally competent to work in complex organisations (McKimm & Phillips 2009; West, 2014). In a recent European study by Czabanowska et al., (2014), a competency framework for health leaders was produced and professional credibility featured in relation to leaders having the competency to synthesise divergent viewpoints.

Credible leaders often exhibit honourable and possess strong moral values about people (Quist, 2009), this provides a platform for credibility (Kouzes & Posner, 2011). In the 1970's, Kouzes and Posner conducted research in America by asking participants to identify key characteristics essential to leader qualities include honesty, being competent and inspiring, in addition to credibility' being the foundation of leadership the use of open ended questionnaires, with more than 1500 managers providing 225 values of traits and characteristics were returned, these were categorised into 15 repetitive responses and the three key characteristics emerged as the key findings:

1. Integrity: is truthful and trustworthy
2. Competence: is competent, is efficient and effective
3. Leadership: is inspiring is decisive and gives direction

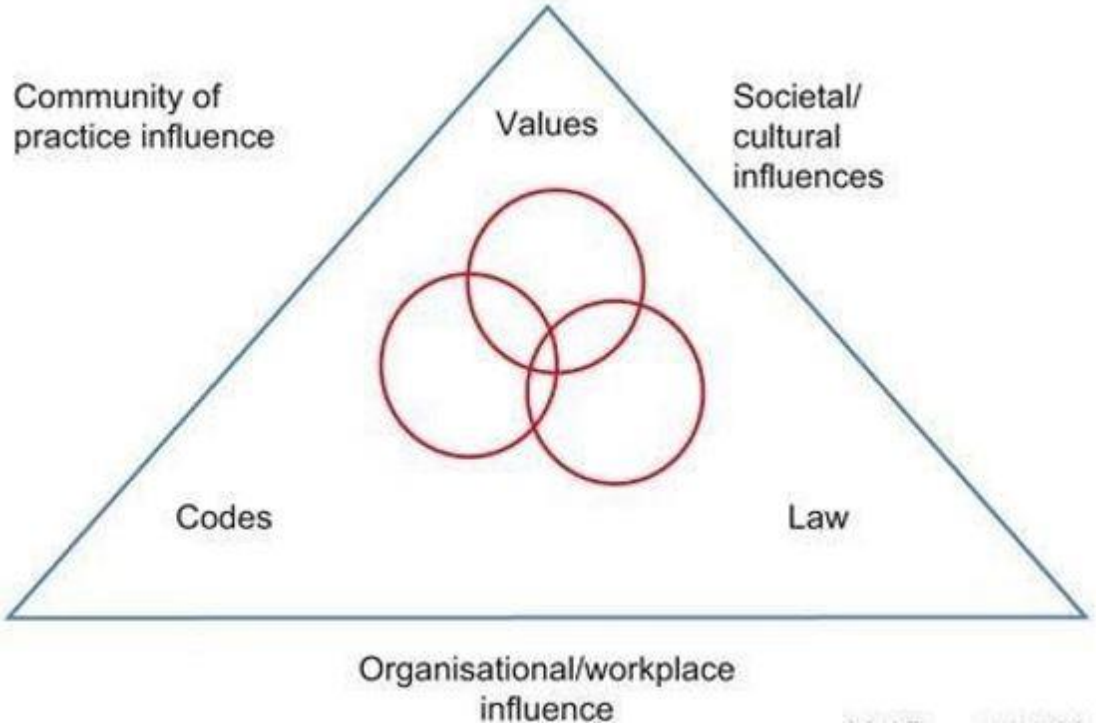
This study was followed up with 800 public sector participants and the findings were replicated, these authoritative researchers have used their studies to inform the development of a checklist of 'Characteristics of Admired Leaders' this has been distributed and responded to by over 75,000 people internationally over the past three decades (Kouzes & Posner, 2011). They have conducted 150 in-depth interviews and, they have written over 1000 case studies, they are arguably the authorities on leadership and credibility. However, throughout the analysis of their papers and books there was no evidence of whether professional identity or indeed having professional qualifications was an influencing factor on a leader's credibility regardless of the organisational form they were located.

Credibility is not described as a specific concept in the literature, it tends to be discussed in relation to a set of leadership traits, behaviours, and skills (Peck & Dickinson, 2008). Evidence suggests successful transformational change initiatives are more likely to occur if the leader is accepted and is a 'credible insider' (Denis et al., 2000). A credible leader to be successful, needs a set of particular qualities which include demonstrating competency and is comfortable dealing with people different to themselves (Quist, 2009). This is particularly pertinent for leaders who need to persuade a diverse set of professionals to embrace a new integrated model (Turner, 2019). Evidence confirms that leadership capability and professional credibility contribute to effective leadership (Turner, 2019). However, evidence confirming whether credibility as a professional is required for integrated team leaders, or a professional identity is limited.

2.8.2 Credibility a professional perspective

Turner (2019) writes extensively about health sector professional credibility and how this forms part of a professional identity, but the research does not explore integrated teams or individuals who have been brought together from culturally different organisations. Professional Identity as a concept is not clearly defined in the literature (Fitzgerald, 2020). It is linked to what the professional's do and the behaviours and activities of the profession, the stronger the identification with the activities and behaviours - the greater the professional identity (Fitzgerald, 2020). Professional identity is multidimensional, formed by bringing together personal, social, political and historical contexts and involving emotional states and value commitments (Rogers & Scott, 2008). Professional identity is shaped by a set of beliefs and values, but the interplay of professional practice and ethics are always in a flux, due to cultural changes and events (McKimm & Phillips, 2009: p129) This interplay of different dimensions is captured in a diagram see Figure 5.

Figure 5*:* Contextual and personal influences on professional identity



Note. Mc Kimm & Phillips, 2009, p. 209.

McInnis and Lawson-Brown (2007) assume that professionals are competent, rational, and moral conducting themselves appropriately. As such, professionals gain the mantle of expertise within their areas of knowledge and competence, which raises the prestige, exclusivity and status of their roles and their practice**.** Losing credibility can be personally and organisationally devastating, impacting on staff morale and productivity, building credibility is an evolving process, but once lost it can be impossible to recover (Kouzes & Posner, 2011). The issue of professional identity and the loss of credibility may have a catastrophic emotional impact on an individual due to their emotional intelligence or indeed their value base (Goleman, 2020).

Credibility, integrated working models, professional identity and leadership is led by the political developments we have seen over the last 25 years. The NHS and Community Care Act (1990) set the agenda requiring joint working across boundaries and this has, to a certain extent, been instrumental in breaking down traditional professional barriers (Hudson, 2002). The most recent Health and

Care Bill (2021) has continued this ambition to integrate services so for the future this model is here to stay. However, there is evidence to suggest that interprofessional teams do not necessarily perform effectively and have generated results indicating a negative or no relationship between interprofessional composition and positive outcomes (Hudson, 2002). Interprofessional openness is suggested as a way to lessen professional identity threat, this is because, as groups value diversity, they are more likely to encourage and respect differences in perspectives between professions (Hudson, 2002).

A profession is often defined by what it is and not what links it to other professions, so encouraging interprofessional working may destabilise traditional professionalism, shifting the emphasis to what professions have in common, rather than what distinguishes them (Joynes, 2018). This may pose a threat to the concept of professional identity and expertise of the individual professional.

The concept of 'profession' has been developed and deployed by the distinctive features of the professions, especially their privileges of self-regulation and self-policing all of which are legitimised by a social contract of prestige and deference (Sullivan, 2000). The term 'professionalisation' is understood to be the process by which a workforce makes a transition to becoming 'professional' and professionalisation is the 'process by which occupations seek to gain status and privilege in accord with that ideology of professionalism (Watson, 2002). In relation to working in multi-agency teams, this may compound the issue of professional identity, as there may be a personal struggle by professionals to assimilate into this new form of team culturally and the challenge of seeking some sense of where their professional identity is positioned adds to the angst (Joynes, 2018). The expectation is that by placing workers from different professions together in a multidisciplinary team will lead to a metamorphosis from a set of disparate cultures, with different strategic frameworks, operational practices and professional expectations, into a unified effective integrated unit, with them all working in harmony towards a common purpose and shared understanding is misguided (Hudson, 2002).

If this is the case for multi-professionals, then it's a challenge to consider how leaders will motivate and engage staff. Leaders need to demonstrate professional credibility to build social capital to harness follower's trust (Turner, 2019).

There has been attempts made to define what a professional credibility is. One such definition was suggested to be that if the majority of practitioners conducted themselves in a professional manner, then the field, they worked in was considered to be a profession (Crawford et al., 2008; Bowman & West, 2016). Whereas others have suggested that to be a 'professional', it is important to possess a high degree of competence and professional expertise in a specific job role to gain confidence and develop a career and be recognised as credible (Crawford et al, 2008). Others have suggested that to have professional credibility, an individual has to be knowledgeable about practice and not necessarily an expert (Fisher, 2015). This concurs with the that to be professionally credible, one has to have knowledge and insight (Turner, 2019). It has also been suggested that to gain professional credibility in respect to clinical leadership in contrast to generic leadership this has to be earned by qualification, experience and successful practice (Turner, 2019, p175).

In a longitudinal study of trainee nurses sharing lectures with medical students, the development of an enthusiastic approach to interprofessional working was less than evident, as it was demonstrated by often sitting people in segregated groups led to concerns about the lack of opportunities to consolidate their own sense of professional identity (Pirrie et al., 1999). For interprofessional working to be truly effective, it requires disparate professional groups to do more than just perform their own discrete professional activities in a shared workspace (Hudson, 2002). Working in an integrated service in a multi-agency team, it remains unclear as to what extent professional demarcation lines can be removed and the blurring of tasks and functions are accepted to ensure that the benefits of multi-skilling are accrued (Snelgrove & Hughes, 2000). This blurring is, however, what professionals are fighting against, as it is perceived as a form of creeping genericism (Brown et al., 2000). It could also be a dilution of the professional identity phenomenon. A definition of multi-professional working must include an epistemology that is dependent on not just a blurring of professional boundaries but also on the creation of a new way of working (Pirrie et al., 1999). Indeed, a multi-professional team must be three or more different professions coming together each bringing with them a set of unique competencies and core skills and distinct set of processes and practice (Pirrie et al., 1999). the changes that follow must take those distinct set of processes and practice (without denying the importance of specific skills and seek to blur some of the professional boundaries, whilst maintaining

the identity of the competencies of the profession by and with a reliance on trust, tolerance and a willingness to share responsibility (Pirrie et al., 1999). It needs to avoid differential treatment of professional groups and values between professionals which can lead to threats to professional identity and interprofessional conflict (McNeil et al., 2013). These issues may influence the credibility of leaders if there are perceptions that there is a lack of parity across professionals working in integrated health and social care services.

2.9 The Evidence Gap

The gap in knowledge in respect to the relational position of professional identity as an influencing factor on leadership credibility of leaders delivering health and social care in an integrated service model.

The gap is evident given the key authorities on credibility and leadership Kouzes and Posner (2011) they do not appear to have linked these concepts in any of their findings. The authoritative evidence that exists in these topic areas focuses on particular attributes and qualities of successful leaders, such as being honest, inspiring and competent and these traits being the source of credibility (Kouzes & Posner, 2011; Quist, 2009). There is a distinct lack of evidence that helps to describe or explain the concept of how professional identity influences the credibility of leaders working in complex integrated health and social care organisations. The literature reviewed whilst offering a comprehensive understanding of credibility and how this theory influences successful leadership, it fails to offer an understanding of the factors that influence of the credibility of integrated health and social care leaders. Much of the credibility leadership research by Kouzes and Posner (2007, 2011) has been positioned in the business world and whilst there has been research in single sector health care environments, they are not UK based, and international health systems are completely different culturally from the NHS. The lack of evidence in the area of integrated service leadership credibility maybe as a result of the model of service delivery still being in its infancy, nonetheless there is an evidential chasm that needs to be filled with data to support these new leaders of challenging and complex organisations.

There are chronologies and detailed reviews of the public-sector development since the onset of the NHS in 1948, and how the emphasis for more integrated working

across health and social care sectors to create better efficiencies and streamlined services. The lessons learnt so far from the development of integrated services, (Hudson, 2002; Timmins, 2015), are plentiful, combined with recommendations on the attributes and leadership styles that need to be adopted for leaders of the new integrate care systems to be successful once established. Yet, none of these large research organisations have provided any evidence to date of an evaluation of whether their proposed leadership theories for ICS leaders are the right ones. This could also be because the evaluation study with the success measures would most likely need to be linked to patient and service user outcomes and this may require a longitudinal study.

There is a sufficient amount of research that has been conducted into professional identity (Joynes, 2018; Turner, 2019) and the positioning of this concept within interprofessional teams. This literature offers a comprehensive understanding of the definition of professionalism, the identity of professionals within interprofessional teams and the issues of hierarchical power and control but surprisingly limited evidence relating professional identity to credibility. There is evidence relating to health sector leadership and the challenges of having dual roles of clinicians being leaders and involved in general management and how these impacts on their professional credibility (Turner, 2019). His findings may have transferability, but they relate to leaders who operate in a highly clinically orientated environment, which is culturally different from an integrated service or a systems leadership model of service delivery. There is an abundance of literature available that describes the research that has been conducted into the development of integrated services (Hudson, 2002; McKimm & Phillips, 2009; Timmins, 2015). What is noticeable about the plethora of literature regarding integrated services, is that most of it sets out how to avoid the pitfalls when developing the services, or how to broker better relationships to improve interprofessional working within the context of integrated systems and services. They fail to discuss the professional training, background knowledge, experience or any expertise that these new systems leaders may need to possess as a prerequisite of these positions (Timmins, 2015). This research study will build and contribute to this subject area of knowledge, as it sets out to discover if professional qualifications matter and what type of leaders for integrated services will be the' best fit' from the perception of the staff working in the service. This will be a different perspective as a recent piece

research looking at what system leadership should look like, was conducted by garnering views from Chief Officers and not practitioners (Timmins, 2015).

Kouzes and Posner (2011) discuss at length what key qualities contribute to making leaders credible, amongst these qualities, they have identified the notion that leaders being competent makes them credible, describing being competent as having technical competency in a functional area (Kouzes & Posner, 2007, 2011). There appears to be a significant absence of literature covering professional identity in respect to whether a person's qualifications and/or training makes them credible if leading professionals from other specialist's fields. There is, however, adequate literature that deals with professional identity, which focuses on multi-professionals but not on service leaders (Hudson, 2010). There exists a deluge of evidence regarding leadership and the emerging theories that have been constructed from decades of research which includes research evidence on leadership styles, qualities and traits (Northouse, 2016; Yukl, 2009; Grint, 2011), but current evidence fails to consider leadership in the context of integrated services and professional identity from a credibility perspective

2.10 Summary

This chapter considered the literature relating to a wide range of leadership theories that have emerged through the decades. From the theories that are task orientated leadership to transformational through to the most recent heralded theories of system leadership.

The literature appertaining to professional identity was also reviewed and positioned within the context of credibility and leadership research with the need to consider the linkages across all these fields. The construct of credibility has been reviewed to consider leadership and professional credibility within the available research and its practical significance within the study environment of integrated health and social care service leadership. The review of literature highlighted gaps in knowledge in respect to the relationship between the concepts of leadership, professional identity and credibility that warrant further research particularly the interplay of the concepts within integrated teams.

Chapter Three: Methodology

3.1 Introduction

The influences of NHS policies over the decades towards integrated services and integrated teams has led to new leadership opportunities for multi-professional staff. Trafford CYPS integrated team leaders working in client/patient facing teams all held a professional qualification. but not one that necessarily corresponded with that of the professions they managed or supervised who were based in the multi-agency teams. Critical examination of current literature exposed a limited evidence base on how professional identity may impact on the credibility of a leader (Fitzgerald, 2020). The professional concerns about being managed by someone who didn't have the same qualification as the practitioner combined with the resistance to change provided a platform for this research and an opportunity to add to the understanding of integrated team leadership. The findings and research messages will inform future service redesign and the selection of leaders for Integrated Care Systems (Timmins, 2015).

This chapter provides the overview of the research approach, it discusses the mixed methods approach, the data collection tools alongside the process of recruitment and study sample. The primary aim of this research study was to examine the perceptions of staff working in integrated health and social care services, to understand if the professional identity of a multi-agency service team leader influenced their credibility. This was be achieved through four key objectives:

- To gain insight into the perspectives of staff from varying professional and non- professional backgrounds as to their understanding of what qualities makes a leader credible.
- To identify key concepts of credibility that contribute to leadership of integrated health and social care service models
- To determine if professional identity is relevant to the success of integrated health and social care leaders
- To extend theoretical understanding of credibility within leadership theories and expose the interplay of professional identity within this integrated care context to inform the practice of leadership selection for integrated health and social care services.

3.2 The Philosophical Stance

As a researcher, consideration of the philosophical value is required when conducting a study; this is to enable the researcher to ascertain why they should be researching into a certain subject area. The paradigm stance for this research study will be one of pragmatism which offers an interface between philosophy and methods (Teddlie & Tashakkori, 2011). It allows for a practical and outcome-orientated method of inquiry that is *'based on action and leads, iteratively, to further action'* (Johnson & Onwuegbuzie, 2004: p.17). For this study the pragmatic approach offers a level of freedom that enables the use of different methods, techniques, and procedures. A further strength of adopting a pragmatic stance is that it can secure a far richer and a more comprehensive understanding from a multi-perspective view (Maxcy, 2003).

A particular limitation associated with a pragmatic approach, is that is can be quite resource intensive, particularly from a time management perspective. This may present challenges when deciding how to order the different types of data collections, as it allows for less stringent set methods and offers a more dynamic approach to research (Maxcy, 2003). The research question should be of primary importance and therefore, more important than either the method or the philosophical worldview that underlies it (Creswell & Plano Clark, 2011). Morgan (2007a), distinguishes pragmatism from the other paradigms by suggesting that pragmatism as a stance is an interest in ideas and their origins which for this research was the exploration of the ideas and experiences of the different multi-professionals which drove the research. Selecting the appropriate methodology that addresses the research question is important, to ensure that the research study produces valid results that can stand up to rigorous scrutiny and challenge (Maxcy, 2003). Creswell (2011), believes that the assumptions that shape mixed methods research requires the researcher to acknowledge the *worldwide view* in order to provide a robust foundation for the research. The influences of the worldview in this study context have been synthesised in chapters 1 and 2, in particular the origins of the different backgrounds and styles of integrated team leaders. The mixed methods pragmatic approach encourages the researcher examine "what works," for who and why, prioritising and seeking multiple perspectives that address the research problem and question whilst valuing both objective and subjective knowledge (Morgan, 2007).

As a senior leader and being a nurse, my pragmatic questioning nature directly influenced my philosophy as a researcher, as the research design selected provides not only a deeper understanding but a generalisability of the data. Throughout leading the integration of services, I have always embraced innovation, asked questions of data, and continually examined performance to improve services for patients and service users. Changes in practice often relied on different sources of evidence, combining qualitative user perspectives with quantitative outcome measures or performance indicators.

The philosophical approach selected for this study reflects the need to fully understand the influence of professional identity on leader credibility from the staff perspective across a large service. The question itself interested me as a nurse having leadership responsibility for many different professional staff groups, as to my own credibility and whether I was perceived to be credible because of my nursing identity or because of the leadership qualities displayed. This reinforced the pragmatic stance adopted as having an interest in ideas and their origin was what drove the research (Teddlie & Tashakkori, 2011). The perspectives of all staff are fundamental to the research to gain a service wide view to provide a robust foundation, from which to extrapolate practice-based findings that are underpinned with leadership theory (Creswell & Plano Clark, 2011). The pragmatic stance adopted and using a mixed methods approach will strengthen the triangulation, as the quantitative approach to identifying what leadership style works for staff, (Morgan, 2007), through utilising qualitative methods, will enable the researcher to seek a deeper understanding of the truth (Greene, 2007). A further strength of adopting pragmatism as a philosophical stance allows for a practical method of inquiry that produced findings which would inform future leadership selection based on evidence (Johnson & Onwuegbuzie, 2004).

3.3 Mixed Methods Rationale

The last decade has seen an increase in mixed methods as a dominant paradigm in the field of health care research (Doyle et al., 2009). Combining both qualitative and quantitative methods within a single study enables a more complete understanding of the research enquiry (Creswell, 2011) although some still believe mixing methods to

be incongruent (Borkan, 2004). For this study, the theoretical perspectives being researched are positioned within a traditional understanding and meaning of leadership, integrated teams, professional identity, and credibility (presented in the previous chapter). The best approach or research method used to examine these concepts are explored.

The measurement of the concept of credibility has been used in the fields of banking financial credibility; social media credibility; credibility of customer feedback and key to this particular research leadership credibility (Tseng & Fogg, 1999; Fragale & Heath, 2004). The key researchers Kouzes and Posner (2007) determined through their research that credibility is a set of characteristics that admired leaders possess. Their research was conducted over three decades using both qualitative and quantitative methods to triangulate their findings (Kouzes & Posner, 2007, 2010, 2011). Their initial research was conducted using an open-ended questionnaire seeking what values employees held as important when determining their leadership success, this was conducted with 1500 managers across different organisations nationwide across the US (Kouzes & Posner, 2007, 2010, 2011). They followed their research up some years later by surveying 800 senior managers from the American public sector government departments, and again applied their 'characteristics of admired leaders' checklist' to a further 75,000 individuals globally. This research was then followed up by the review of over 1000 case studies and 150 in-depth-interviews (Kouzes & Posner, 2007, 2010, 2011). As leading authorities on the study of leadership credibility their continual adoption of a mixed methods approach through large scale research has extrapolated rich data (Johnson & Onwuegbuzie, 2004). Using a survey then in-depth interviews achieved significant transferability and generalisation across different leadership contexts which influenced the selection of a similar robust design for this study.

Professional identity is a concept that requires an integration of personal values, morals and attributes with the normative values of the profession that aligns the individual's personal identity with their professional self (Johnson et al., 2012). Using a single approach to measuring professional identity is not common, as researchers often tailor aspects of theoretical exploration to their study than just examining the construct itself (Randle & Arthur, 2007; Johnson et al., 2012). Indeed, Cowin et al., (2013), examined the psychometric properties of five measures of professional identity

using on-line survey, a study developed specifically to identify the best tool to measure professional identity. They determined that tools for measuring professional identity tend to be bespoke to a specific study (Cowin et al., 2013). This study focuses more on the relationship between professional identity, leadership, and credibility, so the detailed examination of the concept was not required for this study. However, surveys were adopted in a study to test whether credible leaders would generally nurture and develop relationships with their board member, leading to higher levels of trust and lower risk measure, which contributed to the leader's perceived success (Gabris et al., 2001). The researcher then analysed sub-groups within a survey a method which would resonate with this study and the perceptions of different levels of staff with or without a professional qualification of leadership credibility (Gabris et al., 2001).

A mixed methods approach offers the opportunity to develop the enquiry and add to current knowledge and theory relevant to integrated teams (Johnson & Onwuegbuzie, 2004). It was important to acknowledge the resilience of the individuals who have experienced the transformational organisational changes that have led to newly formed integrated management structures. Individuals within the integrated service were now being led by someone from a different professional origin, which for some appeared to influence and shape the perceptions of that leader. There is no escaping the researcher is a senior leader in the service (discussed later in the chapter), but a mixed methods research methodology recognises the researcher's presence in the study. It has been purposely selected as a method to elicit the participants experiences of leadership and facilitate telling their stories without being influenced by the researcher's preconceptions (Silverman, 2010).

The comprehensive study into leadership credibility by Kouzes and Posner (2007), was conducted by using a mixed methods approach of a convergent design (Creswell, 2011). This approach will the allow for large amounts of quantitative data from questionnaires to, be converged with the qualitative interview data to enable a deep analysis to occur. Mixing the two methods is an accepted approach in health service research (Creswell, 2011; Saks & Allsop, 2012). The triangulation of the quantitative and qualitative findings offers strong corroboration thus providing greater validity to the research (Bryman, 2006). It also expands and extends the breadth and range of the study (Greene, 2007). The strength of a mixed methods approach will allow the

researcher to include participant's quotations and present diagrammatical meaning to the narrative (Johnson & Onwuegbuzie, 2004). The weaknesses surrounding mixed methods are relatively limited, but one of the key frailties of this approach can be that it is time consuming and challenging for a single researcher to conduct a full study, this is particularly relevant when two approaches are conducted in parallel (Creswell, 2011).

Researchers encounter difficulties when they attempt to describe how the two elements of mixed methods relate to one another (Tashakkori & Creswell, 2007). The confusion is compounded by a lack of consistency between authorities; some describe it as the collection and analysis of quantitative and qualitative data (Bryman, 2006; Tashakkori & Creswell, 2007) and others view it as full integration of both approaches (Hanson et al., 2005). Mixed methods continue to evolve (Creswell, 2011), for this study qualitative and quantitative research paradigms mixed are viewed as the 'third' paradigm approach (Tashakkori & Teddlie, 2011).

3.4 Research Design

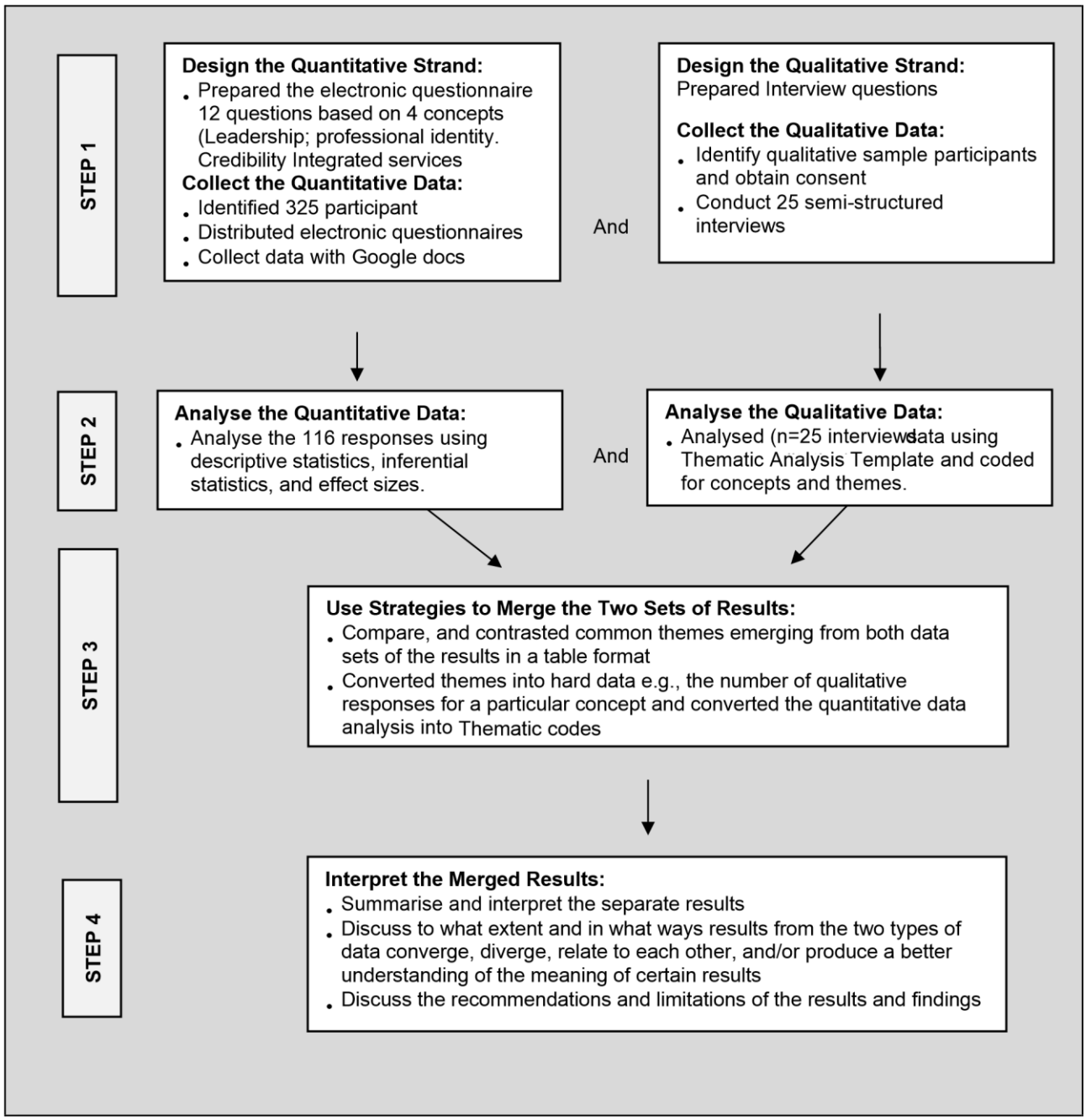
The research design selected for this research design is a convergent design which is one of three basic research designs that underpin the mixed methods research approach (Creswell & Plano Clark, 2011). Figure 6., sets out the different steps for convergent design.

1. Convergent Design where the quantitative and qualitative results are compared.
2. Exploratory Sequential Design, when the interpretation of the qualitative data is explored leading to a quantitative test.
3. The Explanatory Sequential Design, popular in health and social research, when the interpreted quantitative data is further explained by the qualitative data results.

This convergent design was considered most appropriate to extend the enquiry and enhance the validity of the research by producing a holistic and contextual portrait of the perceptions of staff throughout the integrated service at different levels and experiencing different leadership. The decision to select this convergent design was

based on determining the equal priority and importance of the weighting and the timing of the quantitative and qualitative strands (Creswell, 2011) and the desire to obtain different but complimentary data on the same topic (Morse, 2003). Although, the convergent approach was dominant the exploratory sequential design was also partially used. As some initial findings which emerged through the survey were explored as the interviews progressed to gather a deeper understanding, but predominantly the methods were undertake simultaneously.

Figure 6: *Convergent Mixed Methods Design*



Note. Adapted From Creswell & Plano Clark, 2011, p.79

As the selection of the convergent design requires the researcher to collect, analyse and merge both the quantitative and qualitative data and results concurrently, the design sits neatly with the philosophical stance of pragmatism by guiding the merger of the two approaches to lead to a greater understanding (Creswell, 2011).

The implementation of the convergent design progressed in four steps as set out in Figure 6.

Step 1 - involved the concurrent collection of the data from both a quantitative and qualitative perspective relating to the research subject.
Step 2 - was the application separately of thematical analysis of the two sets of data.
Step 3 - the researcher integrated and merged the results of the two data sets, which included comparing the results and strengthening the relationship of the results during additional analysis
Step 4 - the researcher interprets the two sets of data results to confirm or oppose and extend the understanding of how and if professional identity influences a leader's credibility.

3.5 Research Quality and Rigor

The quality of the research needs to be assured throughout the whole process, this is achieved by taking measures to ensure the research is rigorous, ethical, valid and reliable. Rigor in this sense should not be confused with the traditional concepts of measurement, quantification, and generalisability (Ryan-Nicholls & Will, 2009). In quantitative research, there is much emphasis placed upon the achievement of the validity, reliability of the research to enable the potential for generalisation, whereas it is suggested that qualitative research seeks compliance with the principles of credibility, transferability, dependability and conformability (Henry, 2015). This is set out below in Table 9. Mixed methods research is considered to offer a high level of rigor (Gibbs, 2010), as it is given more of a scientific form due to the integration of two methods (Creswell, 2011).

Table 9: *Ensuring rigour in mixed methods research*

Quantitative Concepts	Qualitative Concepts
Validity	***Credibility***
The relationship between the questions in the questionnaire and the free narrative produced results consistent with the research enquiry	Standard open-ended questions within the consistent semi-structured interviews offered opportunities for differences of perceptions from participants to emerge, across different levels of staff from different professional backgrounds
Reliability	***Dependable***
Use of standardised data collection tools: questionnaires distributed to all 325 staff participants in the teams not just a biased small selection	Use of participants quotes from the interviews, enhanced understanding and clarity of responses and meanings
Generalisability	***Transferability***
The analytical process discovered themes and patterns that could be generalised to other population samples or similar integrated multi-agency teams	Storage of data information and emerging findings and repository for information emails/reports in relation to research are maintained; a clear audit trail of process the management of data; the development of findings can be applied to other settings, populations, and environments

Ensuring that there is sufficient detail with regards to how the data is collected will offer a level of credibility to the research, notwithstanding, the history and research experience and expertise of the researcher will also strengthen the credibility of the study and provide a deeper level of quality assurance (Gibb, 2010). The remainder of this chapter brings together the step-by-step plan of the research study, data collection and robust analysis, alongside discussing the researcher tensions as a senior service leader (section 3.10) and the influence this may have on the study findings

3.6 Study Site

The study site was Trafford CYPS this integrated service was formed, in 2007, as a unique partnership between the Local Authority, Primary Care and Acute Hospital Trusts. Its vision was based upon a determination to ensure better outcomes for children and young people by providing integrated commissioning and delivery services (Bright Futures: Working Together Because Every Child Matters – Trafford Children and Young People Plan 2006 – 2011, March 2006).

These were to be co-ordinated around the needs of the child or young person, rather than the needs of the organisations responsible for commissioning and delivering these services. The partnership has evolved and has robust governance underpinned by Section 75., Partnership Agreements that have been sustained through substantial turbulence within the health economy and the challenges facing local government (Gleeson & Knights, 2006). This was because the integrated model has delivered high quality, value for money services whose impact can be evidenced through continuing to improve outcomes for children, young people, and their families. (O'Brien et al., 2009). Services are delivered through fully integrated services across three locality based Multi- Agency Teams (MAT) and a range of borough wide multi-agency services including the Multi-Agency Referral and Assessment Services (MARAS), Looked After Children Service (LAC), Complex Additional Needs Service (CAN), Children Centres, Youth Offending Service (YOS), Child and Adolescent Mental Health Services. (CAMHS). The interdisciplinary nature of these services enables co-ordinated support to be provided to families and the sharing of high-quality professional expertise. Integrated delivery of services is supported and facilitated by integrated commissioning arrangements for child health, social care and education services that enable the effective use of resources, targeting services at key priorities, and the development and commissioning of evidenced based interventions.

3.7 Target and Sample Population

The next stage of the procedure was to identify the participants needed to answer the research question. The total population of Trafford CYPS was 900 staff, this represents the full staff number of employees redeployed from the local Health Trust and Council into integrated health and social care services. For this study a sample of staff needed to be selected from the TCYPS population using a strategy targeting

participants, selected on the basis of their relevance to the research question, which helped to develop and test theories and explanations (Mason,1996). Characteristics such as positions or professional backgrounds in the organisations may or may not have been present in the sample group if a simple random sample had been selected (Creswell, 2009). The participants were drawn from the total sample (n=900) with the Human Resources manager tasked with identifying only the staff who fitted the inclusion criteria (Table 10).

Table 10: *Inclusion and Exclusion criteria for research participation*

Inclusion Criteria	**Exclusion Criteria**
• All staff deployed into CYPS and working directly within the multi-agency services. • Staff that were managed or supervised staff from the multi-agency teams • Staff who hold traditional Health, Social Care and L&D qualifications and who work in multi-agency teams • Staff who work in the Trafford CYPS who do not hold a health, social care and L&D professional qualification but manage or are supervised by someone who has a professional qualification (Commissioning/ Public Health services)	• Staff who work in CYPS but had no direct responsibility for the delivery of care within CYPS (such as admin staff, secretarial staff, finance officers, school improvement officers, IT officers, school admission staff, contracting,) • Staff in CYPS but in a specialised service e.g., Sp Ed; early Years; • Other staff working in schools not managed within a multi-agency team (school caretakers, school crossing patrol, school transport, children centre catering staff). • Staff on Maternity leave or long-term illness during data collection phase

From the 900 staff 575 were excluded from the research, although they were resourced and governed by CYPS as an organisation. This was because they were located in a single management structure and were not sited within the multi-agency services. This included all single service staff across the health and the council who were redeployed into CYPS. There were approximately 85 schools in Trafford at the time of the research, therefore, this large excluded pool of staff was predominantly made up of school support staff such as: caretakers, school crossing staff, catering staff, administrators, finance staff attached to schools and CYPS centrally located staff such as IT Service, HR, Finance, School admissions, catering staff, school crossing staff, staff working in audit, communications, buildings management, contracting and procurement department and those staff on maternity or sick leave.

The overarching aim was to be inclusive, to recruit all staff members being managed and working within in the multi-agency services which included, CAMHS, three Area Based Multi- Agency Teams, Multi- Agency Referral and Assessment Team, Looked After Childrens Service, Children's Centres, Complex and Additional Needs Service, Youth Offending Service and Joint Commissioning Service. Staff eligible for inclusion in this research study totalled 325 participants, each were sent a study questionnaire. The staff included were from varied backgrounds, some were professionally qualified in health and social care, others worked in the fields of Health, Social Care and Education and were working in the area based and borough wide multi-agency teams operating at different levels of seniority. This sample was collated into homogenous groups representing their professional backgrounds and their positions within the multi-agency teams (Table 11).

A purposive cross-sectional sampling strategy was adopted to select participants for the interviews as the emphasis of this research was on quality rather than quantity, the objective was *'not so much about numbers but to gain information which is rich'* (Padgett, 2012: p.198). Collecting data by purposefully selecting participants in qualitative research, allowed the researcher to recruit participants who have experienced the key concepts being explored in this study (Creswell & Plano Clark, 2011). The interview participants (n=25) were recruited from the sample groups at random from a generated list of people who had been sent the questionnaire to participate in the semi-structured interviews. The justification for selecting the interviewees from each stratum of CYPS was to gain an authentic insight and find out

what it was that practitioners, team leaders, managers and directors considered to be important to make a leader credible. The selection for interview was based on gaining an equal number where possible of participants from each stratum which included three Directors of the integrated teams (one not professionally qualified), team leaders, senior practitioners, clinicians/practitioners and care assistants across the different teams.

Table 11: Sampling Frame

	Professional Qualification			**No professional qualification**
	H	SC	L&D	
Directors	0	1	1	1
Heads of Service	2	3	2	1
Operational Managers	6	6	6	2
Team Leader / Senior Practitioners	6	6	6	2
Clinicians / Practitioners / Care Assistants	72	41	57	104
Sub Total	86	57	72	110
Total	**325**			

Key: Health (H), Social Care (SC) and Learning and Development (L&D)

Due to the nature of the service provision in TCYPS each Team Leader and Operational Manager who were selected to participate in the semi-structured interviews (excluding five participants who were not professionally qualified), at this managerial level all had patient /client responsibilities. Some had a greater caseload in practice than others. These included the Operational Managers and Heads of Service who were working in services for Looked After Children Youth Offending, CAMHS, MAT, as they had a high level of case management and clinical supervision responsibilities, particularly in relation to child safeguarding decision making issues. Thus, 17 of the 25 interviewees had clinical/practitioner related activities within their role portfolios. The three Directors were purposefully selected, as the researcher considered their perspectives would be unique and add a level of completeness to the

investigation, allowing for data to be all encompassing to enable a wide range of views to be explored. The cross section of participants selected, offered a balanced spread of professional and non-professionally qualified staff working within the multi-agency teams, to bring richness to the research and offer a stronger level of validity.

In relation to the characteristics of the staff selected for the semi-structured interviews they held a range of professional qualifications and had different career experiences; the health staff possessed registered qualifications in nursing, health visiting, midwifery, allied health professions such as speech and language therapy, physiotherapy, occupational therapy and optometry, some health participants held qualifications in medicine and psychology. The Social Care staff held a Diploma in Social Work, whereas the Learning and Development (L&D) staff selected, held qualifications in teaching, child development, early years, probation, careers advice, youth work, nursery nursing, and career advice/connexions. The interviewees without professional qualifications were purposefully selected based on their positions in CYPS, their inclusion in the interviews was considered to be relevant to the research enquiry because they either managed/supervised staff who held professional qualifications or they themselves were managed/supervised by staff with or without professional qualifications. This sample of staff who were included in the semi-structured interviews who didn't hold traditional professional qualifications were located the multi-agency commissioning arm of CYPS, with responsibilities for developing strategic commissioning plans for health, education and social care services.

Whilst data saturation is often the common criteria used to guide qualitative interview sample sizes (O'Reilly & Parker, 2013), and content saturation for thematic categories was examined during the analysis of the study findings, it was not the only criteria that influenced the number of interviews undertaken. A purposive, cross-sectional sample of (n=25) participants was considered large enough to provide variety of different staff experiences, and an interview number manageable, alongside the full-time working commitment of the researcher. There was sufficient representation of staff from different strata in CYPS, from different professional and non-professional backgrounds, the focus was about seeking different perspectives, looking for differences and similarities to generate a deeper understanding of staff experience, not necessarily achieving information redundancy (Sandelowski et al., 2007).

3.8 Recruitment

The nature of the researcher's professional role in the organisation requires stringent adherence with the code of confidentiality, governed by the Nurses and Midwifes Council (NMC). Alongside the assurance gained from the University ethics committee and organisational approval, information from the personnel department was shared regarding the employees' email addresses, position, and professional background with the researcher.

As discussed in the previous section the (n=325) staff participants who received an electronic questionnaire were selected from the target population of employees (n=900) by the Human Resources department as they met the inclusion criteria as seen in Table 10.

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Table 12: *Base Location of Questionnaire participants*

Staff Location	Numbers
North Multi -Agency Team	99
West Multi Agency Team	68
South Multi Agency Team	79
HSC Commissioning Team	10
	325

An individual email with an information briefing sheet (see Appendix 7) explaining the research along with and a letter (see Appendix 8) inviting them to participate was sent to each individual participant, without other participant's being aware of who had been invited to participate in the research.

A purposive selection of staff (n=25) from the (n= 325) survey participants were approached and invited to participate in the interviews from the personnel list. Their selection was based on their position and professional background from different levels within CYPS to reflect the different professional and non-professional qualified backgrounds at the different levels of the organisational management structure.

Formal letters were sent on email inviting each participant personally to participate in the qualitative element of the research. In addition, an information briefing paper (see Appendix 7) explaining the research topic and the terms of the interview including the process relating to the interview, the storage and use of the data collected. A consent form to take part was also attached to the invitation letter (see Appendix 9). The interviewees were selected based on their level of seniority and professional origin and availability (due to maternity and long-term illness some staff were unavailable throughout the data collection phase). The (n=25) interview participants were granted permission by their employing organisations to attend and were able to claim travel expenses. A formal consent form (see Appendix 13) was also attached to the email, which they were requested to sign if they agreed to participate in the interview and bring to the interview when arranged. An interview was organised at a time that suited the participant, the service, and in a neutral location, so they didn't feel threatened by power dynamics (discussed later in more detail).

3.9 Ethical Issues

Ethical approval was obtained from the Local Research Ethics Committee (LREC), (see Appendix 3), Trafford Council Research & Development Group, (see Appendix 4), Pennine Care FT Research and Development Committee (see Appendix 5), and University of Salford Research Ethics Committee (see Appendix 6). The key ethical considerations included informed consent, confidentiality and anonymity of responses. The ethics of the researcher senior role potential bias and power issues are addressed in the next section.

The research was designed, reviewed and undertaken to ensure integrity and quality. All participants in the research were informed fully about the purpose of the research, the methods that were to be employed and the intended uses of the research and what their participation in the research entailed and any risks. (See Information Sheet - Appendix 7).

Confidentiality of information shared by participants and their anonymity was explained to the participants and respected. All participants were recruited voluntarily and not coerced to take part. No participant was harmed as a result of being involved in the research. Each participant was given a contact number to ask any questions prior to

being involved and opportunity was provided prior to the start of any interview to take time and assure participants regarding their involvement, confidentiality of information, and the anonymity of responses provided. A consent agreement to take part, was signed by the researcher and the participants, with a duplicate copy provided to them for their own records, (see Appendix 9). The researcher was responsible for ensuring that when collecting, handling, storing, using or destroying data, there was no contravention of any legal or regulatory requirements in any part of the UK, and there was full compliance with the Data Protection Act (1998).

The data collected from questionnaire analysis and tape-recorded interviews was anonymised and securely stored in a locked filing cabinet within the researcher's locked personal office. An information sharing governance impact assessment was carried out to provide assurance to the participants. All electronic files collected from questionnaire analysis and digitally recorded interviews were anonymised and coded (with non-identifiable code numbers assigned to each participant) then stored on a password protected and subjected to safe storage regulations.

3.10 Researcher as an Insider

As the researcher and a Director, I needed to consider my leadership position in the same organisation, and the influence this could have throughout all aspects of the study. Holding dual roles, as a researcher and an organisation employee may cause ambiguities which involves role conflict and overload (Coghlan, 2007). The organisational demands are not always predictable in the public sector and consideration had to be given to managing any work-related conflicts with the interview time schedule. I arranged with supportive colleagues to be available during the scheduled research interviews. The balance of power had to be considered as a researcher. This was particularly important, as many participants (all but three) held junior positions to that of myself as the researcher. The significance of this dual role of researcher and senior leader could compromise the ethics of the study in respect to shaping the data that was being collected, as well as people feeling compelled to take part (Coghlan, 2007).

As the researcher I needed to ensure that questions (within the questionnaire and particularly in the interviews) remained objective, reflexive, and authentic to the

research topic, removing and not offering my own view or perspective (Corbin-Dwyer, 2009). Participants needed to be reassured that I was not judging their opinion and I reiterated this at the beginning of every interview, on emails inviting people to take part and the briefing sheet. The challenges of concealing identities can sometimes be virtually impossible (Van Den Hoonaard, 2003). This can be particularly difficult if anyone is closely tied to a particular research setting, they will likely be able to recognise participants and places (Nespor, 2000). This research study location is in a small borough and many of the workforce live locally, and some know each other professionally and socially. Given that the research study is not only geographically identifiable the data collected from questionnaires and interviews reveal the occasional experience of poor leadership behaviour. If the respondent was identifiable through a descriptor of post or gender the integrity of the anonymity maybe weakened. To reduce the risk of breaching confidentiality, I have coded each of the respondent's data presentation in Chapter five and identified them by a number code generated from the data collection database, The potential power imbalance was the largest concern (Moore & Gagné, 2021). To mitigate against the power issues, I used the briefing paper and time to answer questions to provide robust assurance that I was not asking them to participate as a senior member of the organisation but as a researcher. I stressed to people that their participation was purely voluntary, if they chose not to participate there would be no reprisal, it would not affect them in their role. I was fully aware that my role as an insider researcher could change at various times during the research data collection, with different groups and individuals (Allen, 2004).

Throughout the research I reflected on my participation within the study, at the outset I listed my thoughts and presuppositions, I consulted with my supervisors regularly to ensure I was not introducing bias into the interviews or analysis. The advantages of having the in-depth knowledge of the study site and team leadership were useful to reduce the need for participants to describe the service and allowing the time to be focused on interrogating and exploring issues raised across participant interviews to confirm or identify alternative experiences. I kept a research diary, listened to the taped interviews and assessed my performance as an interviewer, with my supervisor offering constructive challenges.

3.11 Data Collection - Questionnaires

The development of the electronic questionnaire was borne from an overarching question, which was to examine how professional identity influences the credibility of leaders of integrated health and social care services. This overarching question led to the development of further sub-questions that focused on the key lines of enquiry in respect to professional identity having a bearing on the credibility of leaders in an integrated service model.

The increasing use of online methodologies raises some ethical issues which are unique to electronic survey research (Buchanan & Hvzdak, 2009), but participants of online questionnaire-based research have the choice whether to complete the survey or not (Buchanan & Hvzdak, 2009). In this study, the survey was anonymous, completed online so a participant's email, or IP address was not traceable. This approach was considered more ethical for participants who worked with the researcher as it allowed them the opportunity to participate, to have their voice heard without being identified. Indeed, surveys administered in this way encourage and increased response rate that the usual 20% expected for questionnaires (Chava Frankfort-Nachmias & Nachmias, 1996).

The research into the use of electronic surveys is sparce and limited considering the dependency on the internet (Reynolds et al., 2006). The researcher for this study offered the participants the same level of assurances in respect to confidentiality as if they were participating in an 'offline' postal questionnaire, Informed consent to participate in the research electronic questionnaire was presumed on the receipt of the questionnaires from the respondents.

I. Designing the questionnaire

The questionnaire (see Appendix 10), was set up using Google Docs, this was the system used in CYPS for organisational related surveys it was considered to be a suitable electronic system to utilise. When designing the questionnaire, careful attention was paid to ensuring the questions were based on the research question and linked to study's objectives. This was to generate data that would inform the research findings. The questions were constructed to ensure the content was not bias and the phraseology and wording was easily understood to avoid any ambiguity. It was important to formulate questions that were not too vague and didn't include any

sensitive questions. The sequencing of the questions was clustered around themes, demographics, leadership qualities and qualifications, leadership experiences and service models. This order sequencing assisted with the question flow, ensuring there was a natural transition to the next question however this may also act as an influencer in respect to responses to the next question (Rowley, 2014). The questions were short in form and did not lead to any assumptions and were adequate for purpose. It was important that the questionnaire was not too lengthy as this could reduce the response rate and increase the risk of premature termination (Rowley, 2014).

There are 12 questions in total in the electronic questionnaire (see Appendix 11). The larger the size of the sample, the more structured and closed the questionnaire will need to be, whereas the smaller the size of sample, the less structured, more open and word-based the questionnaire will need to be (Cohen et al., 2007). The questions selected for this questionnaire were a mixture of closed, open, multiple choice and one was based around a Likert scale to elicits opinions. The open questions allow for explanation and are considered to be preferred to close questions from a researcher perspective for measuring quantities (Krosnick, 2018). Once drafted, the questions were discussed at a supervision meeting, subsequently some of the questions were re-phrased and re-ordered. The questions were then evaluated for suitability with a staff member who had the responsibility and experience for producing and managing the council surveys, he tested in terms of language, ordering and duration of completion, and was satisfied that the questionnaire would elicit responses. Both the supervisor and the council officer offered the questionnaires a level of face validity (Krosnick, 2018).

II. Interviews

The purpose of adopting semi-structured interviews as a method, allows in depth investigation into the key issues of professional identity and how it relates to credibility of leaders in integrated teams. It enables the researcher to discover how individuals think and feel and why they hold certain opinions and deepens the understanding of the key issues (Silverman, 2010). Interviews as a method of collecting data is useful as it allows the researcher to investigate issues in depth and to discover how individuals think, perceive, feel about a particular subject or concept, it also offers the

participants an opportunity to speak freely in a protected confidential environment. Interviews provide a human dimension to data that is impersonal. Interviews tend to have a high response rate, and it offers the researcher an opportunity to clarify any ambiguities (Dilley, 2000).

The participants who took part in the one-to-one interviews were offered complete confidentiality and the responses collected in the interview were analysed to identify any emerging themes that informed the research findings. The data collected has been used for this specific research study and not used for any further studies. The data will be retained securely in password secured files until 2022 when the Doctorate is awarded, the data will then be destroyed and disposed of confidentially. The participants were able to check the accuracy of the data, correct any errors and clarify any points and sign off the transcripts before the data was analysed. The data is anonymous and has been securely stored in a locked filing cabinet within a locked office. In addition, all electronic files have been password protected and subjected to safe storage regulations, and any documentary data evidence that has been collected has been assigned codes to ensure anonymity. Digitally recorded information and data is nonidentifiable as code numbers were assigned to each participant.

The (n=25) interviewees all attended the 1:1 interview, and the duration ranged from 60 to 90 minutes. This length of interview offered the participant time to provide rich data but was not too lengthy so as their engagement in the interview process didn't tire (Kvale & Brinkmann, 2007). The interview method was chosen as a means to explore experiences and ask questions of participants. Interview questions were grounded in the literature in respect to leadership, professional identity, integrated team working and the concept of credibility. The interview schedule and questions (see Appendix 14) was in a simple format of 18 questions, allowing the researcher more freedom when sequencing questions, for a natural flow of progression to occur, but also to act as a script/aide memoir to ensure that critical information was shared with all participants at the beginning and at the end of the interviews (Flick, 2009). Questioning was an iterative, reflective process that led, not just to data, but to specific data that added new knowledge to a larger field of study (Flick, 2009). All interviews were digitally recorded and later transcribed. The data collection continued, and it was noticeable that after the 10th interview data saturation began to be evident (Guest et al., 2006).

With similar responses to the questions the schedule of interviews continued as the mix of professionally qualified and non-qualified participants who had been selected from the stratified sampling frame may have added further rich data.

The interviews took place in a confidential environment, on the organisations site as the venue was accessible both in terms physically and mentally ensuring that the participants felt comfortable with the interview room, the digital taping of the interviews. The individual interviews provided the researcher with an opportunity to access beliefs and experiences of the participants (Smith, Jarman & Osbourne, 1999), one of the problems of interviews is that language is not transparent, and doesn't always reflect people's feelings, thoughts and views (Burr & Chapman, 2004). There are times when people don't say what they mean and can on occasions be inconsistent in what they say, words also may have different meanings subject to the context and the meaning may change over time.

Through listening and employing different interview tools and techniques and a pragmatic approach to treating the data, the researcher was able to begin to understand and ascertain the lived experiences of the different professionals participating in the study (Peck, 2008). Personal interviews as an element of data collection process allow for greater exploration into the emerging themes and perceptions and added more meaning to them in this research.

Semi-structured interviews give respondents some control over the interview (Barnes, 1992) and allowed the researcher to clarify meaning and explore fully the issues raised during the interview. Non-directive' interviews, where the interviewee talks freely without interruption or intervention, was not considered an appropriate approach to achieve a clear picture of the interviewee's perspective (Easterby–Smith et al., 2012). The researcher interviewing participants needed to consider several elements in relation to their own personal abilities and skills regarding their interview techniques, their interactions and behaviours during the interview and of course any bias that they may unintentionally introduce into the interview through questioning.

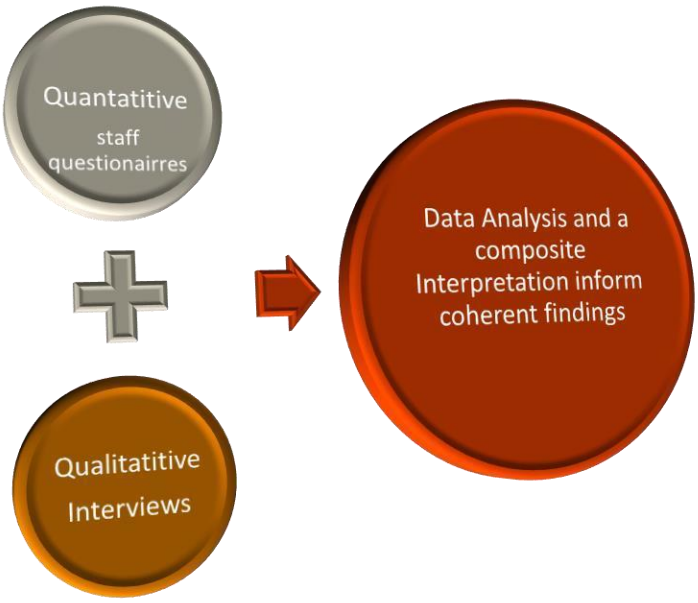
Data collection attained by taped audio recordings enables the researcher as an interviewer to focus on the dynamics of the interview (Kvale & Brinkmann, 2007). The transcribing of taped interviews was a challenging task in itself and the production and

use of transcripts are essentially research activities (Bailey, 2008). Transcription is part of the interpretative process, and a degree of analysis takes place at this level (Kvale & Brinkmann, 2007).

3.12 Triangulation using a Mixed Methods Approach

It is a general rule of research that the researcher should aim to triangulate the data that is obtain data from more than one source to use as evidence to support a particular explanation, this is important in getting other people to validate the researcher's claims to knowledge (Modell, 2009). Using a convergent design of mixed methods were the quantitative and qualitative research is conducted concurrently and analysed separately and the merging of findings supports the research validation (Creswell, 2011). Conducting mixed methods research and combining quantitative and qualitative methods to triangulate findings in order for them to mutually corroborate adds validity to the research (Bryman, 2006).

Figure 7: *Illustration of mixed methods to achieve triangulation*



3.13 The Analysis Process for Mixed Methods Design

A mixed methods research analysis consists of analysing both sets of data, the quantitative data and qualitative data separately, then using techniques to merge the data and results (Creswell & Plano Clark, 2011). What is important when analysing, interpreting and reporting mixed methods research is, that it should be done in such a way that both quantitative and qualitative components are "mutually illuminating" (Bryman, 2007, p8). The selection of a pragmatic philosophical stance for a mixed methods approach allows for the integration of the data at any stage (Bazeley, 2009).

The processes for analysing quantitative and qualitative data requires the researcher to follow similar steps for both data sets (Creswell & Plano Clark, 2011). The authors, suggest that the analysis phase of the process for both data sets takes several steps to achieve. In summary, the steps they recommend consist of:

- Preparing the data for analysis by ensuring there are no entry errors, assigning codes etc.,
- The next step is exploring the data, by examining the trends, patterns, and recording notes and thoughts.
- The next step is the analysis of the data- which can be at multiple levels using a range of techniques.
- Finally, the data analysis is represented in summary form e.g., statements, tables etc.

In mixed methods research studies where a convergent design is adopted, the integration of the data can occur at the analysis stage, this allows for the bringing of the results together. It is important to note that although the analysis of the two sets of data is completed separately and can be integrated at any point in the process (Creswell & Plano Clark, 2011), the presentation of the results from the convergent findings cannot be compared or interpreted until both sets of data are analysed (Morgan, 2013, p81).

The amount of material collected for this research study was challenging to analyse, as there was over 40,000 words of associated narrative with the 116 responses to the questionnaires and a further 50,000 words of interview transcript data from the 25 individual interviews. The analysis of data in mixed methods research is complex due to the use of two data sets.

3.14 Quantitative Analysis Process

As mentioned in the previous section the researcher adopted a number of steps to analyse the quantitative data to ensure rigour (Creswell & Plano Clarke, 2011). The electronic questionnaire data was managed using an excel database. The first step in the data analysis was to cleanse the data that had been collected from the questionnaires. The data set was cleansed by eradicating errors that were clearly obvious, such as incorrect spellings, getting rid of spaces, removing duplicates, changing text to lower/upper case e.g., 'Integrated Teams' and 'Integrated teams', (White, 2003). The researcher then began to examine the raw data, identifying emerging patterns and taking notes from a learning perspective and also to inform the categories for the data entries. Following on from the cleansing of the data, the researcher created categorical ordinal variables that can be measured using a limited number of values and categories e.g.: qualifications, gender and satisfaction ratings. The values allow for repetition for a significant portion of the sample (Allen, 2017). Categorical ordinal variables, whilst qualitative can use numerical values to denote ordering information but only to reflect the ranking order in a particular attribute (Powers & Xie, 2008).

Excel spreadsheets are useful for analysis of data sets as they allow for the entry of categorical and text data within the same database. They also have the facility to provide tools for data comparison, enabling the researcher to identify discernment of patterns though the examination of trends (Bazeley, 2009).

The quantitative analysis from the questionnaires was managed through the use of excel software allowing for the conversion of the raw data into a pivot table. The advantage of using a pivotal table is that, it enables the researcher to correlate the different variables across rows/columns/values in a range of formats, but for this research data presentation, tables were selected as the most informative format. The pivot table in excel aggregates the values as a sum, giving a sum total using the value field setting which produces results that can be interpreted in a meaningful way by the researcher (Etheridge, 2011).

The rationale for the selection of cross tabulation for analysis was to provide a simple method of grouping variables to avoid error. It also offers the researcher the opportunity to examine the data and gain a more in-depth insight into the results because from a managerial perspective it is a useful analysis method for providing

information on how values are related, which cross classification is most selected by the respondents and how these cross classifications differ from each other (Dass, 2010). This is because cross tabulation maps out the relationships between categorical variables which sometimes can be overlooked with more complicated data analysis systems (Macfie & Nufrio, 2005). Cross tabulation using a pivot table assisted the researcher to see the patterns and check inconsistencies. This analysis of the questionnaire data using cross tabulation also allowed the researcher to work with the full text to code relevant notes from the content to match or link to the categorical data (Andrew & Halcomb, 2009). The use of cross tabulation assisted the researcher with dealing with a large amount of data from the (n=116) questionnaire responses, as there were 40,000 words of associated free text.

Once the data was analysed through using the cross-tabulation pivot tables, this allowed the researcher to create themes. Themes were identified by identifying patterns within the qualitative data from the questionnaire respondents' free text (Braun & Clarke, 2006). The first step in the thematic analysis approach purported by Braun and Clarke (2006), in their six-step guide to conducting thematic analysis, is to become familiar with the data. The researcher read and reread the free text, jotting down notes of initial thoughts and particular points of interest. The next stage was to generate initial codes, the researcher systematically ordered the free text data in a meaningful way in relation to the research question, this was done by creating codes to identify similarities of meaning. These coded pieces of text were then ordered together, thus making the data more manageable by reducing the data into small chunks.

The next phase in the thematic analysis process was searching for themes, this involved the researcher identifying patterns that highlighted something of interest which was contained within the data, as the patterns were characterised by significance this created a theme (Braun & Clarke, 2006). To achieve the themes the researcher grouped together several codes, some having a clear fit e.g., coded text relating to leaders in relation to communication, these codes were all collated creating an initial theme called 'leaders communication'. All the coded data was then organised into broader themes that appeared to say something specifically relevant to the research enquiry.

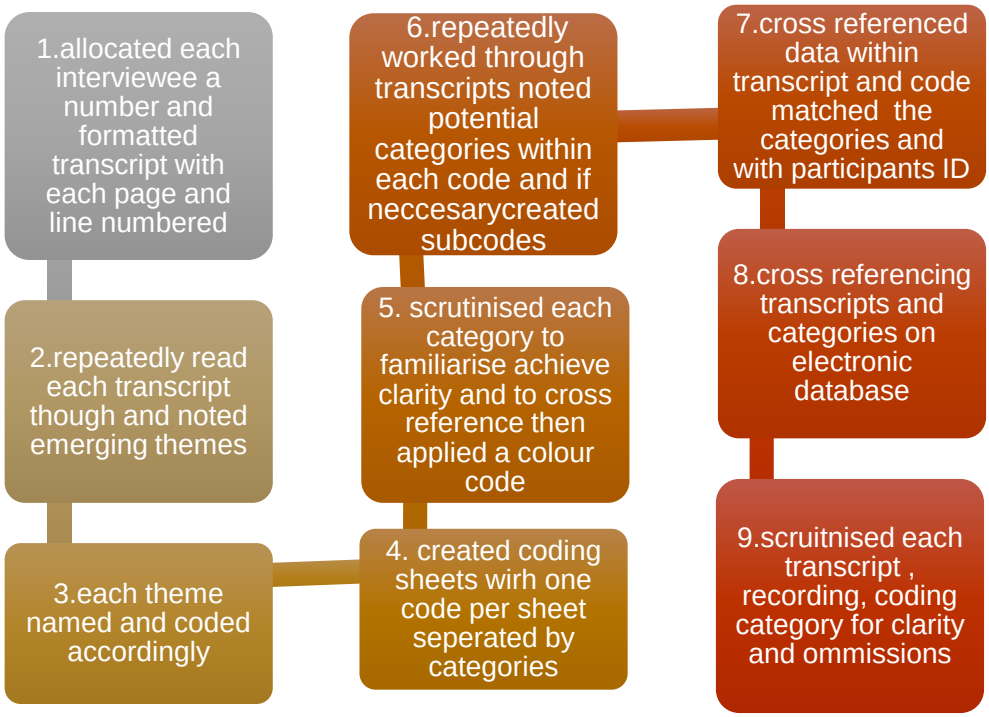
The researcher then pulled all the coded data relevant to the theme together, these were then colour- coded relating to each theme. The researcher began to critically

review the themes, ensuring they each made sense to the research enquiry, asking questions such as: *Were the themes coherent? Did they overlap? Were they in fact two separate themes?* A few modifications were made resulting in some themes being merged e.g., multi-agency working and interprofessional working. This stage of the process led to the creation of sub themes which captured patterns that had emerged that were linked to an overarching theme. The researcher considered that these sub themes added to the richness of the meaning. When the review of the themes was completed, the researcher moved onto refining them, with the aim to identify the 'essence' of what each theme was saying (Braun & Clark, 2006 p.92). This final step in the analytical process gave consideration to the relationship between themes and this resulted in a level of coherence that made sense of the data and how it related to the research study.

3.15 Qualitative Analysis Process

The researcher personally transcribed the interview data therefore reducing the margins for error by being personally involved in the interviews and hearing direct evidence, the recordings were clear and easy to understand (Easton et al., 2000) The transcript data was read repeatedly to allow for a degree of reflection to occur, to enable ideas to be formulated within the framework of the literature review. The process of data analysis for the qualitative element is set out in the algorithm at figure 8, below, which describes each step in the analysis process. To gain a clear understanding of complex data it was deemed appropriate to adopt a template method to allow for the organisation and analysis of the textual data according to themes (Crabtree & Miller, 1999). This method of analysis according to Crabtree and Miller (1999), assists with the management of large amounts of unstructured text. The framework assists with the comparison of perspectives between individual transcripts, explore related trends and to provide insights into the meaning of the participant's perceptions and make inferences. The process of template analysis enables the researcher to organise the text according to themes, by indexing sections of the text which are relevant to a particular theme. Crabtree and Miller (1999) asserted that the development of the coding is part of the analysis process as these codes emerge from the data rather than being fixed from the outset and the coding structure enables more efficient sorting and retrieval reflecting the themes.

Figure 8**:** *Algorithm to show process of data analysis of interview transcripts*



Note. Adapted from Radnor & Noke, 2002, p.84.

Turning to the analysis template at Figure 8, above, which is an adapted version of a template originating from Radnor and Noke (2002: p84) The template was developed to act as tool to assist with the management of organising the data more efficiently and effectively (King, 2004). This template analysis approach allowed the themes that emerged from the data analysis to be grouped together to form broad codes which related to the emerging areas of interest. From these, sub codes were then formed to identify areas of specificity. Caution had to be exercised by the researcher so as not to develop too many codes as this could reintroduce complexity, when the aim of the template analysis is to reduce the complexity of the data (Crabtree & Miller, 1999). Identification of the frequent occurrence of themes gave a level of relevance to the study aims and suggested closer examination of this data, for example, considering if a theme was related to particular professional groups. The researcher also compiled a repository of quotations that represented the themes to aid with the interpretation. The data analysis established to what extent professional identity influenced the credibility of leaders working within an integrated service model. The challenge for the researcher was to connect *'data bits to each other and to the body of literature that yields meaning'* that is useful (Pollock, 1991, p.30). This organisation style allowed for

the structuring of results without losing the richness or variety of the responses, identifying commonalities, this verification helped to ensure corroboration so as to strengthen the credibility of the interpretation (Crabtree & Miller, 1999). Any codes that did not contain any significant data were deleted and related codes with small amounts of data were merged. Peck et al., (2015) suggest identifying meaningful statements and using the method of constant comparison or second order analysis by organising and aggregating concepts. It was important for the researcher to give meanings to those statements by categorising and interpreting them. These statements were then grouped together, by the researcher looking for consistency in concept identification and coding and sub coding the concepts to take forward or discounting or eliminating them as not significant to add richness of meaning. The conceptual codes defined the key domains of the research aims that characterised credibility, professional identity, leadership and integrated services. An example of the analysis template containing the themes, the categorised conceptual codes can be seen in Table 13.

***Table 13**: Analytical Framework*

Theme (Code)	Categories
Leadership (L)	1. Being strategic 2. Policy: having the knowledge and understanding the impact 3. Visioning 4. Planning 5. Staff empowerment and Development 6. Motivation/engaging followers 7. Managing Operations 8. Monitoring Performance
Values (V)	1. Beliefs 2. Personal Experiences: How I am led; How do I lead? 3. Conflict with organisational values 4. Professional voice 5. Decision Making
Interprofessional Working (I)	1. Co-location 2. Team Relationships/Dynamics 3. Silo Working 4. Expertise (sharing) 5. Clarity of Role 6. Understanding Roles of Others
Credibility Factors (C)	1. Experience 2. Expertise 3. Qualifications 4. Behaviours/Modelling 5. Leadership Qualities 6. Communication

3.16 Summary

The main aim of the research was to gain a greater insight on whether professional identity influences the credibility and success of leaders of integrated health and social care services. This research is important to inform the growing number of integrated services and teams in their selection of appropriate leaders and contribute to a limited evidence base and theoretical understanding of credibility and professional identity. From a target sample (n=325) staff were invited to participate in an online questionnaire because they worked within the local Council and NHS Trust in the CYPS. A purposive sample of (n=25) staff drawn from different levels of seniority and professional groups, qualified and unqualified and were invited to participate further with an in-depth interview.

A pragmatic approach using a convergent mixed methods design (Creswell & Plano Clark, 2011), sought to explore what works and what doesn't for staff with respect to integrated team leadership (Morgan, 2007). This allowed the emphasis to focus on the importance of the research problem and question, valuing both objective and subjective knowledge. The interplay of the key themes of leadership, credibility and professional identity are addressed in the next chapter through the presentation of the study findings. Chapter 4, explores the demographic breakdown of the staff responses and the challenges of data analysis. Chapter 5, presents the key findings extrapolated from the integrated mixed methods data.

Chapter Four: Leadership in Integrated Teams

4.1 Introduction

The research study to explore the influence of professional identity on the credibility of an integrated team leader was implemented and new and original findings exposed. The convergent design facilitated quality data combining a questionnaire to examine the wider staff perceptions of their current leader and interviews to allow the rich understanding of why, when, and how a leader was considered credible. The findings are presented in two chapters; chapter four and chapter five.

This chapter provides a contextual explanation of the participant sample's characteristics, identifying demographic profiles for the cohort, to consider if any characteristics of the cohort has any bias, influence, or impact on the study data findings. The thematic analysis of the findings is presented in three core themes. The fist theme and the concept of leadership is then explored, Chapter five combines the second and third analytic themes of the data of credibility and professional identity.

4.2 Challenges as an insider

The positionality of the researcher as an insider in this study had to be fully considered, particularly focusing on participant recruitment (Moore, 2012). As previously described the researcher held a senior leadership position within the organisation where the research was being conducted. It was important therefore, to consider the implications in respect to the recruitment of the research participants. The recruited participants were from the cohort of employees within the sector that the researcher was a director, and the physical and psychological proximity of the researcher could influence the social dynamics of a research study (Ganga & Scott, 2006).

It was important for the researcher to have cognisance of this potential bias and consider their presence as an 'insider' and to whether their relationship with the questionnaire respondents and the interview participants would have an influence on their willingness to participate in the questionnaire survey (Chammas, 2020). The researcher as an insider reflected and cogitated at some length on the selection of the interview participants to ensure that they would not be burdened to provide a particular perspective to the research study.

Theoretical sampling was used to identify participants from different levels of staff and professional groups and to stratify the sample into different groups (Parsons, 2014). Participants were then selected at random from the groups (from a full list of people) by the research supervisor, to prevent research bias in selection, with the researcher selecting people with a particular view. This method of recruitment of participants provided a level of ethical assurance as the interviewees were to be extrapolated from a large cohort of professionally and non-professional qualified positions at different levels within the organisation but all were outside the direct line management scope of the researcher.

Participants were approached by email (see Appendix 8) so there was not a feeling of coercion that could be experienced if invited face to face, their participation was voluntary, and all those approached agreed to take part. Prior to the start of any interview the researcher reassured participants that their opinion and responses would be anonymous and confidential, the data was being captured for research only and not to influence the direct management of the service. Confidentiality was key for participants to speak freely and the respect and trust for the researcher within the service certainly provided additional reassurance that their responses would be confidential. This robust and considered approach enabled the researcher to gain a range of rich insights from across the four key professional groups, health, social care, learning and development, and commissioning within CYPS. This method of recruitment reduced the risk of any partisan perspectives being proffered by research participants.

4.3 Response Rates

All of the participants at the time of the research were from a population pool that were employed by either Trafford Metropolitan Borough Council (TMBC) employees or from Pennine Community Care NHS Foundation Trust (PCFT) deployed into the integrated service known as Trafford Children, Young People Service (TCYPS).

The questionnaire survey was distribution through an electronic questionnaire (Google Docs) platform to (n= 325) staff as the target population. The sample of employees who received the electronic questionnaire were purposefully selected by the researcher from an anonymous master list of staff in the service, who had been stratified into groups based on a specific inclusion/exclusion criterion as identified in Table 10, but the

overarching criteria was that they were working in multi-agency services in TCYPS. An administrator sent out the emails to staff and the link to the anonymised online survey, this was to avoid researcher bias in targeting certain staff. Reminders were also sent through the administrator to all target population. These purposefully selected participants from the different professional and non-professionally qualified backgrounds, were either managed by or provided supervision/management to someone who may not be from the same professional origin. For example, a social work practitioner managed by a professional health manager, or a non-professionally qualified commissioning manager, who provided supervision to youth workers who held a learning and development professional qualification.

The distributed electronic questionnaires elicited (n=116) responses, which equated to a 36% response rate. The importance of the response rate offers a level of validity to the research findings (Baruch, 1999). The average response rate to general paper surveys is 55.6%, although studies which involved senior management or organisational representatives (as this research study does), a much lower response rate was likely. Achieving a 36% response rate as Table 14 illustrates, in this research survey offers a level of strong validity as Baruch (1999) asserts from his research that an average response rate of 36.1% with a standard deviation of 13.3% is robust.

To boost the adequacy of returns for the online survey, the researcher sent gentle prompts of email reminders (through the administrator) on two occasions to all participants, allowing a gap of 4 weeks between each of the reminders (Nutty, 2008). A higher response rate should decrease the risk of bias in survey research (Groves & Peytcheva, 2008). However, response rates to web and email surveys are lower than postal surveys due to a possible lack of familiarity with the web, the reliability of internet access and the lack of trust in respect to internet security regarding confidential information may have influenced the rate of response (Scott, 2011). The use of online surveys at the time of the data collection stage of the research were not a common method to gain staff feedback in CYPS in 2014. There was a greater use of paper feedback forms for specific projects, which may have influenced the 36.1% (n-116) response rate. However, a response rate of 30% is average for survey methods, as people filter ‘spam’ emails and the spam filters can particularly target email distributed surveys (Lindemann, 2019). Another influence that may have resulted in a non-

response rate of 209 participants (63.9%) could have been 'survey saturation' and the frequency that specific groups that are requested to complete surveys (McPeake et al., 2014). Although the researcher wasn't aware of competing staff surveys circulating at the same time the questionnaire was administered, survey fatigue may have been an issue that the researcher was unaware of at the time. There is a balance with questionnaires, indeed surveys need to seek constructive criticism, as simple numerical ratings tend to result in less responses (Nutty, 2008). Feedback was sought by the researcher at the design and formulation stage of the questionnaire development, by colleagues and they suggested to add space for staff to write more and add their thoughts. With this in mind the free text boxes could have deterred some staff from answering thinking it would take up too much time to respond. From those that did respond the wealth of free text data accompanying the survey responses added to the richness of the findings, an enhancement to the numerical responses.

Table 14: *Overall Sample Response Rates*

	Professional Qualification			**No prof qual**	**Target survey response**	**Survey Response Rate**	**Interview Response Rate**
	H	**SC**	**L&D**				
Directors	0	1 (1)	1 (1)	1 (1)	3	3	3
Heads of Service	2 (1)	3 (2)	2(1)	1 (1)	8	8	5
Operational Managers	6 (2)	6 (2)	6 (2)	2 (1)	20	20	7
Team Leader / Senior Practitioners	6 (2)	6 (2)	6 (1)	2 (1)	20	18	6
Clinicians / Practitioners / Care Assistants	72 (1)	41 (1)	57 (1)	104 (1)	274	67	4
Sub Total	86 (6)	57 (8)	72 (6)	110 (5)	325	116	25
Total						**116 (36.1%)**	**25**

Key: Health (H), Social Care (SC) and Learning and Development (L&D)

A 47% response rate for an online survey is the best reported response but is only deemed adequate if the sample group exceeds (n=750) participants (Nulty 2008). A

response rate of 36.1% proportionately would appear an adequate response rate for a sample size of (n=325), offering a level of validity and robustness to the findings (Baruch, 1999, Nulty, 2008). In this study, the spread of participants responses across the staff different groups and teams, to provide a variety of opinions and experiences, is equally as important as response rate, and a balanced response was achieved, identified in Table 14.

The response rate for the questionnaire was 36.1% (n=116) out of (n= 325). All (n=25) participants were recruited for the interviews, with a good spread of participants representing the different staff groups shown in Table 14.

Demographic data of the (n=116) questionnaire respondents and (n=25) interviewees were interrogated, focusing on different variables to understand the study sample:

- Age and Gender
- Roles and Positions
- Professional qualification/origin

This is presented separately for the questionnaire and interviews in the following sections.

4.4 Demographic Sample Characteristics

Demographic characteristics for this study were important as they offer a level of information, understanding and significance to the research when considering the different variables in relation to the research findings, such as the participants age, profession, or gender. In this study the participant's characteristics will provide an insight into their understanding of credibility and how it is positioned within the concepts of professional identity and leadership.

Of the target population of (n=325) as identified in Table 15 below, describes the demographic characteristics of the questionnaire respondents (n=116), the table identifies their position held in CYPS. Over 90% of the respondents were female, with a similar proportion holding posts in the multi-agency teams. The data identified that two fifths of the questionnaire respondents described themselves as 'leading a team'. There were thirty job titles identified and these were grouped into six categories, it is

noteworthy that ‘leading a team’ (n=50) is a far broader category than those indicating that they held positions in ‘Management’ (n=16), and ‘Commissioning’ (n=7) as seen in Table 15. These terms will be referred to during the presentation of the analysed findings.

Table 15: *Characteristics of Questionnaire Respondents*

Characteristics	**Category**	**N**	**%**
Gender	Male Female	11 105	9.5 90.5
Age Group	18-25 26-33 34-43 44-51 52-59 60-67	5 10 27 43 24 7	4.3 8.6 23.3 37.1 20.7 6.0
Multi-Agency Team	Yes No	104 12	89.7 10.3
Lead a Team	Yes No	50 66	43.1 56.9
Main Position	Admin Clinical Commissioning L&D Management Social worker	14 33 7 29 16 17	12.1 28.5 6.0 25.0 13.8 14.7

Source: Questions 1-5

The age and gender profile mix of the questionnaire respondents (n=116) showed that 9% (n=11) of the (n=116) respondents were male with 91% (n=105) being female, this is an unusual split within a female dominated healthcare workforce. Most responses came from those participants in the 41yrs to 51year age band as presented in Table 16.

Table 16: *Questionnaire respondents - age and gender*

Age group	18-25 years	26-33 years	34-43 years	44-51 years	52-59 years	60-67 years	Total
Female	5	9	25	40	20	6	105
Male	0	1	2	3	4	1	11
Total	**5**	**10**	**27**	**43**	**24**	**7**	**116**

Source: Questions 1-5

The integrated organisation CYPS's workforce profile is weighted heavily towards the female gender. The CYPS organisation workforce profile at the time of the research presented a gender split of 76.98% female and 23.02% males (HR departments Trafford Council and Pennine Care NHS Trust 2015/16). Most responses (n=9) were received from males were aged between 34yrs and 59 years, with no response from younger males (18-25).

Table 17*: Questionnaire respondents – roles and positions*

	Professional Groupings					
	Clinical Practitioners	**Commissioning**	**L&D Practitioners**	**Professional Clinical Managers**	**Social Work Practitioners**	**Total**
N	33	7	43	16	17	116
%	28.4	6.0	27.1	13.8	14.7	100.0

Source: Questions 1-5

A total number of (n=325) participants were targeted (including the (n=25) interviewees) for this research study, from the CYPS workforce of 800 staff. The sample demographic was in paid employment of the two organisations which formed the multi-agency CYPS, Pennine Care NHS Trust and/or Trafford Council. Participants were invited to voluntarily contribute to the quantitative element of the research, selected because they originated from a health, social care, learning and development or commissioning service background. Table 17, exposes the different backgrounds and roles of the (n=116) respondents. The rationale for selecting these participants

was based on them either receiving or providing professional, clinical, management supervision from and to multi-agency staff within CYPS.

Staff who met the inclusion criteria were invited to participate in the questionnaire but if they chose not to take part they were withdrawn. Staff who were excluded were finance officers, school admin staff, school caretakers, school crossing staff, business analysts, IT officers, school admission staff. Although these staff worked effortlessly to support CYPS they were excluded because they were managed and supervised by functional/technical Heads of Service from their deployed agency and not multi-agency staff (for example business analysts and IT staff were managed by Head of IT and Performance). The staff excluded did not have direct patient/service user contact nor did they receive professional supervision or leadership support or advice from a professional leader other than their functional Head of Service. Multi-agency team secretarial and administrative staff were included as they were managed directly by multi-agency Heads of Service, Operations Managers or Team Leaders who were not trained in admin or secretarial functions.

Some post holders within the cohort of (n=325) questionnaire respondents did not hold traditional clinical, social care or learning and development professional qualifications (e.g., Commissioning staff). However, they managed and supervised multi-professional groups of staff who had contact with service users/patients (e.g., Public Health clinicians), so were included. This reflected the aim of the study to identify evidence of organisational or professional cultural differences, experiences or perceptions of leader credibility related to being managed by someone not originating from a traditional professional background. The gender and professional origin of the semi-structured interview participants (n=25) identified that male interviewee participants (n=8) were weighted towards the learning and development professions (n=4) as can be seen in Table 18. This professional group includes youth workers, youth offending workers and connexions workers. There were no male health professionals interviewed as no male health professionals were employed within CYPS at the time the research was conducted. The respondents with no qualifications (n=4) originated from commissioning department within CYPS with 50% representing each gender as shown in Table 18.

***Table 18**: Interview participant - gender and professional group*

Gender	Health Quals	L&D Quals	Social Work Quals	No Quals	Total
Female	5	5	5	2	17
Male	0	4	2	2	8
Total	**5**	**9**	**7**	**4**	**25**

Source: Questions 1-5

The gender profile and age of interview participants was compared is shown in Table 19 below, again showing that lower age groups were not available within the teams at the time of the research, with the majority were female and drawn across ages 34-59 years similar to the questionnaire respondent profile.

***Table 19**: Interview participant – age and gender*

Age group	18-25 years	26-33 years	34-43 years	44-51 years	52-59 years	60-67 years	Grand Total
Female	0	1	9	1	5	1	17
Male	0	1	3	2	2		8
Total	**0**	**2**	**12**	**3**	**7**	**1**	**25**

All interview participants were coded and their demographics such as age, gender, professional group, and team collated as identified in Table 20.

Table 20: *Interview participant research code and demographics*

Code No.	Personal Descriptors			
	Gender	**Position**	**Qualification**	**Team/Service**
1	Male	Manager	L&D	MAT
2	Female	Manager	Health	MAT
3	Male	Manager	L&D	MAT
4	Male	Manager	Social Work	MAT
5	Male	Practitioner	Social Work	MAT
6	Male	Manager	L&D	MAT
7	Male	Snr Manager	No Prof Qual	SAT
8	Female	Practitioner	Health	MAT
9	Female	Practitioner	Health	MAT
10	Female	Manager	Social Work	MAT
11	Female	Manager	No Prof Qual	MAT
12	Male	Practitioner	No Prof Qual	MAT
13	Female	Manager	L&D	MAT
14	Female	Snr Manager	L&D	MAT
15	Female	Practitioner	L&D	MAT
16	Male	Manager	L&D	MAT
17	Female	Officer	No Prof Qual	MAT
18	Female	Practitioner	L&D	MAT
19	Female	Manager	Health	MAT
20	Male	Manager	L&D	MAT
21	Female	Practitioner	Social Work	MAT
22	Female	Practitioner	Health	MAT
23	Female	Officer	No Prof Qual	MAT
24	Female	Manager	Health	MAT
25	Female	Snr. Manager	Social Work	MAT

Source: Interviewee consent list - ***Key:*** *MAT: Multi- Agency Team / SAT- Single Agency Team*

The qualification referred to in Table 20 include:

- L&D - Learning and Development; Teaching; Youth Worker; Child Development
- Health - Registered Nurse; Health Visitor; Medical Dr; Psychologist; Physiotherapist; Speech & Language Therapist; Orthoptist; Occupational Therapist
- Social Work - Dip Social Work

4.5. Converging Data and Thematic Analysis

The mixed methods approach using a convergent design was adopted, this method allowed for the integration of both strands of the data collected from the questionnaire and the semi-structured interviews. The convergence of the data was performed at the analysis stage for interpretation purposes, to identify similar categories and themes from both data sources, but also to assist with the discovery of any unique responses that may have a significance to the study. The findings of the integrated analysis of the questionnaires and transcribed interviews, focused on three key themes that emerged from the in-depth data analysis.

The themes were generated by the researcher through becoming familiar with the data identifying and recording patterns from across the data sets (interviews and free text collected from the questionnaires) initially, each data collection was analysed separately to produce two sets of findings. The coding process was applied to both data sets, the process was borne from reviewing and revisiting the data (Creswell & Plano, Clark, 2011). Tags were assigned to the data, thus reducing the codes further to afford deeper analysis by developing categories (Creswell & Plano Clark, 2011). A process of triangulation was applied to both sets of findings with the intention to corroborate and integrate similar interview (qualitative) data with the questionnaire (quantitative) data, and/or identify challenging alternative perspectives. This process provided a more complete perspective of whether and how professional identity may influence the credibility of leaders working in an integrated service.

The researcher triangulated the data by listing the emerging themes separately for each set of findings, where there was an agreement across both data sets, or if there was a disagreement or complementary information as these could offer additionality

to the understanding of the research study. Both sets of data were converged to form three overarching key themes and associated sub themes, surrounding the key concepts of the study leadership, interprofessional challenges, and credibility as seen in Table 21.

***Table 21**: Overarching themes and sub-themes*

Leadership	**Interprofessional Challenges**	**Credibility**
Vision & Knowledge	Co-location	Experience
Values	Team Dynamics	Expertise (professional)
Staff Development	Silo Working	Behaviour Modelling
Engaging Followers	Expertise (sharing)	Qualities
Management	Clarity of Roles	Communication

To assist with the differentiation of the quotes, any direct quotes which are attributed to the interviewees are referenced by codes and their professional grouping whereas, the quotes extrapolated from the questionnaire responses (which were included in narrative form by the respondents) are referenced as respondent with corresponding numbers, as explained earlier in the chapter, the anonymity of the respondents was important given the geographical location of the research site and the risk of identity confidentiality. The raw quantitative data collected from the questionnaire responses is presented in a tabulated form, integrated throughout the chapter to add depth of understanding, and richness to the insightful participants experiences shared.

4.6 Theme One: Understanding Leadership

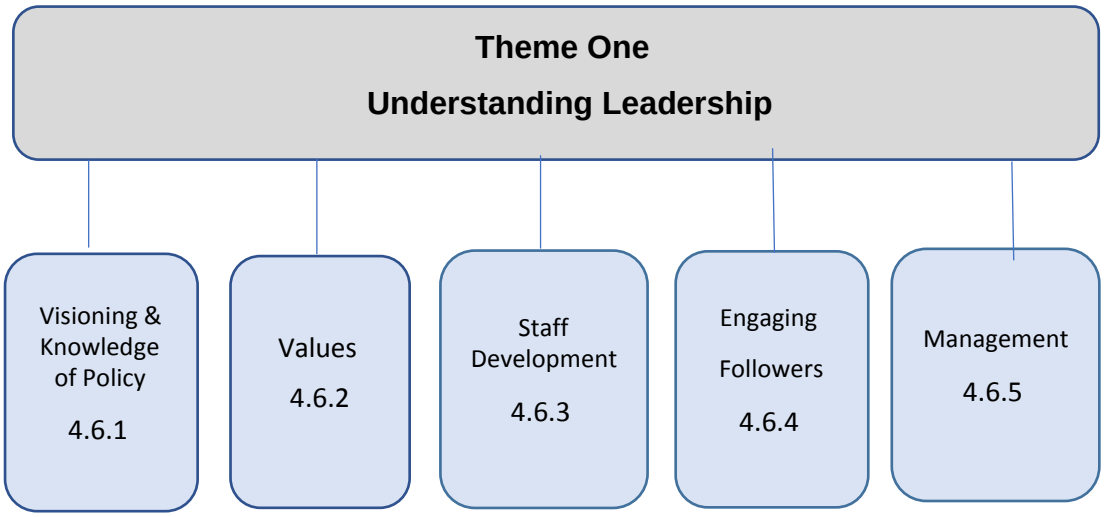
Understanding Leadership was the first emerging theme identified during the analysis of the responses to the questionnaires and the interviews. There was a distinction in the understanding from participants of how leaders are perceived, with some analysis referring to leaders as strategists and others as managers.

The concept of leadership as a phenomenon came through strongly in all the data analysis which resulted in the formation of natural groupings of responses into sub themes under the overarching theme of *understanding leadership*. These sub themes were developed from the emerging evidence, as there was a clear indication of what

the participant's beliefs and perceptions considered to be the key issues/ideas in respect to what made leaders credible. these beliefs and/or perceptions appeared to be based on their theoretical knowledge and their personal experiences of them being either led as a 'subordinate' or in the role as a leader.

Figure 9., presents the overarching theme "Understanding Leadership" and the associated sub themes, each theme will be discussed in turn.

Figure 9: *Theme One - Understanding Leadership*



This theme emerged as an overwhelming concept for many of the participants, indeed, there was a significantly high level of responses which referenced the distinction between strategic leaders and managers, the repetition of the use of the terms 'strategic leaders' and 'managers' was found in both the quantitative narrative free text and qualitative analysis. The references to the two distinct concepts i.e., strategic leadership and management were articulated through a range of personal examples, experiences, in addition to the participant's expressing and demonstrating their knowledge of leadership and management theory. There was a significant amount of evidence that reflected their attitudes, values and beliefs when referring to the subject area of leadership and management. The subthemes that supported the overarching theme enabled the researcher to gain a clearer understanding of leadership, as several participants described leaders as being strategic, by describing leaders as people who possessed a knowledge and understanding of public and local policy. The

analysis of both methods of data collection continued to demonstrate a perception that successful leaders have an ability to interpret key messages for organisational change purposes.

The participants in their responses also described strategic leaders as being visionary with an ability to convince and persuade others to operationalise an organisation's strategic plans. The analysis found several references to 'good' strategic leaders being empowering. Empowering as a concept was explained by participants by suggesting that those leaders who were committed to staff development to deliver the vision were credible leaders. Another key emerging message from the analysis was the need for leaders to be motivational and engaging which was considered by many participants as necessary to create a culture which produced committed followers.

Merging the findings from each of the relational concepts during analysis allowing for the formulation of the sub themes enabled the researcher to identify what the participants understood to be the key influencing factors which contributed to good and/or credible leadership.

4.6.1. Visioning and Knowledge of Policy

The findings were indicating that credible leaders understood the impact of government and local policy on services and how these political edits influenced the configuration of service delivery models. There were several references made in the interviews and the free text analysis to leaders acting as transformational agents and their success at persuading their subordinates/followers was wholly dependent on the strength of staff engagement strategies adopted by leaders. A key finding that emerged as a critical factor to a leader's success was their ability to understand and interpret national and local policy and how this would be applied to service provision. This ability to interpret national, regional, and local policy would be an important factor for leaders working within a multi-agency environment as there is a need to juggle and manage the competing political and professional priorities. The Council is politically driven with the Executive being elected members whereas NHS Trusts have a greater emphasis on quality within a financial context, therefore, the ability of leaders to understand any policy implications and the potential impact on service provision within the different organisational cultures is significant for leaders of integrated services.

One interviewee felt that understanding policy and risks was a fundamental part of a leader's role:

> *"Having the ability to interpret ideas and new initiatives and being able to convey this to people…. what it is and what it means from an organisational perspective and from a strategic perspective"*

(L&D Manager 3)

This was reinforced by another suggesting that to be a successful leader from a credibility perspective, they need to have a repository of knowledge and understanding to inform their decision making:

> *"……but then to be a good credible leader… it is being aware of all the different theory, policies, practice, research, and having the knowledge about how that is applicable to what services you are leading to underpin your judgement"*

(Social Work Practitioner 5)

Policy and practice knowledge which is underpinned with theory was thought to equip leaders to use a range of management tools to enable them to transform services and inform their decision making when leading major change programmes. One respondent noted:

> *"…. he led us through some very difficult organisational changes because he knew the tools to use, engaging us and keeping us informed at all times- I thought this was very important."*

(Questionnaire respondent 49)

There was significant reference made in respect to the ability of leaders to not only describe the vision but also explain and be clear about the journey towards achieving the outcomes, this was articulated by a health manager who said:

> *"To have good leadership is about being able to map progress so that you do not just know the beginning and the end, but you know how you're going to get there"*

(Health Manager 24)

This was reinforced by the free narrative from the survey:

"They have true vision and have good ideas about how to get everyone on board to make this vision happen".

(Questionnaire respondent 82)

The key influencing factors associated with having a good experience of leadership are presented in Table 22. Having a clear vision only received (n=12) responses from 10.3% of the cohort. Notwithstanding there was evidence that a leader's ability to communicate the vision played a major factor in leadership credibility too with (n=27), 23.3%, placing communication within the top five criteria for positive experiences of good leadership. Communication as a quality will be considered later in the chapter.

Table 22: *What made your experience of good leadership good*

	N (N=116)	%
Listening	40	34.5
Supportive	33	28.4
Staff empowerment	29	25.0
Communication	27	23.3
Strong knowledge base	17	14.7
Felt valued	15	12.9
Open and honest	15	12.9
Approachable	14	12.1
Fair	14	12.1
Offers praise	13	11.2
Clear vision	12	10.3
Staff development	11	9.5
Role model	8	6.9

Source: Question 8

The findings identified a need for leaders to not only sell a vision but also to be clear about the process of implementation. The analysis discovered the need for staff to know how services are affected because of organisational change but also how staff are personally affected by the introduction of changes to the organisation, indicating it directly affects team morale. Further evidence emerged supporting the notion that leaders needed to possess a comprehensive knowledge of policy impact on service areas. This knowledge and understanding of policy were identified as an important issue as illustrated in Table 23, which identifies what makes a leader credible. The

findings suggest that this was a key influencing factor, particularly when leaders are attempting to engage staff in the process of change: this was articulated by a social work practitioner who shared their personal experience of working with their leader:

> *"… What made this experience good was: she was intelligent and understood the policy issues for the service, she knew her stuff and shared her understanding with us."*
>
> *(Non-Professionally Qualified Officer 23)*

This interviewee went on to reinforce the importance of leaders having the ability to explain the organisation's vision to staff but also for the leader to share the journey of change too and the expectations but allow devolved autonomy to achieve the outcomes.

> "……. *what gives me confidence in a leader is… as well as someone who puts across a clear vision and communicates some (not all) ideas about how to get there. I would describe this as someone who 'sets the ball rolling' but puts trust in others to steer it in the right way, because they have given the tools, confidence and support to enable them to take it in the right direction, at the right pace. "*
>
> *(Social Work Practitioner 21)*

During the integration of the two data analysis sets, there was a significant correlation between the findings referring to the notion of the importance of leaders being visionary and possessing an understanding of strategy and communicating the direction of the organisation. This was believed to be key feature in respect to the credibility and success of a leader. The data analysis offered several references to this perspective.

> *"……. they explained the bigger picture and not just what you needed to know but how to get there"*
>
> *(Questionnaire respondent 45)*

> *"Their vision of how they wanted to take things forward and involve staff in that process. This meant making necessary changes to practice/procedure against a backdrop of why this was being done."*
>
> *(Questionnaire respondent 24)*

"Leadership is really about achieving an outcome and demonstrating how you can get things to happen…."

(Health Practitioner 22)

The view that a credible leader needed to understand the political environment to give the appropriate messages was reinforced by a manager from Learning and Development who stated:

"…….as a leader, you need to know how to read those environments and understand the people that you are working with, understand the message that you are trying to give if you are trying to change something then you need to understand the change process and what needs to happen..."

(L&D Manager 6)

There were also recurring patterns of evidence that referred to the need to achieve 'buy-in' (*sic*) to realise the vision. This was articulated in the free text of the questionnaires on several occasions:

"…... *Some leaders don't know how to get 'buy in' as they don't realise what's important to the different professionals to gain their loyalty"*

(Questionnaire respondent 96)

"…. A leader is somebody who is clear about the direction of travel…."

(Questionnaire respondent 22)

"…. the best leaders are confident 'teachers' and are able to motivate and inspire."

(Questionnaire respondent 67)

One respondent shared their personal experience of leaders translating the vision into actions:

"……*my experience of good leadership has come when they ensure that staff are aware of what is expected of them…."*

(Questionnaire respondent 44)

A respondent commented positively on the support they received from their leader to achieve the vision through monitoring:

> *"……my leader gave me direction and kept me on track, made me be accountable and required me to consider the political climate and the bigger goals of the council…"*
>
> *(Questionnaire respondent 33)*

There were several respondents who referenced their high regard for their leaders and shared their positive experiences. A particular example was shared during the research interviews that helped to explain how policy can sometimes be at odds with professional beliefs. This interviewee provided a powerful example that highlighted the risk to a leader's credibility, when there maybe conflict present between decision making, a child's interest and policy guidance

> *"We had a child whose placement broke down and they needed to go back to a foster placement and there was also a foster carer who the child had previously been placed with, from birth for several years. We thought the best thing for that child was to go there. The difficulty was that foster carer was already full, so the decision had to be made, do we allow this foster carer to go over numbers.... now for me that decision comes down to what is the best decision in the interest of the child, I know how important that attachment is for the child and so on. It was decided as Ofsted would look poorly on us as an organisation if the numbers of children placed with carers was over the agreed criteria/amount, but for me that comes second to the child's best interests, but it was decided to comply with Ofsted's rules"*
>
> *(Social Work Practitioner 5)*

This suggests that for leaders to be credible they should understand policy and implement it according to the guidance. The interviewee appears to argue that for leaders to retain credibility, they may need to go beyond their responsibilities to the organisations if the policy application is too rigid and conflicts with the interest of the children/ the interviewee appears to be proposing that the leader's professional judgement should overrule the policy requirements. The balancing of policy and

professional judgement is the day-to-day business of strategic leaders in multi-agency services but the collision of the two dimensions can certainly impact on the leader's credibility.

This interviewee explained further their concerns about leaders of organisations erring on the side of caution when applying policy over the interests of the service users:

> *"…(its) possible for an organisation or a leader to be part of a wholesale change, and to function in such a way- that what you do is good for the kudos of the organisation- but not actually delivering what you should be delivering for the service users*
>
> *(Social Work Practitioner 5)*

A further response highlighted the need to manage the policy implications from a service user perspective:

> *"…Even if they had to make decisions that went against the general consensus and it seemed to go against policy, but the eventual outcomes were beneficial for the organisations and people it served, it must be worthwhile…"*
>
> *(Questionnaire respondent 45)*

The interpretation suggests a leader of multi-agency services would need to ensure flexibility in relation to the application of policy to sustain staff support to policy change. Ofsted regulations are extremely rigid and there is little room to manoeuvre for interpreting other than as read. Therefore, the challenge maybe a difficult one to resolve and may require a level of expertise or professional knowledge and experience (for example in public law in respect to care proceedings) to defend decisions in relation to the application of specific policies.

Further findings emerged from the data analysis relating to the role of leaders in respect to policy application having negative implications for services, which results in staff perceiving leaders as less credible: one interviewee who came from a learning and development professional group reported:

> *"There is a lot of short-term stuff that is going on and I do not think people have got the opportunity to really, properly see things through from A to B that does*

not happen anymore- it is a bit like for example 'Transformation' that is happening now, yes, transformation is a good idea in principle but it should not be driven by austerity, and leaders try to disguise cost savings as transformation…."

(L&D Manager 16)

This sub-section of the overarching "*understanding leadership*" theme has shared a number of direct and survey quotes that have supported this emerging finding from the integration of the data. This finding clearly places the influencing factors of being *visionary* as a leader and possessing a good sound *knowledge of policy* and an *understanding* of how policy may affect services core to a leader's credibility. Interestingly, political awareness did not rank highly in the quantitative element of the data, it achieved only 10th place from a total of 11 places and only 8.6% (n=8) (see Table 4.8) below identifying qualities required to be a credible leader.

Leaders with an ability to share the vison and possess the knowledge is important, but there was also clearly evidence that emerged that reinforced a leader's credibility if they demonstrated to staff the application and the impact that any policy would have on service provision and service users- without this there was a risk of low 'buy in' to the vision.

The findings indicated the importance for staff to have an understanding of the direction of travel of the organisation, what this this would mean for both service users and the employees. This would be all the more complex within a multi-agency service as there are two different policy drivers. There would be a need for leaders to align two organisational strategies to create a cohesive integrated strategic plan. This plan would need to set out a programme of change that didn't create confusion for staff working in a multi-agency service. It would appear from this finding that the challenge would be for any leader of a multi-agency service they would need the ability to make sense of the complex policies, create an integrated strategy with a single implementation plan to ensure clarity of the delivery of the objectives. Any such leader would have to have a good grasp of organisation politics both culturally and economically.

***Table 23**: What makes a leader credible when leading a team*

	Managing a team		Total
	Yes	**No**	**N=116;**
Communication	33	34	67 (57.6)
Trust	26	38	64 (55.1)
Honesty	21	38	59 (50.8)
Experience	20	25	45 (38.7)
Making Decisions	25	18	43 (37.0)
Listening	12	25	37 (31.9)
Managing Relationships	21	12	33 (28.4)
Confidence	15	10	25 (21.6)
Seeing ideas through to the end	11	13	24(20.6)
Political awareness	6	2	8(6.9)
Professional qualifications	2	5	7 (6.0)

Source: Question 6,7,8,9

During analysis, there appeared to be a variance between council and health service respondents, with health professionals significantly more likely to view a leader's credibility being stronger if there was a level of 'political awareness' present (5/33 vs 2/59). The quantitative responses ranked 'political awareness' as the 10th from a list of 11 influencing factors with only (n=8) 6.9% scoring this as an indicator of leadership credibility, notwithstanding, that knowledge of policy was significantly evident in the qualitative data.

4.6.2 Values

When considering what was deemed to influence the credibility of a leader, their values emerged as another sub-theme. The participant's responses referenced the importance of a leader's value base as being relevant to the notion of credibility, during the integrated data analysis there was evidence to suggest that to be credible it was necessary for a leader's beliefs to be aligned to the values of the organisation. There were many examples given by the participants that were borne from their personal experiences. Some of these experiences were gained from directly witnessing conflict between a leader's values and that of the values of the employing authority. This was noted specifically in relation to the area of decision making by leaders in respect to their application of policy, especially during times of austerity, as referred to in section

4.5 (a) above. The responses both from the interviews and the questionnaires articulated a need for a strong professional voice being positioned in an organisation. There was evidence of concerns in respect to professional representation especially during times of economic prudence. There were concerns about the risks that may ensue if low capacity and capability and there is no strong professional presence at a senior level. There was a widely held perception that austerity could compromise the quality of the care that children and young people received, and it was suggested that a leader with a professional background may have a repository of knowledge, experience and evidence to draw on to secure additional resources for those children and families who are at greater risk. There was also evidence that a strong voice offered a level of professional presence in an integrated organisation.

This was articulated by several interviewees from all the three professional groups learning and development, social care and health.:

> *"... how do we ensure that we get the same level of priority and support from the lead organisation (council), there are too many senior leaders from a council background – our professional views may not be considered if they don't understand our professional concerns…"*
>
> (*Health practitioner 22*)

Another respondent spoke of their concerns at the lack of interest in their professional work as they perceived that the senior leaders were bias to their own professional agenda, she said:

> "…. *I understand that safeguarding children is the top priority and we all* get *that, but a couple of senior staff don't see our role as important as the social worker - we do a lot to stop the kids from arriving here…but I worry that we are becoming to social services oriented"*
>
> *(Health Practitioner 9)*

The particular female interviewee working in a multi-agency team as a youth worker (L&D) spoke positively of their leader's values:

> *"…. she had a vision for the service that she was prepared to fight for, she was prepared to challenge poor decisions by her managers that were having a negative impact on the service, she was creative, acted 'out of the box' and had a 'can do' attitude, she was prepared to say and act on what she thought was right, even if it meant challenging the politicians, she had integrity, she was not hierarchical, she worked hard…."*
>
> *(L&D Snr. Manager 15)*

This interviewee's leader was from a different professional background than the interviewee, she came from a social work background. This is interesting as this may suggest that a leader's value system and not their professional expertise is the essential factor in a leader's credibility and this set of values combined with their skills at managing people and managing relationships are the success criterion and not their professional training or qualifications.

The connectivity of individual leaders and their staff could result from them sharing the same values, such as the same moral values or ideology which reinforces the perception from a follower (employee) that a leader has a high credibility rating.

Some of these issues were considered by the participants as part of the questionnaires and during the interviews. In particular, the integration of the data found that most interview participants perceived that a leader's value system served as a key component to them being both effective and credible as a leader. This assertion was overwhelmingly supported by the qualitative data:

> *"Leadership skills… I think values are very important, along with vision I believe values are critical"*
>
> (*L&D Manager 20*)

This view was supported by other interviewees, regardless of gender or rank, a senior leader in learning and development shared her reflections:

"A leader has to be genuine, as people can see through them, if a person is not being genuine with their values, their actions might not follow. So, it is something about…. your values and what you think is important that makes you a successful leader,"

(*L&D Snr Manager 14*)

Again, this view was shared by another respondent but this time it was in their capacity as a follower and not as a leader although they too were a senior leader in the organisation

"I need to agree with their (leaders) values and support their values, what they are about and what they want to achieve; even though I might not agree with them in relation to their advice, it does not mean I do not respect them as a leader".

(L&D Manager 6)

There were also examples of staff reflecting on their personal experience when the leader's values were out of line with the subordinate:

"…she had a lack of insight and little compassion, she was removed from ground basic working day, dictator type personality and one who is not self-aware or compassionate towards others…."

(Questionnaire respondent 76)

Another respondent noted in the survey of the poor values displayed by one of her previous leaders as being devaluing when she recalled her personal experience of her leader's behaviour towards herself:

"Being spoken to in a negative manner, especially in front of other colleagues".

(Questionnaire respondent 76)

It became evident in the data analysis that an emphasis on being client/patient focused demonstrated a level of altruism that was perceived to contribute positively towards a leader's credibility, this was illustrated frequently during the interviews and referenced within the questionnaire free text. A senior social worker offered their view:

"…I always say to my team, the child's needs come absolutely first, and I think over time it comes out in the decisions that you make and the people you end up employing in the service - I think you end up making a team in your own image"

(*Social Work Manager 4*)

Another manager reinforced this by articulating their need to improve outcomes for children and young people:

"…I want to make a difference to the service that I am managing, and if I put that at the core then how do I make that difference, what do I need to do to make that happen - I believe that services that I manage should be striving to be the best service of all time both in terms of how you deliver it and the service user at the end of (it)...."

(*L&D Manager 3*)

He continued to describe what a credible leader looks like to him:

"From my perspective if I am looking at someone as being a credible leader it has to be somebody who I believe what they say, I agree with their values and support their values, what they are about and what they want to achieve, even though I might not agree with them, it does not mean I do not respect them as a leader".

(L&D Manager 3)

4.6.3 Development of Staff

This sub-theme was extremely strong in its presence as there was many references scattered throughout the interviews and the questionnaire narrative citing examples and experiences from the participants. These references appeared to inform their perceptions and beliefs of a leader's success, suggesting that a leader's ability to develop staff to take responsibility and operate autonomously was a significant influencing factor in leadership credibility.

A commissioning officer described their personal experience of being led:

"The leader in question was happy to devolve responsibility, whilst ensuring that they were available to contribute if required. They also ensured enough time was given to ensure that the task was clearly specified and scoped out, with clear definitions, boundaries and limitations"

(Non-Professionally Qualified Officer 12)

Another reference to support the sub- theme of developing and empowering staff was proffered by a social worker who was being managed by a health professional:

"My experience of a good leader was someone who gave me autonomy within my role, recognised my skills and supported me to find opportunities for further development. They provided me with a good balance between advice, support and challenge. They also helped me to acknowledge my achievements and pushed hard for further progression and quality"

(Social Work Manager 4)

The issue of devolved autonomy and staff development shone through teach iteration of the data analysis and was supported by a plethora of references to illustrate the strength of the participant's beliefs that staff development was critical to the credibility of leaders in a positive sense, a female health practitioner revered previous managers who had delegated responsibility to her:

"Managers who I have worked with who in my opinion have been good leaders have allowed and encouraged self-direction – they have expected high standards and would give challenge and support for this to be achieved…"

(Health Practitioner 9)

This was reinforced in the survey responses; indeed, the following response was strong however, the discourse reference of being **'allowed'** was quite stark as a descriptor contained within this perceived statement of empowerment:

*"My manager **allowed** me to try new ways of working and evaluate the learning for these experiences rather than dictate what I should do then criticise*

unsuccessful outcomes. They had faith in me and advertised my successes at every opportunity.

(Questionnaire respondent 38)

A contrasting and possibly less provocatively worded but equally articulated response from a survey respondent that supported the significant findings, described their positive experience in respect to the development of staff being key to a leadership credibility:

*"My experience of a good leader was someone who gave me autonomy within my role, recognised my skills and **supported** me to find opportunities for further development. They **provided** me with a good balance between advice, support and challenge. They also helped me to acknowledge my achievements and pushed hard for further progression and quality."*

(Questionnaire respondent 66)

Further evidence emerged from the data analysis which provided a strong indication that leaders were perceived as supportive when delegated responsibility to junior staff whilst ensuring the responsibilities were enabled within a 'safe' learning environment. This was eloquently articulated by a health practitioner:

"I think the best experience of leadership is when I have been supported and encouraged by the leader of our service to make decisions and take responsibility myself with the clear understanding that if I were to make a mistake or if there were any issues, I would be protected and supported

(Health Practitioner 9)

This finding was corroborated in the survey offering a level of validity to this perception:

"…this manager had an excellent balance of authority and genuine interest in your development and skills, to achieve without taking the success away from you. This manager had very, very high expectations but they were still realistic and proportionate as well as encouraging and challenging. Allowed you to make mistakes and see through your ideas if you could prepare and present your ideas

and augments even when they may not have agreed they were willing to let you try out and trust your and your team's decision"

(Questionnaire respondent 63)

There was a suggestion that whilst delegated authority maybe a positive experience, there remains a need for strong governance to support reflective praxis. This was illustrated by a social work colleague who expressed their experience positively but suggested a cautious approach to ensure there was a degree of protection to enable personal development to occur:

"…What is important, is to be trusted to do your work with clear direction from above but with the understanding that you won't be 'hung out to dry' (sic) if there are any issues."

(Social Work Practitioner 21)

Findings suggested that those staff in management positions were more likely to believe that *staff development* was a key influencer in them having good leadership experiences. From the survey however, only identified 9.5% (n=11) respondents perceiving this as contributing factor to their positive experience of leadership, therefore this should be cautiously interpreted with such a low number of responses.

4.6.4 Engaging Followers

As a sub-theme *Engaging Followers* informed the overarching theme of *'Understanding Leadership',* these findings explained the importance of how leaders ensured that there was 'buy in' to the vision of the organisation.

The need for leaders to engage and motivate staff emerged as a key contributing factor to leaders being successful in their ambitions for the organisation and how this was perceived by followers (employees) in relation to leadership credibility.

A manager commented on his own leadership responsibilities:

"Whatever the outcome is, even if it means significant changes for your organisation, then it is about how you communicate it as a leader and how you implement that change and if you can get the people within your organisation to

help you to actually deliver whatever changes that need doing…then it means that they can be part of taking the services forward into the new way of working "

(L&D Manager 1)

A commissioning officer without a professional background shared their views of leadership in respect to staff engagement:

"Leadership for me is about being able to deliver that message so it actually engages the staff and they do it for themselves"

(Non-Professionally Qualified Officer 17)

Another interviewee from a health management background offered their view:

"*Leadership is motivating your staff but almost energising the vision of Trafford so that they are on board with and can do it themselves- not with anyone standing over them and making them do it, but by being part of the process type thing*"

(Health Manager 2)

The survey free text suggested that engagement of staff was important to enable staff to feel involved in-service developments:

"A leader must be equitable, have the ability to engage people and must recognise the equally important contribution that all people, at all levels within the organisation…."

(Questionnaire respondent 22)

Interestingly some participants perceived leadership as a set of skills that were additional rather than integral to their job role this was a response received from a questionnaire respondent:

"I have come to the conclusion through general experience, being a leader is something you do as an addition to your job, but it is a fundamental skill set and it is something that you have to work at and develop."

(Questionnaire respondent 57)

The need to engage through effective communication was deemed to be one of the highest-ranking qualities expected in a leader, with (n=67) 57.76% of participants indicating the ability to communicate effectively was one of the most important qualities of a credible leader as presented in Table 23.

The most frequently cited reason by participants which contributed to low levels of satisfaction with the current multi -agency management structure in CYPS was poor communication. A lack of and ineffective communication was referenced, and examples provided including lack of information and communication from management to direct care staff.

A powerful statement from a questionnaire respondent identified poor communication as being the reason why the leadership performance impacted on their personal development:

> "…. *I found it very disheartening to try, based on very limited information, to respond to a task to the best of my ability, only to be told that it was wrong each time I presented my results. Often, these conversations would result in new information being shared in relation to the tasking, which would again skew the task. Within a couple of weeks of receiving the tasking, conversations about the task ……in general it tended to result in a broader discussion of whether I was "up to the job" when in fact the issue was really about poor communication, poor delegation and lack of trust and understanding…."*
>
> *(Questionnaire respondent 14)*

Another Questionnaire respondent shared their dissatisfaction at the number of meetings held to communicate the organisational changes, they stated:

> *"...there are too many meetings, there's a meeting for another meeting and then a meeting for that meeting..."*
>
> *(Questionnaire respondent 32)*

4.6.5 Management

This sub theme of management was supported by an overwhelming amount of participant responses. An understanding was offered from some of the participants that leadership and management were clearly two distinct concepts, others perceived

leadership and management to be the same. The references that follow serve to illustrate the views of the participants and their understanding of how management as a concept is positioned in the context of leadership.

A manager in Learning and Development gave his view:

> *"I think there has been lots of debate about the difference between a leader and a manager and I do not think there are two distinct positions."*
>
> *(L&D Manager 3)*

He went onto explain further:

> *"…I do think a leader sometimes can be part manager and sometimes a manager is part leader as well, but in terms of management it is about managing everyday business, to me management is about looking at practice, looking at how the service is delivered on an everyday basis and making sure that there is compliance by meeting targets etc….."*
>
> *(L&D Manager 3)*

Another participant from social care also considered the idea of leaders and managers and saw these as being interchangeable by inferring that there are two different skill sets or qualities required:

> *"Management can be an element of leadership and leadership can be an element of management. I know people who are managers, but I don't see them as being good leaders and vice versa"*
>
> *(Social Work Practitioner 21)*

A health practitioner struggled to describe the definition of a good leader in respect to the qualities or skill set required to lead to success:

> *"At the moment, I do not understand what defines a good leader, but I think that has been lost over time – I do not know how to define a good leader in this day and age that we are in…."*
>
> *(Questionnaire respondent 2)*

A manager who heralded from a non-professional background believed managers and leaders played two different roles, one as operational and one as a motivator he explained:

> *"I think you can be a manager if you just tick boxes and deliver, but in order to be a leader you have got to take people with you and enthuse them and motivate them and enable people to believe in themselves as in where you are going and know what it is you want to do"*
>
> *(Non-Professionally Qualified manager 7).*

The final quote in this sub section refers to an interesting assertion which seems to form the basis of a significant number of findings where the term management and leadership were either distinct from each other as concepts or interchangeable, the quote was extrapolated from the questionnaire free text:

> *"There seems to be a focus on management rather than leadership and I wonder whether people are coached in management skills rather than leadership skills".*
>
> *(Questionnaire respondent 29)*

Approximately two fifths of the survey respondents chose 'Experience' and 'Making decisions' 45% and 43% respectively, when selecting what they believed made a leader credible. Experience and decision making as key skills or qualities could be perceived as both transactional and transformational and align with both theoretical concepts of management and leadership. Interestingly, during the cross-cutting analysis of data comparing professional groups and the question responses there was some evidence which suggested that social workers placed a greater emphasis on 'Making decisions' as an influencer on a leader's credibility

These findings in relation to management are interesting as they position management in a transactional context with an emphasis on performance, business management and target driven, whereas a strategic leader is seen as inspirational, transformational and driving change which results in quality improvements. These findings need to be considered within the context of the concept of professional identity and whether a professionally trained manager is considered to be more credible than a leader who demonstrates a strategic style of leadership but has no formal management or

professional training. The evidence requires further consideration as to whether a greater credibility rating is proffered to either a ‘pure manager’ or a ‘strategic leader’ or indeed someone who has a blend of both management skills and strategic leadership qualities which may strengthen their credibility as a leader in an integrated public-sector organisation.

4.7 Chapter Summary

This chapter presented the demographic data relating to the (n=325) questionnaire and the (n=25) interviewees. There was a need to consider the positionality of the researcher as being an insider. By ensuring reflexivity and objectivity and acknowledging their position in the research process, the risk of bias is reduced Chammas, 2020). The response rate to the questionnaires was 36%, this was a reasonable response rate proportionality and offered validity to the results (Nutty, 2008). The analysis of the combined data from the (n=116) questionnaires and the (n=25) semi structured interviews generated three overarching themes, Leadership, Interprofessional Challenges and Credibility and each having five related sub themes., and this chapter focused on the theme of Leadership.

The findings produced new knowledge, which will contribute to leadership theory in respect to integrated services. The need for leaders to have a strong professional voice, when leading integrated services. This was not because this is a behaviour expected from all leaders, the evidence gave rise to concerns that an integrated service may reduce professional. Influence. A related finding to the ‘strong professional voice’ requirement for future leaders of integrated services is the evidence that leaders must have experience and be informed decision makers these attributes gained 45% and 43% of responses respectively A further notable finding from the leadership theme was the issue of leadership and management being perceived as two distinct concepts this is interesting, as despite the contemporary leadership theories promoting distributive leadership, the evidence is that there continues to be perception that not everyone is a leader. These will be discussed in more depth in Chapter Six, the remaining overarching themes, Interprofessional Challenges and Credibility will be presented in Chapter Five.

Chapter Five - Interprofessional Challenges and Credibility

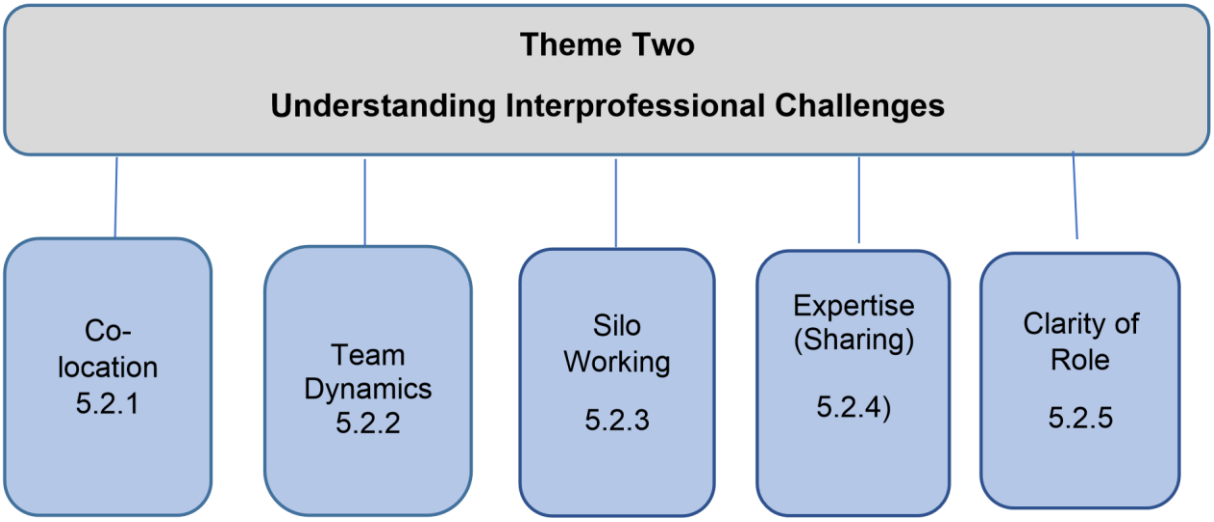
5.1 Introduction

The previous Chapter presented the findings of the integrative thematic analysis of the data for the first overarching theme, Leadership. This chapter will present the remaining two themes of Interprofessional Challenges and Credibility. Each of these themes have a set of five sub themes which will be presented to offer an insight into the beliefs and perceptions of the respondents working in integrated services with respect to what needs to be considered when selecting future leaders of these services.

5.2 Theme Two: Understanding Interprofessional Challenges

Theme two focuses on the emerging findings presenting the participant's understanding and experiences of inter-professional challenges within an integrated team. The associated sub themes are presented below in Figure 10. Then each subtheme in turn will be examined offering a more in-depth understanding of the participants perceptions of Interprofessional working, challenges and how this can impact on the integrity of the services.

Figure 10 *Theme Two: Understanding Interprofessional Challenges*



5.2.1 Co-location

The issue of co-locating services was considered by participants to be key to improving working relationships between multi-professionals. This was an opportunity for team

members to support each other, improved inter- professional communication, sharing information and providing an improved understanding of each other's roles – all these benefits of colocation was believed to be beneficial as the risks to children and young people would be reduced. The sharing of workspace identified several challenges as borne out by the emerging findings below:

Comments indicated that perceptions changed over time as people adjusted to different working spaces, although some found it difficult to adjust:

> *"…when we first moved in there was quite a lot of resistance from health staff, things like, we couldn't access the same electronic network, the social care staff are not very clean (kitchen and dining areas were not left tidy or hygienic, but as time has gone on, it is really nice to see them sharing info and interacting over lunch."*
>
> *(Health Practitioner, 22)*

> *"I do not like this open office, rent a desk type of arrangement it's better being in offices with staff of your own profession"*
>
> *(Health Practitioner 8)*

> *"…I found multi-agency exciting but when we moved into shared space, I found it hard to adjust as it was like a new language and rules to learn and getting used to health staff being very much organised"*
>
> *(Questionnaire respondent 48)*

There were further positive responses from respondents in respect to one of the benefits of integration was co-location, one such respondent highlighted the improvements made by collocating they stated*:*

> *"...integrated working but maybe you focus on the things that have actually made it better like co-location and partnership working as opposed to some of the things we cannot really deal with like IT systems not being shared…."*
>
> *(Questionnaire respondent 74)*

Another respondent commented on how vibrant and informative colocation can be, they shared their views that*:*

"The co-location for me has its advantages when we get that right mix of people and the opportunities it creates to get that ad hoc conversation to get somebody's expert opinion in their professional areas is fantastic…"

(Questionnaire respondent 93)

A social work interviewee added that sitting with same professional groups but within a co-located area doesn't offer the best opportunities to form relationships, he stated that

"…. if we are sat in our teams within our co-location, we are reducing those opportunities to walk across to another team where you do not really know people as well".

(Health Practitioner 8)

An interviewee from a non-professional background suggested that if she was a team leader, she would organise the teams slightly differently but would support colocation:

"I would have some level of co-location, I would not have people in their professional teams, I would have it all mixed up a bit maybe teams focusing on specific areas of work or projects"

(Non-Professionally Qualified Officer 17)

5.2.2 Team Dynamics

An interesting finding that emerged from the integrated data analysis showed a propensity towards positive experiences of working in a team - once the team was established but at the beginning of the team development there could sometimes be fraught experiences.

Social workers suggested that:

"…as long as all of the team are aware of their boundaries and understanding of work ethics then things will work out fine…"

(Social Work Practitioner, 21)

And the ingredients to good team working was:

> *"Having mutual respect for the team members', trust, confidentiality and sharing information –makes the team work well together."*
>
> *(Social Worker, Practitioner 5)*

Further observations were made from a survey respondent who commented on the team dynamics and how these contributed to the team working successfully:

> *"…team members who had poor time management - no self- awareness – and…. members' who don't appreciate the impact of their behaviours on a team can cause upset in the team…."*
>
> *(Questionnaire respondent 89)*

A Social Work Manager spoke of how his experience of working within a multi-agency team and being managed by a health manager was a positive experience:

> *"I have experienced: well-structured team meetings where everyone is encouraged and able to contribute, and their input is valued and respectfully challenged when necessary".*
>
> *(Social Work Manager 4)*

There was also evidence from the questionnaire respondents that suggested that team dynamics were predicated on how their leaders managed the team the following illustrations show different experiences:

> *"The team leader had a fair and a flexible approach, making sure all members were being treated the same. This helped the team to function productively"*
>
> *(Questionnaire respondent 54)*

> *"There were chaotic working patterns of a particular team member working a lot out of office hours and expecting others to do the same…"*
>
> *(L&D Practitioner 18)*

"I have also witnessed times when a manager has addressed a difficult issue with a team member in front of the whole team and this has been distressing for everybody."

(Questionnaire respondent 66)

The contributions to the workload by team members and their scope of responsibility also played a part in effective teamwork, a respondent to the survey noted:

"All team aware of boundaries and understanding of the work ethic"

(Questionnaire respondent 102)

A social work team member commented that relationships between managers and team members can affect the team dynamics adversely:

"When managers bring personal relationships with the team into the workplace and all staff are not treated equally or expected to have equal workloads".

(*Social Work Practitioner 21*)

There was a concurrence of this opinion by a questionnaire respondent who strongly felt the need to ensure that there was no place in the workplace for close personal relationships – as it had an adverse impact on the staff within the team, they described a personal experience to support their opinion:

"I think that a Team Leader should not be working with close friends as I have found it difficult to approach them when they are chatting about home life, it feels like you are intruding, and often you clearly are!! So, you either wait for a gap if possible, or risk the cold headmistress treatment…!"

(Questionnaire respondent 47)

The following direct narrative from the free text of the questionnaires provides an illustration of the respondent's views when they were asked about leadership in respect to effective team working:

> *"They broke confidentiality and were prone to picking 'favourites and non-favourites'" …!"* *(Questionnaire respondent 5)*

The perception of favouritism continued to be observed in several responses, ranging from not being fair to using divisive behaviour to cause conflict.

One respondent reported that a team leader did not behave fairly:

> *"They are not fair and treat favourites differently!"*
>
> *(Questionnaire respondent 65)*

> *"They 'set one worker against another' and left them to resolve conflicts in the team" …!"*
>
> *(Questionnaire respondent 89)*

> *"Favourites were acknowledged and thanked for doing good work, those not in 'gang' were never acknowledged." …!"*
>
> *(Questionnaire Respondent 103)*

The analysis of the questionnaire data as Table 24, shows the reporting of favouritism by 4% of managers and 16.9% (n=11) of non-managers to be an issue when identifying contributing factors of a poor leadership experience.

***Table 24**: Experience of poor leadership and what made your experience poor*

	Managing a Team		
	Yes (N=50; %)	No (N=66; %)	Total (N=116; %)
Poor communication	19 (38.0)	20 (30.8)	39 (33.6)
Not listening (marginal)	7 (14.0)	17 (26.2)	24 (20.6)
Autocratic behaviour	11 (22.0)	9 (13.8)	20 (17.24)
Favouritism	2 (4.0)	11 (16.9)	13 (11.21)
Poor knowledge base	6 (12.0)	6 (9.27)	12 (10.34)
Not available (marginal)	8 (16.0)	4 (6.2)	12 (10.34)
Not supportive	6 (12.0)	5 (7.7)	11 (9.48)
Other			

Source: Questions 1,2,3,4,5,8,9

This sub-thematic narrative evidence extrapolated from the free text from the survey provides an illustration of the potential adverse impact on the team dynamics when leaders are perceived to be displaying favouritism towards some individual team members and not others.

5.2.3 Silo Working

Several examples emerged from the analysis of the data that indicated that silo working had an adverse impact on team working. A social worker referred to their personal experience before they were deployed into a ‘multi-agency team:

> *“Working in a silo was a negative experience: there was an unwillingness to share leadership with partners”*
>
> *(Social Work Manager 4)*

It would appear from the evidence that some workers didn't seem to internalise the multi-agency ethos and continued to operate as an un-professional, a health practitioner interviewed suggested that:

> *"A social worker in our team continued to work to their own rules which are different to those that were being promoted by the team leader who wanted us to all work together as a multi-disciplinary team".*
>
> *(Health Practitioner 9)*

The need to share values was found to be best achieved if staff worked as a member of a multi-professional team rather as a lone professional, one respondent noted:

> *"I believe that working as a lone professional does not would help staff to develop a shared value base, and it can lead to becoming professionally isolated and too self-referential."*
>
> *(Questionnaire respondent 59)*

Another questionnaire respondent commented:

> *"…. multi-agency working that has to be the way forward and not silos of people operating in isolation."*
>
> *(Questionnaire respondent 67)*

An interviewee noted the influence that organisational change has on silo working:

> *"I think there is an element of people getting little bit protective again and kind of going back into silos and trying to protect their area of working in some respects."*
>
> *(Senior Social Work Manager 25)*

An interesting observation by a social worker in relation to one of the leaders who was selling the vision of multi-agency working was very powerful, they suggested:

> *"Leadership is provided from a director from the same professional background as many of the team members in my team are currently, but there is very little*

encouragement to seek a multi-agency point of view when dealing with complex situations"

(Social Work Practitioner 5)

Also went onto say:

"This has led to silo working within a multi-agency team, which is a shame as the enthusiasm and energy from a Leader would have led to new ways of working and challenges"

(Social Work Practitioner 5)

A Social Work Manager observed the silo working of health colleagues:

"Some staff still sit in professional silos although they are part of a MA Team, but I suppose some of it cannot be helped like access to the health networks they need to sit together and then they get issues nothing to do with social care or integrated welfare so they are going to have issues and seek support from their own"

(Social Work Manager 4)

Silo working was perceived to behave a negative impact on the organisation:

"I have experienced different professionals who stay bolted into their own disciplines to the detriment of the organisation".

(Questionnaire respondent 75)

A questionnaire respondent offered their view in respect to the advantages of not working within a silo

"I think it is important to have varied types of experience and working with other professionals enables us to continue to learn from each other".

(Questionnaire respondent 94)

An interviewee observed teams operating in silos as opposed to individuals:

> *"We have got to bring people out of those silos within your teams; the colocation is great but there are little silos of teams within that need to be broken up; along with the systems being put in place then that will make a big difference as well."*
>
> *(Health Practitioner 22)*

5.2.4 Expertise (sharing)

Evidence emerged from both the interviewees and the questionnaire respondents that working within an inter-professional team offered better opportunities to share expertise to inform better outcomes for children and young people.

> *"Working with other professional in an integrated team means that we have a bank of expertise that we can call on when we are struggling to find answers to difficult client related situations"*
>
> *(L&D Practitioner 18)*

A health manager commented that:

> *"…it is fantastic being able to sit beside the social workers and police and know that they can provide immediate advice if you have particular concerns about a child or a case…this has been the best thing about being in CYPS"*
>
> *(Health Manager 19)*

A survey respondent was opposed to the term 'expertise' they commented:

> *"I don't really like the word expertise, what is an expert? I think experience is important."*
>
> *(Questionnaire respondent 38)*

A social worker referred to the close working with commissioners and referred to the opportunity to share expertise between commissioners with no traditional professional training in respect to childcare:

"…Having a service where all professionals are working together and working in partnership with commissioners this helps commissioners understand what is important when they are designing services for children who are at risk or being take into care, they can then focus on quality and not targets – we can share our expertise with them."

(Social Work Manager 4)

Sharing of expertise can be a challenge:

"…. you may not have the expertise that gives you that safety net with issues. but very often what you will get, is a plethora of info (if it is somebody who is an expert) and you have to look beyond all the details and hear the important messages they are sharing with you.".

(Social Work Practitioner 5)

A questionnaire respondent commented that:

"…sharing expertise, sharing knowledge and skills can lead to better quality outcomes for service users…"

(Questionnaire respondent 70)

5.2.5 Clarity and Understanding of Roles

The emerging evidence from both the interviews and the survey offered an emphasis on the need for leaders to clarify roles within the teams and to for leaders to understand roles of the different professionals within the multi-agency services. The results from the questionnaire in respect to the benefits of being managed by someone from the *same* professional background suggested that this was due to the managers having a much better understanding of roles. This included the managers having their own experience and working knowledge of the professional responsibilities and the challenges the staff faced.

The need for clarity and understanding of roles was expressed by all professional groups, health, social care and learning and development:

"As part of a multi-disciplinary service I think good leadership shows an appreciation of different professional roles and the leader demonstrates that they can value different skills roles and values"

(Social Work Practitioner 21)

This was asserted in a less positive way by another social worker, but the essence of the meaning appeared to be the same*:*

"Some senior managers do not seem to be on the same wavelength as the rest of the teams, no understanding of roles and responsibilities, therefore a lack of effective leadership and communication."

(L&D Practitioner 15)

The narrative accompanying the questionnaires offered a strong assertion supporting the importance of understanding roles when leading an integrated team, one respondent shared their opinion:

"…. She does not understand my role and is also extremely busy trying to learn the new ways of working and get used to her own role which has changed …. She is not able to support me because she does not have the answers to any of the questions I have, and this is because she does not have the authority or the knowledge to answer them because they need to be answered from higher up. She is a very nice person, but she just doesn't understand what we do…"

(Questionnaire respondent 49)

An interviewee stated:

"…understanding of people's roles in the context of their lives and the workforce assisted me with leading change" (L&D Manager 1)

The importance of understanding roles was key:

> *"… being able to understand enough about their roles and priorities and the leadership qualities that they can bring to the team, you can bring that out of the people you are managing, it helps support yourself."*

(Health Practitioner 8)

Assumptions were made in respect to roles by other multi-agency team members, the lack of understanding became more focused when a team member was absent, and others had to cover the casework load:

> *." That means it is difficult sometimes to get the police officers who are seconded to the team to genuinely do all the roles that other people assume that they do. So, they don't do some of the office duty, they don't contribute everything. Health has been similar. Social care, Probation, Education much less……."*

(Social Work Practitioner 5)

An interviewee raised the idea that whilst everyone understood their role, the individual professionals felt that leaders didn't understand the roles of the different professionals who they managed:

> *"I think we need to realise that people are kind of aware of their own professional roles and responsibilities and boundaries. I do not think there is an issue, as there seems to be an anxiety with some professionals that we as managers do not understand the different roles of the multi-agency staff."*

(Non-professionally Qualified Manager 7)

Finally, a manager with no professional qualifications commented that a good understanding of the different professional roles existed:

> *"I think in Trafford what's really noticeable is the understanding of each other's roles that the agencies have got and the willingness to work together towards a common goal without feeling threatened –and not everybody wanting to safeguard their own bit."*

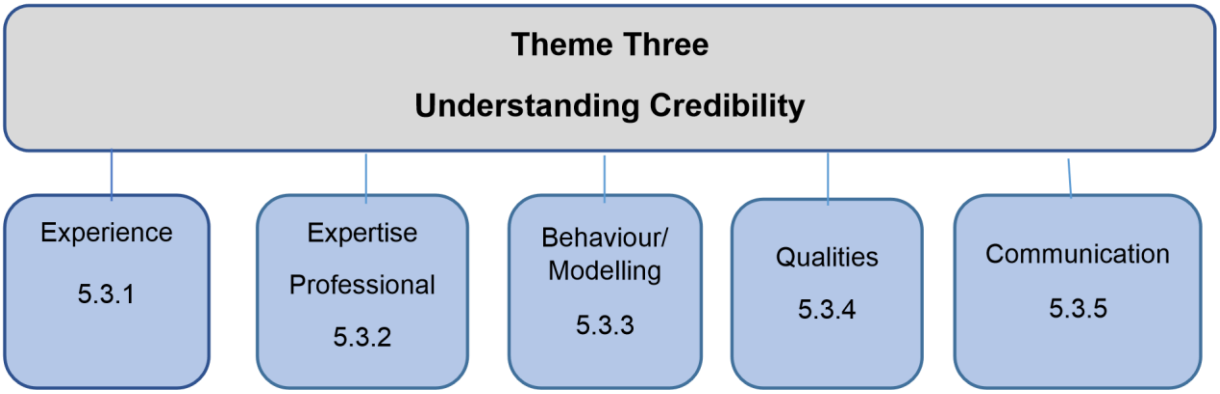
(Non-Professionally Qualified Manager 11)

The evidence is suggesting that for leaders to be credible they need to have a clear understanding of the roles and responsibilities of the different professional staff working within a complex multi-agency structure. This allows for the team members to believe that their challenges and demands of the job are taken into consideration.

5.3 Theme Three: Understanding Credibility

The concept of credibility and how it fits with leadership is an interesting phenomenon, which drove the research from the outset. The analysis produced a series of sub themes that fed into the overarching theme of *Understanding credibility* exposing a wide range of perceptions, but a common understanding of what the notion of credibility meant to the participants who are working in a multi-agency environment as seen in Figure 11.

Figure 11: *Theme Three: Understanding Credibility*



5.3.1 Experience

The issue of experience featured heavily in the findings with many examples of the importance of the 'experience' of leaders being key to their credibility. The length of experience was expressed, as was the type of experience that leaders held. There were numerous references made with regards to a leader's 'professional experience', as a concept this was not elaborated upon by the participants, and is therefore, worthy of further consideration as a definition or concept within the context of this study.

A senior health manager commented:

> *"You need to possess a range of generic skills that you can transfer into any setting, so there might be times where you need to use your professionalism*

which would come from your background and your training but more importantly your experience of assessing and managing situations."

(Non-Professionally Qualified Officer 24)

The questionnaire respondents were asked to offer a view on what makes a leader credible, by choosing from a list of key factors shown in Table 23, where 38.7% of respondents (n=20) managers and (n=25) non-managers believed experience contributed to the credibility of a leader.

This was reinforced in the interviews, when a participant shared their reflections that leadership was related to experience as staff with less experience followed those with greater experience:

"I have been thinking about leadership and my manager is of being a strong character and lengthy experience that the less experienced workers follow her leadership"

(L&D Practitioner 18)

Another interviewee argued that leaders with more experience than qualifications were more credible to them:

"If they have experience on the job experience and life experience is more important than being professionally qualified in a specific area…"

(Non-Professionally Qualified Manager 11)

A learning and development worker from the youth service observed that a manager that he was currently working with was successful and credible because he had experience and not because of his training or academic background:

"They had vision and courage based on their experience of working with people regardless of whether their knowledge was based on academic study".

(L&D Practitioner 18)

There was also evidence in the free text from the survey that supported this contention:

"Support from an experienced professional who is able to support and advise and challenge good direction and ideas is worth more than someone who has a battery of qualifications"

(*Questionnaire respondent 75*)

Another questionnaire respondent referred to a leader as being extremely confident as:

"……. she had years of professional experience that gave her the confidence to be decisive and lead from the front…."

(*Questionnaire respondent 87*)

A learning and development manager believed that professional experience was important:

"Professional experience is important, there is an immaturity and the more you are exposed to higher level discussions you gain confidence…."

(L&D Manager 1)

A social worker commented:

"I would rather have someone with the professional experience rather than the qualification because I think the qualification enables you (without some understanding of the professional experience) to take a more theoretical approach but in the real world it does not work like that…"

(Social Work Practitioner 5)

The length of experience appeared to offer a level of credibility to leaders, regardless of their professional background, a social work manager noted this of a health professional in a management position:

"I manage half of the social workers and my boss the ops managers they manage the other half of them. My management style is less confrontational, but I am not as experienced – we both have different strengths"

(Social Work Manager 10)

The findings suggest that experience is a contributing factor to the credibility of leader, an understanding of what defines 'professional experience' was not evident in the findings and warrants further investigation.

5.3.2 Expertise (Professional Knowledge Base)

The findings present an interesting picture in respect to understanding expertise from a professional perspective as opposed to the sharing of expertise within a team.

The questionnaire offered an opportunity for respondents to share their opinions in respect to describing an experience of leadership that they believed to be poor, they were also asked to provide information as to what it that made leadership poor (Q9). Of the responses 10.4% (n=12) referenced their experience being poor when working with a leader with a poor knowledge base. A poor knowledge base in respect to this subtheme of the study refers to a lack of professional expertise.

The notion of professional expertise in this research is considered in the context of the concept of professional identity – when referring to those leaders who share the same professional background as those that they lead. This is illustrated succinctly by a health practitioner who commented:

> *"I am satisfied with the management structure because it so happens that my Head of Service is from the same professional background, and she has the expertise to support me if I am faced with difficult clinical decisions"*
>
> *(Health Practitioner 9)*

The concept of expertise referred to in the narrative appears to be originating from professional qualified training as there was no reference in the evidence to support expertise being derived from 'on the job' experience. A learning and development practitioner suggested:

> *"…. although we are managed on a day-to-day basis by someone from a different professional background to ourselves (she is from a social work background) we know that we can seek expertise from someone in our own profession who is a*

manager of another team but is trained in education if we ever need skilled support"

(L&D Practitioner 18)

A senior manager who didn't have a professional qualification suggested that there was a distinction between expertise and leadership and reinforced the need for other skills and qualities rather than professional knowledge:

"You need experts, but you don't necessarily need them to be your leaders, maybe leadership is about having someone that listens to the experts and makes decisions based on that and its more about accountability decision making rather than expertise, so it's making sure that every decision made is scrutinised by the right people."

(L&D Practitiioner18)

Another interviewee who didn't hold a professional qualification shared a similar view to the previous participant regarding professional expertise:

***"....** I am not necessarily convinced that to be a credible leader you have to be from a professional background and that you cannot take accountability and responsibility for people outside your professional scope, because I think it works really well, but I think you have got to be committed to the vision and one of your skills is to be able to demonstrate your commitment"*

(Non-Professionally Qualified17)

A senior manager who also came from a non-qualified professional background commented:

"I don't think you have to have the same professional background to be recognised as a leader. I think what you have to have, is an ability to understand the language of other professions and to be able to be responsive to the demands and challenges that are facing other professions as well"

(Social Work Manager 10)

A questionnaire respondent was concerned that being managed by someone without a professional qualification could introduce risk:

> *"...if there was a manager without professional training, then safeguarding may be compromised"*
>
> *(Questionnaire respondent 103)*

The statements above from those participants who do not possess professional qualifications concur with the results from the questionnaire. One of the questions in the survey was designed to investigate the respondent's opinions of the CYPS management structure these can be seen below in Table 25.

Table 25: *Preference of management structure*

	N	%
Managers from a different professional background	10	8.6
Managers from the same professional background	82	70.7
Managers with no professional qualification but extensive management experience	24	20.7
Total	**116**	**100.0**

Source Question 11

This question was posed to elicit whether the participants had a preference in respect to a manager's professional background. 20.7% (n=24) of the cohort, said that they would prefer to be led by someone with no professional qualification but who had extensive management experience as seen in Table 2 above, where the respondents were requested to select from three options.

The results showed an overwhelmingly majority of respondents (n=82) 70.7%; almost two thirds of the respondents preferred a management structure where the leaders shared the same professional origin as the staff in the team. Less than 1:10; 8.6% opted to be managed within a structure where managers originated from a different professional background.

These results alone do not provide a richness to the research as the triangulation that occurred by integrating the qualitative data with the questionnaire responses offers a deeper understanding to the quantitative responses and only 6% of respondents indicated *professional qualifications* being important for leadership credibility in Table 23.

A health professional commented that the lack of expertise is sometimes masked by the leader possessing the ability to be confident, but this alone may lead to them becoming unstuck:

> *"Confidence is a basic core skill in a leadership role and if you can demonstrate confidence that seems to be what makes someone appear to be an expert for example, we have all seen people in senior positions or team Leaders positions from a clinical or professional perspective and they are fabulous at talking the talk but if you scratch the surface there is nothing underneath. so, it is being able to back up what you say and how you behave with evidence…confidence alone could be risky."*
>
> *(Health Manager 2)*

The results presented in Table 24, were accompanied by narrative which reinforced the importance of expertise/knowledge base when it came to supporting team members:

> *"…. The leader in question did not have the knowledge base to give considered advice or directions so invariably was being asked of you as a worker was not in fact achievable*."
>
> (*Questionnaire respondent 48*)

There was evidence of practitioners expressing deference towards managers who were not from their own professional backgrounds but who had expertise in other areas- however, as the results suggest there was evidence that practitioners preferred to be managed by professional managers of the same origin, one health practitioner shared her opinion:

"My manager has excellent knowledge, experience and management skills in her existing role but her position in the organisation and expertise which is different from my own professional background means in my opinion that she is not in the right position to lead me in my field of expertise, and this has had a negative impact on my job satisfaction and role."

(Health Practitioner 8)

This was supported by a social worker in respect to their manager from a health background:

"I believe my manager does not have the organisational understanding or expertise to support and advise me in my current role as a practitioner"

(Social Work Practitioner 21)

They continued:

"…. the manager would (at least initially) appreciate the pressures and experiences of the staff. They would understand the professional culture and would hopefully be familiar and up to date with professional issues that concern the staff….."

(Social Work Practitioner 21)

The preference for someone to be managed by a someone from the same professional background was again reinforced by a health employee:

"…my manager is very approachable; will always make you feel valued, and I feel this is because they are from the same background and have been in similar situations themselves".

(Health Manager 2)

A learning and development professional noted that being qualified professionally may offer career progression:

"……as a professional you are also aware that there are opportunities for progression through management if that is your preferred plan. Having a professional identity may offer you more opportunities to develop in your career."

(L&D Practitioner 15)

A questionnaire respondent suggested that leaders should have an understanding regardless of professional training and expertise:

"……. you need to be able to (in whatever context you are in) understand complex issues……. you need to be able to do that whether or not you have professional knowledge or expertise of the particular issues"

(*Questionnaire respondent 68*)

The preference to be managed by someone who has no professional qualifications or professional expertise was considered to be appropriate if other skills were developed to enhance their leadership position; a learning and development practitioner stated that leaders without the professional expertise had to develop other skills such as 'listening':

"The ability to listen and understand (particularly when you are operating in a multi-agency setting and you may not have the expertise that gives you that safety net with issues"

(L&D Practitioner 18)

The questionnaire narrative provided an understanding that managers who originated from the same professional background were believed to offer a beneficial advantage to staff as they shared the same professional identity because there was a belief that these leaders had a similar understanding of roles having 'worked up the ladder' therefore had a working knowledge of the job's responsibilities and challenges. It was suggested by some respondents that a key benefit of leaders originating from a different professional background was indeed advantageous as these leaders brought a range of knowledge and expertise and many new ideas and innovative ways of working.

A questionnaire responded observed:

> *"I think it is important to have varied types of experience and professional training so you can all continue to learn from each other*".
>
> (*Questionnaire respondent 74*)

Another stated:

> *"…. that such input from a range of staff would help staff to develop a shared value base, and to avoid becoming isolated and too self-referential"*
>
> (*Questionnaire respondent 15*)

There was evidence of support for the current management structure model where staff are managed by someone from a different professional background, however it was suggested in the respondent narrative that when appropriate professional support needed to be readily available:

> *"…. professional guidance and leadership are needed for the safeguarding work that is undertaken".*
>
> (*Questionnaire respondent 38*)

The findings suggested that there was a perception that the multi-agency management structure in CYPS also had disadvantages. The questionnaire explored these further (Q13) and identified that the main disadvantage was the issue of team members being managed by people from different professional backgrounds. It was believed by some respondents that being managed by someone from a different professional background was disadvantageous because they tended to adopt a narrow-minded approach and maybe closed to ideas from other disciplines and therefore not see the wider picture:

> *"...narrow minded managers from a different professional background may have a tendency to treat every issue in the same way as they would for their professional background"*
>
> *" (Questionnaire respondent 26)*

Another notable disadvantage was the issue of professional identity, due to self-protectionism, some questionnaire respondents stated:

"…some staff are so protective and fearful of losing professional identity that they struggle to respect leaders from different professional disciplines to themselves"

(Questionnaire respondent 47)

Another respondent noted:

"…*at times, it can cause conflict between clinical and management objectives because the professional believes their viewpoint is superior to the management perspective".*

(Questionnaire respondent 94)

The results with respect to the importance of professional qualifications in relation to leadership credibility were least important, gaining the lowest in the statistical responses with only (n=7) believing they were an important factor in leadership credibility as listed in Table 24. Conversely professional experience was ranked at number 4 by (n=45) representing 38.79% of the cohort considering this as important. This is interesting when compared to the context of the responses (Q11), exploring the preference of management structure: where 20.7% of respondents would prefer to be managed with no professional qualifications but with extensive management experience as seen in Table 25.

These interesting findings offer an opportunity to consider the credibility of leaders who possess professional qualifications or not and how professional identity contributes to the credibility of successful leaders.

5.3.3 Leadership Behaviours

Leadership behaviours, as a sub theme was included because it emerged during the integration of the data as an important factor in relation to the participant's views of the concept of leadership credibility. The data elicited from the interviews and the questionnaires frequently referred to a leader's behaviour in relation to how this shaped the views of the participants. Questionnaire respondents were asked (Q 10) to comment on what influenced the organisational management structure in CYPS. On a scale of 1-4, the respondents were asked to indicate how satisfied they were (1 being very dissatisfied; 4 = very satisfied). This question was designed to gain an

understanding if the management structure was appropriate and if the multi-agency leadership model that had been adopted by CYPS was working for the different professionals within that structure.

The evidence found that a high number of respondents 87.1% (n=101) indicated their satisfaction with the current management model, offering a score of 3 or above. A total of (n=44) 88% of management respondents (score 3 & 4) with 59.09% (n=26) indicating a high level of satisfaction (score 4). 13% of the total (n=116) respondents were less than satisfied (n=15) with (score 1 & 2), Table 26 below identifies the degree of satisfaction scores.

Table 26: *Degree of satisfaction with management structure by whether leads a team*

Lead a team	Very dissatisfied	Dissatisfied	Satisfied	Very satisfied	Total
Yes	2	4	18	26	50
No	4	5	20	37	66
Total (%)	6	9 (7.8)	38 (32.7)	63 (54.3)	116 (100.0)

Source Questions 1,2,3,4,5,10

The data analysis showed no difference between leaders and non-leaders with respect to their satisfaction with the current management structure in their service as can be shown in Table 26 above.

Table 27: *Comparison of mean scores by whether leads a team*

Lead a team	Mean	N	Std. Deviation
Yes	3.4	50	.86
No	3.5	66	1.06
Total	3.47	116	.97

Source Questions 1,2,3,4,5,10

The council employed respondents in multi-agency teams indicated that they were more satisfied with the current management structure than those employed by the health service.

One respondent remarked in the free text narrative:

"I have scored a four because my management structure is clear…"

(Questionnaire respondent 38)

A respondent wrote freely to explain their response score to this question:

"…in my opinion this is probably better in Trafford than most other places I have worked hence the high satisfaction score."

(Questionnaire 39).

Another respondent believed there may be opportunities to improve their dissatisfaction with the management structure:

"*I am being managed within a very complex set of arrangements which could be further developed to provide greater satisfaction than I am feeling presently…*

(Questionnaire respondent 2)

The analysis revealed frequent references in the free text narrative were made to managers/leaders being supportive (n=15) and of the availability/visibility of leaders/managers (n=11) to team members for advice and decisions. Leaders/managers ability, experience, knowledge, efficiency and good understanding was also referred to, but this was less frequent.

A respondent noted:

"I believe teams need strong leadership with a physical presence."

(Questionnaire respondent 8)

Some of these leadership behaviours were evident during the integration of the data, with evidence of the participants believing the behaviours and not merely the professional qualifications shaped a leader's credibility, a health manager noted that her direct line manager led by example, she noted:

". they also worked hard themselves, they led by example and were incredibly dedicated."

(Health Manager 24)

This was reinforced by other interview participants regardless of their professional origin:

"They led by example; they were honest and trustworthy. They protected their staff, but still lead from the front."

(Non-Professionally Qualified 11)

There was evidence to suggest that if a leader's behaviour was inappropriate then this had an adverse impact on their leadership credibility regardless of how strong they were in their field of expertise.

"This person's knowledge base and experience in the area of the service being led was second to none but her behaviours of being unpredictable with her moods sometimes outweighed this and therefore affected the way she was viewed as a leader."

(L&D Manager 13)

There was recognition that leadership behaviour can be shaped with the length of experience and other factors – a senior manager in learning and development commented:

"I think some of the leadership skills you acquire throughout your career, and I look back to some of the decisions I previously made and I cringe and think now I would of never have done that, or said that or behaved like that but it comes with maturity and through aspiring to somebody who is visibly seen…"

(L&D Snr Manager14)

They went onto say:

"… I think that creates credibility for you without you having to try too hard, if people can see then maybe model their behaviours on you."

(L&D Snr Manager14)

A senior health manager also commented on self-reflection as a leader in respect to their behaviour:

> *"Some of your skills you can take that from a variety of people, it's that constant self-reflection about how you behave, how you are seen, the way you reflect, the way you act..."*

(Health Snr. Manager 15)

Leadership behaviours were considered important one health interviewee commented:

> "…l*eaders can distance themselves from people, although their work schedule is busy time needs to be made to introduce themselves to the people they are leading. There needs to be more recognition of staff strengths & commitments i.e., good sickness record*."

(*Health Manager 19*)

Availability of managers was important, 10.4% (n=12) respondents suggested that lack of availability of leaders led to poor leadership experiences as seen in Table 24, this was a factor that a Learning and Development practitioner believed was critical to a leader's credibility they commented that:

> *"Leaders need to be visible in order to be credible leaders."*

(Interviewee 20)

The themes which have emerged from the questionnaire were not listed as multiple choices in (Q9), the respondents were requested to freely share their experiences of poor leadership (see Table 5.9) 17.4% (n=20) of respondents found *autocratic behaviour* to be a factor demonstrating poor leadership) there was several respondents who noted those leaders who had their, own agenda as having a negative influence on their experience. Aggressive behaviours were also identified in the free text as having an adverse impact on a respondent's experience of poor leadership Autocratic leadership style can influence outcomes:

> *"…you may have someone who are autocratic, and they get the team ticking along nicely but the team's motivation is not necessarily from that inspiration to*

do the job it could be out of fear to get it done, so you can be a bad leader in that perspective but a good manager because you get the results."

(Questionnaire respondent 58)

Another respondent made an observation of one of the managers within the organisation stating:

. *"X is probably seen as a powerful leader but is viewed as a bit of a tyrant, but* I *don't know them so cannot speak personally."*

(Questionnaire respondent 68)

This perception that autocratic leaders were not motivational as leaders and displayed bullying behaviours was provided in further questionnaire narrative:

"They were directive, autocratic, and bullied members of staff. I did not feel I could effectively work with them after witnessing some of their actions with other members of staff and team leaders and as such I looked for other opportunities and left as soon as something suitable became available."

(Questionnaire respondent 50)

Staff who experienced working with those leaders who modelled autocratic styles expressed how they felt undervalued and disempowered:

"… a particular leader treated staff and at times service users unfairly - Gave limited supervision and team meetings, those that were held were of poor quality and were very autocratic and not supportive..."

(Questionnaire Respondent 94)

"…. there was a lack of ownership and failure to make a decision – they were very bureaucratic, autocratic with a bullying style of management. They didn't allow anyone to finish a sentence, they reached a decision long before staff even uttered 2 words or could even answer any questions that were put to them..."

(Questionnaire Respondent 49)

5.3.4 Qualities

Qualities of leaders featured strongly in the findings and the questionnaire respondents offered rich data to support this emerging theme.

The respondents were asked to identify what they thought were the most important qualities of a good leader by selecting four factors from a list of ten. In addition, they could also specify other factors that they thought were important qualities of a good leader (Q6). A scrutiny of the data found that several respondents selected more than four of the given choices. These cases were judged to be invalid and excluded from analysis since it was deemed impossible to tell the relative importance of these selections. The results are shown in Table 28 below.

Over 80% (n=100) respondents' thought *being able to communicate effectively* was one of the most important qualities of a good leader are listed in Table 28. *listening* was believed to be important by more than 70% (n=82). More than half considered *following up on what is promised* and *professional experience* as important qualities of a good leader.

Around a third of the respondents considered *managing resources effectively* and *accepting challenges* as important qualities of a good leader respectively.
17.2% (n=20) thought that *personal experience* was important in this context.

Conversely, less than one in ten believed *having good ideas* was important. Very few thought that *professional or academic qualifications* were important qualities of a good leader. Other factors suggested by the respondents included *vision* (n=3,), *being fair* (n=2), and *integrity* (1 each). Compared to 'team managers', those not managing a team were more likely to think '*listening', following up on what is promised* and *personal experience* as the most important qualities of a good leader. In contrast, those leading a team were more likely to consider *managing resources effectively* and *accepting challenges* important. They were also more likely to think *professional qualifications* were important, but the difference was not significant due to the low numbers in the two sub-groups for this factor. There were no statistically significant differences between these two groups with respect to other leadership qualities which are shown in Table 28.

***Table 28**: Most important qualities of a good leader by whether leading a team*

	Managing a team		
	Yes (n=49)	**No (n=58)**	**N=116**
Being able to communicate	46	54	100 (86.2)
Listening	33	49	82 (70.6)
Following up on what is promised	22	38	60 (51.)
Professional experience	26	32	58 (50.2)
Managing resources effectively	22	15	37 (31.9)
Accepting challenges	21	11	32 (27.6)
Personal experience	5	15	20 (17.2)
Having good ideas	6	3	9 (7.7)
Professional qualifications	5	1	6 (5.1)
Academic qualifications	1	0	1 (0.86)

Source Question 6

The composition of the sample with respect to the respondents' positions are shown in Table 29, below. There were no overall statistically significant differences between these professional groups with respect to any of the qualities described above, although it appeared that compared with staff in the learning and development group, social workers placed more emphasis on professional experience (12/17 vs 11/29). The lack of variance among these groups could be due to the diverse background of the sample leading to low figures for each sub-group, especially when they were further divided by different responses to each item, which limits the utility of certain statistical analysis.

***Table 29**: Grouped role (professional background)*

	Grouped role						Total
	Health	**Commissioning**	**L&D**	**Management**	**Social**	**Other**	
N	33	7	29	16	17	14	116
%	28.5	6.0	25.0	13.8	14.7	12.1	100

A high proportion of respondents believed the *integrity* of a leader was more important for credibility than the leader's ability or competence.

One respondent commented:

> *"In my first formal line management role, I had a head of service who nurtured my ability, he understood the gender dynamics between male and female managers, and he led us through some very difficult organisational changes with honesty and integrity."*
>
> *(Questionnaire respondent 43)*

During the integrated interview and questionnaire analysis (Q6) and the additional free narrative there was evidence of a differentiation of views from managers and non-managers, are shown in Table 28. The results indicate that managers view the qualities of *managing relationships* (21/50 vs 12/66) and *making decisions* (25/50 vs18/66) as important influencers of credibility.

Honesty was deemed by 55.7% (n=59) of (n=116) respondents as being an important factor to a leader's credibility as seen in Table 23. From the cohort who identified *honesty* as an influencer 57.58% were non-management respondents. *Listening* as another key credibility influencer was considered by 22.29% (n=37) of nonmanagement respondents to be important. On further examination of the data evidence demonstrated that those staff from the different professional groups viewed the qualities differently, with those staff from a learning and development professional background placing *Trust* as a more important quality than social workers, whereas social workers placed a higher level of importance on the ability for leaders to *make decisions*. Interestingly, when comparing staff from the different employing authorities, the council employees emphasised *decision making,* and health employees placed greater emphasis on *listening* and *trust*.

Table 5.8 shows the factors that were relevant to the respondents with over half of respondents considering *Communication, Trust,* and *Honesty* as the most important factors that make a leader credible. Again, *professional qualifications* are one of the least reported factors, notably being ranked as the lowest in the statistical responses with only 4.2% (n=7) believing *professional qualifications* were an important factor in leadership credibility, conversely *experience* was ranked at number 4 by (n=45) representing 27% of the cohort. It is necessary to note that the difference from the

data analysis is not statistically significant. There are no significant differences between different professional groups with respect to any of the factors.

The free text narrative from the questionnaires supported the statistical analysis and below are a range of questionnaire respondent's commentary to illustrate this:

> *"…the manager didn't listen, it was their agenda during supervision meetings, and they took over and didn't treat me like a credible employee more like 'their employee' rather than a council employee."*
>
> *(Questionnaire respondent 9)*

Listening as a quality was reported as a key influencer in the perception of respondents, a survey participant noted:

> *"I feel that at times managers do not listen or value your opinion. The current working environment has created a hierarchy and managers sit separately and manage from a distance which goes against the whole idea."*
>
> *(Questionnaire respondent 71)*

The correlation with the interviews and the respondents of the questionnaire in respect to the qualities of honesty and openness being an important measure of credibility a social worker commented on their health leader as being credible and honest:

> *"Open and honesty -what you see is what you get, Fairness, honesty, equality and the willingness to support staff."*
>
> *(Social Work Manager4)*

A non-professionally qualified commissioning worker noted that:

> *'Credibility' is a difficult characteristic to define, and leaders can achieve credibility in different ways - for some 'followers' the professional status will be important - this seems to be particularly the case in health - where status/credibility appears to be earned through academic qualifications and even where the qualifications were achieved!"*
>
> *(Non-professionally qualified 23)*

They went onto to describe what they believed was the way to achieve credibility for others without professional qualifications:

> *"For other staff credibility is more about charismatic leadership - the (often natural) ability to motivate and inspire - this often engenders a confidence in staff and therefore a credibility."*
>
> *(*Non-professionally qualified *23)*

A learning and development manager believed that professional qualifications were less important:

> *"Personally, I like leaders to be bright, honest and above all authentic and am less concerned as to which professional discipline they happened to choose years ago."*
>
> *(L&D Manager 6)*

5.3.5 Communication

The ability to communicate effectively and with clarity to staff (followers) emerged as a strong sub-theme and a key influencer in respect to the credibility of leaders. This quality was overwhelmingly believed to be the most important factor that contributed to the credibility of a leader. Table 23 above shows that 86.2% (n=100) identified *communication* as the most important quality of a good leader.

The evidence suggests that a leader's ability to communicate effectively was more than merely a skill but a personal quality, one interviewee from a learning and development professional background suggested:

> *" The first thing is that you have to be a good communicator, and you have to be comfortable and confident to communicate with different types of people at all different levels, in different settings."*
>
> *(L&D manager 1)*

Participants clearly believed communication was key to credibility as a leader, one respondent asserted:

"A poor leader in my view only communicates individually when a task is required. A person who finds it difficult to articulate praise and when feedback is provided- it only comes in the form of negativity without clear guidance on how to improve."

(Questionnaire respondent 84)

A Learning and Development manager noted that communication wasn't merely about messaging it was the tone too that gave credibility to a leader:

"Attention needs to be made across the board to communication skills; good communication does not stop with practitioners and their clients. I am talking about email etiquette, discretion, tact and respectfulness."

(L&D Manager 1)

Another interviewee supported the need for leaders to communicate effectively by interpreting complex information into understandable messages:

"….it is critical for leaders to have good communication skills and to have the ability interpret ideas and convey the messages to the people."

(L&D Manager 1)

A respondent suggested that leaders who didn't have the quality to inspire through being effective communicators were hampered in their endeavours:

"I have known some leaders who are very strategic in their thinking but actually they lose the staff's interest as they are unable to communicate to them what the goals of the organisation are in a clear and understandable way…"

(Questionnaire respondent 104)

An interviewee reflected on their own communication skills as a quality in respect to their own leadership:

"As a leader, myself, I want to be a clear communicator so as my staff to have an idea of what they can do in terms of their responsibilities and also if they are unhappy about things what they can do about it…"

(L&D Manager 16)

One respondent spoke of managers who couldn't cope and how this affected their communication abilities:

> *"The manager took her own work stresses out on her staff and had poor communication skills."*
>
> *(Questionnaire respondent 40)*

Another interviewee spoke of their experiences of leader's communication is important to and the importance that communication has on staff motivation:

> *"In my experience, I have worked with a lot of people with reams and reams of qualifications but if they have not got communication skills and the qualities to convey the information - they are not going to make a strong leader because they cannot engage with people, they cannot draw out that fire in you."*
>
> *(L&D Manager 3)*

A health practitioner shared their views in respect to a leader's credibility in the context of them communicating negative feedback to staff:

> *"… for a leader to have a level of credibility they need to be able to feedback effectively but sensitively even if it is not necessarily what you want to hear and explain to staff why and how that feedback came about …is it performance or a personal development issue…whatever the reason they need to communicate it in such a way that staff don't feel demoralised and remain motivated."*
>
> *(Health Practitioner 22)*

The importance of feedback was also identified from the questionnaire, a respondent noted:

> *"Regular communication on an individual level as well as with other managers made staff feel valued."*
>
> *(Questionnaire respondent 74)*

A social worker made a powerful statement in relation to the qualities of a leader and how communication is critical to achieving credibility he suggested that:

"…being a strong leader means that your staff need to have faith in you and trust you, you can do this by making sure that your communication is open, and you are keeping staff informed and being consistent with the information…this gains you respect you. I think if you are poor at communicating you risk losing your credibility and the respect of the staff."

(Social Work Practitioner 5)

A questionnaire respondent offered a view that leadership credibility was influenced by the effectiveness of the leader's communication and how these play into staff motivation and development, they commented:

. *"In order to communicate effectively you need to understand the kind of relationship that happen in the workplace…. it is down to communication to understand these as it means understanding that conversations work on many levels…."*

(Questionnaire respondent 114)

The findings were robust in this sub-theme of understanding credibility as communication featured highly in the questionnaire response data analysis. A total of 67) (n=100) 86.2% of the cohort of questionnaire respondents (n=116) identified the ability to communicate as being the most important quality of these respondents (n=46) were managers and (n=54) non-managers as shown in Table 28. Poor communication accounted for 33.9% (n=39) of participants identified as being the key contributing factor to respondents having a negative experience of poor leadership as seen in Table 24. Interestingly, 23.3% (n=27) of those respondents who experienced good leadership identified communication as the 4th factor influencing positive leadership experiences, with 34% (n=40) citing *listening* as their first influencer (n=40) (See Table 5.7)

Finally, when asked to identify what makes a leader credible, Table 23, shows that 57.76% (n=67) recorded *communication* as the key factor, with 49.25% being managers and 50.75% being non-managers, suggesting that communication is a key factor for all levels of staff.

5.4 Chapter Summary

This is the first study to consider professional identity and the influence this has on leadership credibility of those leading integrated health and social care services, the findings provide an opportunity to b consider the granulated thinking of those working within these joined up – integrated organisations. Combined with the previous chapter the key findings for the study are

Key findings:

Theme One – Understanding Leadership

- Leaders of integrated services must have a strong professional voice to represent professional groups at an executive level as some professional groups believe there is a bias towards the host staff groups,
- Leaders of integrated services must have experience and knowledge to inform professional decision making to support professional staff in the multi-agency teams.
- Leaders of integrated services must review the leadership development of staff to reflect the model of systems leadership as there is a perception that not everyone is a leader in an organisation, some are managers.

Theme Two - Interprofessional challenges

- Leaders of integrated services must reduce the opportunities for staff who are co-located together to continue to operate on professional silos
- Leaders of Integrated services must be cognisance of not expressing favouritism towards their own professional groups of staff. As this causes damaging team relationships.
- Leaders of integrated services must ensure that there is a clear understanding of the roles of each professional group to ensure none feel undervalued or other feel more important that they all have equal value.

Theme Three – Credibility

- Leaders of integrated services do not require qualifications to be credible

- Leaders of integrated services must have extensive professional experience to be credible
- Leaders of integrated services must consider the professional governance arrangements as over 40% of staff from Multi -Agency Teams prefer to be managed by someone from their own profession.

The new knowledge this study presents is discussed in the following chapter alongside relevant evidence to critically examine the evidence generated. A summary of the key points is identified below:

- The study showed that professional qualifications do not influence the credibility of integrated service leaders
- Experience and expertise which inform decision making is seen as crucial to successful leadership
- Social care staff placed a greater emphasis on leaders who demonstrated in professional decision making whereas health staff perceived leaders who listened and demonstrated conviction more credible.

Chapter Six: Informing Integrated Service Leadership – discussion

6.1 Introduction

The original findings generated from the mixed methods study offered a myriad of multifaceted and complex views from multi-professional staff in respect to what they believe to be the greatest influencers for a leader's credibility with a particular emphasis on those leaders who manage integrated health and social care services. Indeed, the study focused on examining whether leadership credibility was influenced by the professional identity of the leader exploring the staff perceptions from one of the first integrated teams (CYPS) functioning across Health and Social Care (Chapter One). The research, completed sometime ago, is equally as relevant today with the formation of Integrated Care Services and Systems emanating from The Health and Care Bill (2021), it is just as important and will influence and inform the appointment and training of integrated service leaders.

There has been a continuous drive by successive governments over the last four decades towards establishing new ways of working, to improve patient outcomes and achieve resource efficiencies by creating legislation and opportunities to facilitate the integration of health and social care services (Glendinning, 2003; Ham et al., 2012, Baxter et al., 2018). The drive for service reform is accelerating and this places leaders of these new organisations in unique positions, but there is an absence of robust evidence to inform the recruitment and selection of these leaders. When I embarked on this study, I had experienced such a kick back in practice as a senior leader in an integrated service, from people leading teams that didn't have the same professional background and qualifications. There were conversations that seriously undermined the credibility of some of the leaders in the organisation because they weren't perceived to have had the professional grounding. A search of available literature at the time offered no solution as to whether appointing people without the qualification would make a difference to the service leadership. This lack of evidence as to what influences the credibility of an integrated service leader, drove the idea for this D. Prof study coupled with my passion to generate evidence to help to contribute to the knowledge surrounding these ambitious service integration reforms.

A battery of integrated leadership studies exists offering an understanding of the type of qualities that integrated service leaders need to possess to be successful (Mc Kimm, 2009; Timmins, 2015; Baxter et al., 2018). There is much rhetoric shared on the importance of being collaborative as leaders, and integrated services not being the place for heroic leaders (Sim et al., 2022). Think Tank organisations are currently working on overdrive to support the establishment of the Integrated Care Systems that are legislated to be established by July 2022 (Thorstense-Woll & Bottery, 2021). There is an array of ideas and suggestions from a variety of stakeholders on the development of these new integrated organisations (Kings Fund; SCIE; AQA) but none so far have considered the potential recruitment and selection elements to ensure that those who are appointed are prepared for leading integrated service provision and systems, they appear to be defaulting to the traditional school of thought and selecting from the same pool of potential candidates (Timmins, 2015).

Interestingly, the release of the (The Health Care Act, 2021) and the accompanying policy paper *Review of Health and Social Care Leadership in England: Terms of Reference* (2021) calling for research papers informing effective integrated service leadership reinforces that further research is still needed and these study findings are timely, relevant and generate new knowledge.

There is existence of a series of statements which are embedded in a plethora of documents and strategies in respect to integrated services (Baxter et al., 2018; LGA and SCIE 2019; Miller et al., 2021; Thorstense-Woll & Bottery, 2021), that reference workforce development requirements for integrated services (Sims et al., 2021). There are suggestions from the researchers that *'clear leadership'* must be present when leading integrated health and social care organisations (Smith et al., 2020), yet no one describes what this means in reality.

Current evidence offers a general notion, that existing leaders from single (as opposed to integrated) organisations have skills and qualities that are transferrable and that the presence of longstanding and respected leaders as part of ICS leadership teams will be key enablers for successful integrated care systems change (Charles et al., 2018). This gives a sense of 'more of the same', yet the Secretary of State says this service reform leading to Integrated Care Services and Systems are so far reaching nothing has been seen like this since Griffiths in the mid 1980's. (Health Care Bill, 2021).

The nature of the integration of bringing two similar but quite different culturally organisations together as a unified service with a large group of diverse professional groups. Yet there is no research available that distils this evidence to offer a deeper understanding of whether knowledge of each of the organisations professional cultures is an essential requirement of these leaders, (Lalani et al., 2020).

There is a lack of understanding of whether any professional qualifications, length or type of experience, level of expertise or specific abilities are required to ensure that those leaders selected are more likely to be successful.

This study contributes to the evidence, providing an opportunity to triangulate the theory with the perspectives gained from the professionals working in the integrated service, generating new insightful knowledge to inform practice.

The discussion in this chapter brings together key novel findings alongside the current evidence to address gaps and identify recommendations for practice. Influencing practice was an underpinning aim of this D. Prof research, to identify what qualities, professional qualifications or experience is needed for integrated service leadership to be recognised and credible.

Key themes discussed include:

- Distinguishing between Leaders or Managers
- Credibility and Leadership Qualities, Values and Knowledge
    - Possessing qualities
    - Values do matter
    - Having the knowledge
    - Leading with style
- Credibility and Professional Identity
- Leading an Integrated Team
- Extending integrated leadership theory

6.2 Distinguishing between Leaders or Managers

The findings revealed that managers have a distinct role from service leaders, with managers having greater operational responsibilities with more of a supervisory role than that of a leader. The study results considered leaders as being visionary and managers being about delivering the business (Rajan, 2000). This would suggest that the perception of leadership and management are two distinct concepts. The findings presented a weighty number of references illustrating how respondents considered both roles as being interchangeable. As with transactional and transformational leadership, as referenced earlier in the thesis, it is recognised that there is a view that management and leadership are also intertwined roles and complement each other (Elliot et al., 2020). There are distinct differences between leaders and managers, leaders establish direction, create a vision and set strategies whereas managers plan, budget, establish agendas and set timetables (Northouse, 2019). It is suggested in the findings that an individual to assimilate both roles would be challenging. The solution to reducing the difficulty of carrying out both roles would be to understand the differences between the two roles, each set of characteristics could then be applied to a given situation (Kotterman, 2006).

The structure in CYPS uses the terms manager and leader as job titles for different positions in the integrated service and there is a hierarchical structure of inter-professionals who hold the positions of Team Leaders, Operational Managers, Heads of Service and Directors. The need to adopt a distributive leadership approach within a hierarchical structure may be achievable but there may be a potential for positional cultural nuances that act as a barrier (Gronn, 2008). The findings didn't highlight any credibility gap between being a leader or a manager (Zaleznik, 2004; Buchanan et al., 2013), they are equally as credible. The evidence referred to Directors as having strategic leadership roles whereas Team Leaders and Heads of Service were considered to be more operational. This aligns with the notion of there is a distinction between the two positions. Leadership is everyone's business (Kouzes & Posner, 2007). This is an interesting finding as there is a challenge for a paradigm shift from management towards leadership (Timmins, 2015). It but it would appear from the research study findings that the distinction remains despite the drive towards a more collective model of leadership. as in Figure 4.

Key Summary

The findings revealed that managers and leaders of integrated services are perceived as two separate roles, and each are perceived as both having equal credibility. It was found that leaders who are visionary and can motivate commitment from staff whilst managers are more operational. Both roles are intertwined and complement each other (Zaleznik, 2013).

6.3 Credibility and Leadership Qualities, Values and Knowledge

6.3.1 Possessing qualities

Synonymous with current literature an early finding from this research highlighted the broad range of understanding amongst participants in respect to defining leadership. A mixture of theory-based responses or characteristics was presented with no definitive evidence supporting a clear definition for leadership., this is not surprising as we know there are already over 200 definitions (Turner, 2019).

Several authorities on leadership from the earliest theorist through to more recent researchers identify the challenges presented by the plethora of definitions of leadership that exist (Grint, 2011; Yukl et al., 2009; Northouse, 2016; Turner, 2019). The term leadership, therefore, may not offer clarity to anyone seeking a simple explanation to understand what is needed to be an effective or successful leader (Northouse, 2016).

There were strong views in the data discourse that suggested that to be perceived as a credible leader, you had to have a have certain qualities and particular skills (Kouzes & Posner, 2011; Northouse, 2016). The study identified that the relationship between leadership credibility and a leader's qualities is integrity. This was a key factor influencing credibility and was considered to be more important than a leader's competency (Holmes & Parker, 2017).

Behavioural integrity of leaders is linked strongly to the leader's ability to communicate as this is closely related to their values (Holmes & Parker, 2017). This supports the finding in respect to poor leadership communication and how this can affect a leader's

credibility, in particular when delivering negative feedback. Having strong integrity and being relied upon to deliver on promises gains trust from followers. Having trust in the leader creates a strong organisational culture. The misalignment of follow through on decisions has been shown to weaken cultures (Tschannen-Moran & Gareis, 2015). Communication was overwhelmingly found to be the key factor influencing leadership credibility. It was held to be to be a principle characteristic and failure to communicate effectively has resulted in some leaders losing their positions (Davila et al., 2012). Having the ability to communicate effectively with clarity was important to achieve credibility, but there was also a strong view that the tone was equally if not more important than the message (Mast, 2007).

The findings identified that effective communication was found to be the top key factor in this study to achieving high levels of leadership credibility for integrated service leaders. The challenge for service leaders is that communication has to also be authentic when delivering a vision to multi-professional groups of staff (Men & Stacks, 2014).

A recent study into the messaging from government officials during the covid pandemic found that the tone adopted by the leaders influenced the levels of anxiety and the confidence in the honesty of the messaging, the actual content of the message mattered less (Sobral et al., 2020). This has implications for leading integrated services as the issue of communicating complex and sometimes difficult messages in terms of managing change, especially as often change is associated with service efficiencies, and this may affect staff engagement in the change process and become demotivated to participate in achieving the organisational goals. The importance of communication and the tone of messaging becomes even more critical during turbulent times. The study found that those leaders with good communication skills, who had the ability to deliver messages with clarity in a supportive and constructive manner were considered to be credible leaders. There was evidence to suggest that leaders who delivered messages that were of a negative nature but in a less supportive and constructive manner ran the risk of demotivating staff. If integrated service leaders want to gain credibility and keep it, they need to be mindful of their tone and manner when providing staff performance feedback. as it is linked to the leadership qualities of trust and honesty. The findings also suggest that leaders need to listen and receive

messages as well as give them, which may vary according to the subject material. Some leaders may be effective at listening to technical information whereas others are more effective at listening to interpersonal content (Bodie & Worthington, 2010). For example, the nature of health and social care services and interprofessional working the information content tends to be grounded in a socio-psychological construct (Huff, 2021). Compared with clinical services using medical devices for children with complex health needs to support care and support at home, technical related communication is needed. A significant finding from the study highlighted a linkage between poor communication and low job satisfaction. There is evidence that supports the perspective that good communication has a positive impact on staff engagement and job satisfaction, however there is no correlation with performance (Pongton & Suntrayuth, 2019). As a senior leader with the portfolio for strategic health but accountable for multi-agency professional, I set up monthly meetings with all Heads of Service across the borough, to share strategic and any relevant operational communications. This was met with a barrage of criticism, mainly from council staff as they didn't believe it was necessary for them to attend 'health related 'meetings' they were not actually health specific as the information shared came via Trust Board, and corporate leadership team meetings. I reflected on this reaction and accepted that the organisational cultures differed, health was maybe too focused on meetings and the council wasn't focused enough. Interestingly, a couple of years later, the Heads of Service who complained became a champion of the meeting, inviting staff to present their projects to us so we could share with their achievements, e.g., successful Duke of Edinburgh Award Schemes, Early Intervention projects. The communication within TCYPS was effective and the leadership was judged outstanding following a safeguarding inspection (Ofsted, 2015).

This research identified that if a leader is to be credible then they need to be actively engaging and motivating followers. This leadership approach fits naturally with trait theory where leaders possess traits which informs their behaviour that can positively influence followers (Judge et al., 2009; Northouse, 2013). The participants believed that engaging and motivating staff was a key quality of a credible leader. This engagement and motivation of staff and followers is a dimension which reconciles with situational leadership (Grint 2011, Northouse, 2016).

It is noteworthy that all professional groups in TCYPS agreed that communication was the key quality of a credible leader notwithstanding, communication could be described as a skill, but the finding presented under the quality section of the responses.

A variance in the responses from the different professional groups in regard to trust as a key influencer for credibility is interesting, as health and learning and development staff identified qualities of honesty and trust as significant credibility factors, whilst listening was the key credibility influence for social work staff. Trust is developed based on a perception of competence and reliability thus, it encapsulates acting with integrity (Cairney & Wellstead, 2020).

Key Summary

This study found that communication was regarded as the highest-ranking quality that influenced a leader's credibility. If a leader is an effective communicator and they deliver on their promises, they will be perceived as having a high level of integrity. Possessing integrity as a public sector professional will be an important quality to possess due to the fundamental confidential nature of the work that this group of professionals are involved with. Trust as key influencing factor ranked as the second most important quality that makes a leader credible followed by honesty as the third ranking quality that influences leadership credibility and professional experience as the fourth most influencing factor for leadership credibility.

6.3.2 Values do matter

A leader's values were found to be significant key influencing factors to achieve credibility. This study provided an abundance of personal stories shared by participants in respect to their own beliefs of what characteristics they perceived to be important to increasing a leader's credibility as listed in Table 30. Kouzes and Posner (2011), who conducted research into the characteristics of 'Admired Leaders', concluded that personal values defined individuals as credible leaders.

***Table 30**: Characteristics perceived to be important for leadership credibility*

CYPS Study Cohort	Admired Leaders (Kouzes and Posner (2011)
Communication 57.6% Trust 55.1% Honesty 50.8% Professional Experience 38.7%	Honesty 84% Competent 66% Inspirational 66% Forward Thinking 62%

When comparing the responses from this research study with those of Kouzes and Posner (2011), *Honesty* emerged as common key value from both study cohorts The variance between the responses of both study groups for this key value is 33.2%. Kouzes and Posner (2011) cohort ranked *honesty* as the top quality that they admire most in leaders whereas in this research study *honesty* was the third most important key value. The only other influencing factor that could have a tenuous link between both study cohorts set of key values re the influencers are Professional Experience and Competent. This of course would require this study researcher to make a value judgement on the data without the opportunity to qualify this co-relation and that would compromise the integrity of the comparators.

Evidence in this study discovered shared values between followers and leaders were essential to achieve successful organisational outcomes, to set the strategic direction for business decisions and strengthen leadership credibility (Kouzes & Posner, 2011).

Staff from the integrated service expressed their concerns in respect to leader and organisational value conflict, this was more notable during times of financial austerity, when leaders were executing resource cuts. One leader shared their experience of when their own personal values had been sorely tested during a particular challenging time of public consultations to reduce service provision to achieve savings. They attempted to persuade the organisation to change their values by presenting evidence to the senior leaders of what the impact maybe on service users if service provision was to be reduced. The leader believed this gained them greater loyalty from their

subordinates. Although they didn't achieve the outcome of retaining the service, they did achieve a pause in the consultation proceedings to offer an alternative plan, they believed this demonstrated to their staff team that the organisation had tried to be conciliatory by re-aligning their values to listen to staff concerns. Further findings support the perception that an organisations values tend to be more general and act as an enabler to govern the behaviour and conduct of employees as opposed to a leader's values which were personal to them.

Key qualities, values and knowledge needed for a credible integrated leader include:

- to be a 'strategic thinker' coupled with being visionary
- possess integrity, honesty, and trust
- effective communication and listening skills
- engaging and motivating followers
- professional experience
- confident and able to make informed decisions
- having political awareness
- managing relationships
- confident and having a strong professional voice

This study identified that being knowledgeable and having the competencies to make decisions were key indicators of a leader's credibility. Having professional experience was considered to be the fourth most important factor that influenced leadership credibility, yet possessing a professional qualification ranked as the least influencing factor to gain leadership credibility.

The findings from this study have thrown shade on the findings that emerged from the research conducted by Kouzes and Posner (2011), whilst both studies indicated the importance of honesty as an influencing factor this study revealed that the key influencing qualities for leadership credibility with the exception of honesty, differed from Kouzes and Posner (2011). This could be due to the different cultural norms or the length of time between both research studies its almost 4 decades since they first

conducted the research (Kouzes & Posner 2011) and there has been significant societal changes in societal that may have influenced the differences in the findings.

Key Summary

The key influencer of effective communication as the top-ranking quality from this study reflects the diversity of the nature of integrated services possessing knowledge of the organisation's environment influences credibility (Turner, 2019). Having the ability to engage and motivate followers was key along with being professionally experienced and confident, these are essential when working a cross different organisations that are complex systems (Bawany, 2016; Timmins, 2015).

6.3.3 Having the knowledge

The findings from this study emphasised that service leaders needed to possess knowledge of the internal workings and governance arrangements of both the council and NHS is essential. In TCYPS there were two different routes of accountability for providing assurance at an Executive level. The council being highly political, with elected members having overall responsibility, and the NHS Trusts with an appointed Trust Board consisting of a Chair, Non-Executive and Executive officers. The cultural nuances of each organisation are distinct, (Turner, 2019). There is an expectation for service leaders to deliver services in an integrated form through a single service system and process. This service model is sourced from two organisations with separate assurance processes that need to satisfy both corporate and professional governance arrangements, therefore the knowledge of the internal operational machinations of each organisation was an influencing factor on the credibility of the service leaders. This finding in relation to knowledge increasing credibility correlated with the view that individuals were perceived as being credible if they demonstrate a credible knowledge of the environment (Turner, 2019).

Two key skills for an integrated team leader are the need to be a 'strategic thinker' coupled with being what was termed as being visionary. A deeper analysis of the data found that this meant that for leaders to be credible they had to possess an in-depth knowledge and understanding of public and local social care and health policy with the ability to interpret key messages from the strategies to their followers. This ability to

interpret national, regional, and local policy was considered by participants to be an important factor for leaders working within a multi-agency environment, as there was significant legislative, practice guidelines and policies that underpinned corporate and professional practice. An integrated service leader had responsibilities to ensure that the agencies who commission and provide services fully understand any risk implications for the organisations. The importance of having this in-depth knowledge of policy with the ability to translate it into service outcomes is to ensure that any strategic vision will be clearly understood by the various audiences from the partner organisations (Hackett & Spurgeon, 1999). This finding is important for integrated service leaders as they are responsible for managing complicated competing political and professional priorities of two similar but differently governed organisations but having to ensure synergy to achieve a mutually successful combined effect.

The findings identified several references made relating to a leader's level of knowledge and understanding with the ability to interpret policy, structures, systems, and processes, these areas of specific knowledge were important factors to leadership credibility. A deeper analysis of the data found that this meant that for leaders to be credible they had to possess an in-depth knowledge and understanding of public and local social care and health policy with the ability to interpret key messages from the strategies to their followers. This ability to interpret national, regional, and local policy was considered by participants to be an important factor for leaders working within a multi-agency environment, as there was significant legislative, practice guidelines and policies that underpinned corporate and professional practice. An integrated service leader had responsibilities to ensure that the agencies who commission and provide services fully understand any risk implications for the organisations and the governance arrangement meet the expectations (Exworthy et al., 2017). The importance of having this in-depth knowledge of policy with the ability to translate into service outcomes is to ensure that any strategic vision will be clearly understood by the various audiences from the partner organisations (Hackett & Spurgeon, 1998). This finding is important for integrated service leaders as they are responsible for managing complicated competing political and professional priorities of two similar but differently governed organisations but having to ensure synergy to achieve a mutually successful combined effect.

A further key requisite for leadership credibility of integrated service leaders is the need to possess an in-depth understanding of the accountability structures within each integrated organisation. There is a lack of research which considers competing forms of accountability structures in integrated organisations that are formed as partnership arrangements and the challenges they present to leaders. Recent evidence suggests that traditional vertical structures that currently exist in public sector organisations will need to shift towards horizontal structures to facilitate the new Sustainability and Transformation Partnerships (STPs), which are due to convert to Integrated Care Systems (ICS) by July 2022 (Moran et al., 2021). ICSs will be statutory partnership arrangements between local organisations to plan and co-ordinate services that improve population health and reduces inequalities (Health and Care Act, 2021). The ICS is strategic in its quest and is not to be confused with Integrated Care Services which is the service delivery model of provision which is the focus of this research study.

Key Summary

The knowledge integrated leaders need to gain leadership credibility includes:

- An in-depth knowledge and understanding of public and local social care and health policy
- The ability to interpret key messages from the strategies to their followers
- An in-depth understanding of the accountability structures within each integrated organisation

6.3.4 Leading with style

There is substantial research which emphasises the benefits of the rationale for integrating services (Curry & Ham, 2010; Timmins & Ham 2013; Humphries, 2015). In addition, there is an abundance of research promoting leadership theories, with discussions on leadership styles that can be adopted to achieve different organisational cultures and service outcomes, ranging from transactional styles through to the more contemporary authentic and distributive leadership approaches (Grint 2011; Timmins 2015; Northouse, 2016; Turner, 2019). It is known that change is a continuous feature in the public sector as identified in The Health and Care Bill

(2021). This requires leaders to be aware of their styles to ensure that change is sustained, and staff are engaged throughout the process (McKimm & Phillips 2009; Northouse, 2016; Turner, 2019).

Leaders of integrated services have had to develop a vision that transcended the differences in cultures that were brought about by the different professionals working within the integrated service (Anning & Barker, 2006). Transformational leadership is the style that is engaging and persuasive, an important leadership quality when implementing change and be cognisant of the impact it may have on service users. The staff member suggested that leaders who placed their professional judgement above any legislative or policy guidance would attain a high level of credibility. This of course would require a management programme (Mc Kimm & Phillips, 2009). A recent study which explores the relationship between emotional intelligence and transformational leadership found that those leaders who adopted more of a transformational approach and lead with their heart delivered the best outcomes (Brown & Nwagbara, 2020). A social worker in this research described how low emotional intelligence impacted on the leader's credibility. They shared their experience of being part of change management project and how their leader at the time failed to share what the journey of change may look like and underestimated the emotional impact that this organisational change would have on service users and the staff.

Leadership is a process of influencing, facilitating on an individual basis or collectively, with the intent to share agreed objectives (Yukl, 2009). The need to continue to engage followers is essential to achieving successful change, if planned changes are not realised at an individual level, then they are unlikely to be successful at an organisational level (Faupel & Süb, 2019). This was a concern as we were about to embark on a full-scale change programme to establish TCYPS, losing the enthusiasm of those who were in support of the vision was too high a risk, as there were already rumblings of unrest. I had the overall leadership role for health and this was a major service reform – so it was a testing and challenging time for myself personally – but with the right strategy and the resources we ensured there was effective communication.

The importance of leaders sharing the details and journey of the change process to achieve the strategic vision was found to be reflective of a contingent trait leadership style (Northouse, 2016). Where the expectation for leaders to gain credibility was based on them having the quality of communicating, engaging staff with the ability to clarify goals and expectations (Mullins, 2008) agrees this approach to leadership tends to produce improved performance. Another interviewee in the study, discussed how they believed that leaders needed to have the ability to understand policy and be able to translate how the guidance fits with professional practice leader to have a high level of confidence and professional courage, for them to endorse departing from policy guidelines. They may be credible to some staff but not necessarily at a corporate level if risk was not acceptably mitigated professionally and legally. This would be a high-risk strategy if working within different corporate governance cultures in an integrated service as what may appear to be a professionally robust implementation plan for one organisation maybe financially weak for the other partner agency.

If integrated service leaders decided to set aside the policy guidance and decide to dilute the intent this is known as authentic leadership (George, 2007). The adoption of authentic leadership styles can be problematic, particularly if a leader's values do not align with those of the organisation (Gruenfeld & Zander, 2011). This finding is relevant to this study, because of the nature of public sector services, their delivery is underpinned by a plethora of legislation, policies and guidance, therefore, a core skill of a leader in these organisations is the ability to interpret policy in the context of professional practice.

The study findings suggest that leaders of integrated health and social care services need to be acutely aware of the consequences if there is a conflict between national or organisational policies and their professional judgement, as their application of the guidance may impact on their leader's credibility. Having political awareness as a credibility factor featured in the findings but not significantly to be a key factor to influence credibility. It is interesting to note that some health professionals considered political awareness to be a key factor for leadership credibility. This exposed the difference in health staff working in a 'softer' political environment with NHS governance arrangements, consisting of a combination of standards set by professional bodies and the NHS Trust Board risk assurance arrangements.

Compared to social care and education staff are culturally assimilated and familiar with working within ‘hard’ political environments (Local Government Act, 2000), the statutory duties of councils and their elected members, managed through mayoral, cabinet and committee structures.

Key Summary

Leaders of integrated services need to adopt a medley of leadership styles to achieve and sustain success in integrated service organisations (Sim et al., 2021). The alignment of the service leaders’ values with the organisations need to align with the organisation to achieve credibility. Those leaders who adopted a blend of styles that display behaviours that reflect high levels of emotional intelligence and adopt facilitative and coaching approaches that are grounded in transformational achieve better outcomes (Brown & Nwagbara, 2020).

6.4 Credibility and Professional Identity: Key findings

The clustering of the concepts of leadership, professional identity, and credibility as a group of inter-related theories required deeper investigation to determine their relevance for future leadership development. As presented in Chapter One, despite there being a number of studies into of credibility and leadership by Kouzes and Posner (2011), who have conducted formative research across a multitude of organisations including public sector organisations, but they have not researched leadership within an integrated health and social care service. Indeed, this formidable evidence base (Kouzes & Posner 2007, 2011; Gabris & Ihrke, 2000), has provided minimal references to professional identity to its positioning within the leadership and credibility theory.

This study provides the first evidence exploring the influence that professional identity has on the credibility of integrated service leaders. It also builds on current theory and practice. It has identified that leaders of integrated services do not require qualifications, but they must have extensive professional experience to gain credibility. It is significant that the research study found that professional governance arrangements have to be robust as the evidence emerging from this study found that 40% of Multi Agency Teams preferred to be managed by someone from their own profession. Integration across healthcare professional groups is narrow (Best &

Williams. 2019), so there is limited knowledge in existence why this is, but further exploration is needed.

Professional identity is fundamental to integrated working (Best & Williams, 2019), and is dynamic and can change according to an individual's work experience (Pratt & Corley, 2012). There is further research required to consider the reasons why some professionals chose not to work in multi-agency services. This is interesting as the senior leader for healthcare in community services, I led the staff consultation, and despite giving assurances to two experienced clinicians that the integrated service would offer strong professional governance to their professional group, indeed I involved them both in developing safe governance arrangements for their professional group which, I had thought this may have increased their confidence in the process that their concerns were being listened to but they subsequently resigned from their posts as they believed integration would place their patients at risk.

There is a bricolage of evidence relating to the concept of professional identity as presented in Chapter Two, but similar to leadership as a concept, there is no clear definition and has been described as having 'the sense of being a professional' (Trede et al., 2013; Goodwin, 2016). Following a synthesis of associated literature, they suggest that possessing technical and interpersonal skills doesn't guarantee the development of professional identity as a leader of integrated services, which interestingly contrasts with the views of Smith et al., (2018) who found that leaders working in interprofessional teams should possess a level of technical expertise.

The research findings from this study found that professional identity as a standalone term was not specifically referenced (Goodwin, 2016) but the emergence of strong evidence supported the theory that leaders possessing professional knowledge as being an important credibility influencer, this aligns with the findings from Turner (2019), who suggests that professional leadership credibility is earned from possessing contextual knowledge relating to the area of speciality. The study revealed findings that supported the need for leaders to have a strong professional voice that represented the diverse groups of professionals at a strategic level in the organisations. the challenge is to avoid genericism and retain a professional voice when working in an integrated service (Brown et al., 2000).

The need for leaders to possess professional qualifications did not feature strongly in the findings. Professional qualifications did not appear to be linked to professional knowledge and appeared to be viewed as separate entities. The participants hadn't expressly referenced or linked both as being interdependent of each other.

The unimportance of professional qualifications as a credibility influencing factor was interesting, as the findings revealed that social workers placed a great emphasis on the linkage between leadership credibility and strong decision-making skills. There was rich narrative that supported the finding that to be credible as integrated service leaders they need to have a high level of professional experience and expertise.

The relevance of the context of this view is because there is the need for senior leaders to be available from a professional governance perspective to support social workers on a daily basis as they require confident and informed decisions to be made in the sphere of public and child welfare law. Safeguarding children through ensuring that the child protection casework is supervised is a key role function of a social worker, therefore the credibility factor for a leader who offers robust decision-making support would be heightened. Jenkins et al., (2020), suggests that a credibility judgement is determined by three dimensions one of which is having expertise which is a perceived level of knowledge and education. This view is supported by Turner (2019), who discusses professional credibility in the context of clinical leadership, and he suggests that this is earned by having qualifications, experience and successful practice. The findings revealed that there was a conflation of expertise and experience as factors that were considered important for leadership credibility is a need to further understand and seek to define 'professional' in the context of experience and expertise. Leaders of integrated services are generally recruited from a pool of former single service leaders and often selected on the basis of their ability to deal with challenges within an organisation. This has been supported by Bryman (2006), who suggests that leaders with charismatic leader personality traits are more likely to be recruited as they are considered to be the most able to resolve challenging organisational pressures

Key Summary

There is such limited evidence available in respect to professional identity and credibility and the professional identity of professionals working in integrated services that there is a need for further research. This research study however now offers new

knowledge that clearly states that to gain leadership credibility as a leader working in an integrated service possessing a professional qualification will not improve leadership credibility.

6.5 Leading Integrated services

If professional qualifications aren't crucial for integrated team leaders to be credible then they need to demonstrate expertise knowledge and experience and align these with their values. To achieve credibility, they need to understand the organisational environment and support the interprofessional working ethos. This research found that leadership credibility was increased by the leader having behaviours that motivated and engaged staff to share the vision and achieve the service goals. These included:

Table 31: *Key qualities, behaviours and skills to influence Integrated Service Leaders credibility*:

- ✓ **Being visionary.**
- ✓ **Have the ability to translate strategy into clear key messages.**
- ✓ **Being politically aware.**
- ✓ **Have robust professional auditable professional governance arrangements in place.**
- ✓ **Know and understand the roles of all professional roles staff groups.**
- ✓ **Have in-depth knowledge of organisational environments.**
- ✓ **Know and understand public policy related to Health, Social Care and Learning & Development Services and understand the practice implications.**
- ✓ **Be aware of leadership bias toward professional groups of own professional origin.**
- ✓ **Being an effective communicator.**
- ✓ **Being honest, open, and trustworthy.**
- ✓ **Being a confident decision maker.**
- ✓ **Place the professional voice at the centre of all strategic decision making.**
- ✓ **Manage relationships vertically and horizontally across the organisations.**
- ✓ **Adopt different leadership styles that are emotionally Intelligent and transformational.**
- ✓ **Be open to ideas and new ways of working.**
- ✓ **Have a strong professional voice.**
- ✓ **Create an open and strong organisational culture that supports all professionals.**

Leaders can learn from research studies such as this, how to improve the working environment for the professionals working within these new models of service provision. As leaders of integrated services and systems, a credibility challenge is considering the impact of leading change and establishing multi-agency teams. Transformational leadership behaviours can have a powerful effect on integrated working (Smith et al., 2018). Indeed, innovative working within the TCYPS multi-agency service for Looked after Children was recognised as outstanding for the integrated work that achieved good outcomes for young people leaving care (Ofsted, 2015).

A fundamental enabler to successful working relationships between professionals is co-location but it can be a very thorny issue to address (Hudson, 2002). The research findings highlighted several benefits of co-location such as the improvement in communication and information sharing between professionals. This contributes to safer practices in respect to child protection and being based together in the same office is seen as a pre-requisite to integrated working (McLaughlin et al., 2010). The findings showed that sharing workspace with a range of different professionals was beneficial, although, there was a significant amount of discord in respect of the limited availability of office accommodation. Giving meaningful consideration to the quality of the co-located workspace is important for a positive staff experience. It isn't sufficient just to base different groups of professionals together without investing in training resources to support inter-professional working (Hudson, 2002). This was reinforced by a social worker who highlighted that sitting with same professional groups but within a co-located area didn't offer the best opportunities to form relationships (Wilson & Pirrie, 2000; Glasby et al., 2011). Professionals need time and opportunities to get to know one another outside of the working environment (Hudson, 2002). In addition, logistic challenges for staff in this study and other professionals trying to integrate their work practices provides a barrier to achieving a smooth transition to integrating services (Wilson & Pirrie, 2000).

There was an abundance of narrative informing the findings in respect to the importance of staff development, and the increased credibility of those leaders who promoted the philosophy of a learning organisation. This significant finding highlights that development and empowerment of staff in an integrated service is a significant

influencer of how leadership credibility is perceived. What is interesting in regard to this finding is this evidence was overwhelmingly identified by staff who have roles at a practitioner level within the multi-agency teams and there was no evidence to suggest that Directors and senior managers viewed enabling staff development as a leadership credibility factor. Further evidence indicated that leadership credibility was influenced by untapping staff potential, by offering strategic leadership development opportunities, there were several examples of participants expressing their appreciation of these opportunities. There was also evidence that presented examples of leaders that were viewed to have low credibility, these were associated with leaders who adopted a reactive management approach to a crisis rather than enabling a learning culture to promote staff development opportunities. rather than developing a culture of learning. Leaders who foster collaboration by power sharing and enabling others to act, had a greater an influence on leadership credibility (Kouzes & Posner, 2007, 2011)

The findings in respect to professional qualifications not being a significant influencer for leadership credibility, and the lack of research that exists in respect to professional identity in integrated services suggests that a leader's value systems and qualities are what matter to gain credibility and this set of values combined with their skills at managing people and managing relationships are the success criterion for influencing credibility and not formal professional qualifications.

6.6 New Knowledge: Extending integrated leadership theory and credibility:

This study provides the first evidence exploring the influence of professional identity on the credibility of integrated service leaders building on current theory and practice. The unique knowledge that this research contributes to is:

That integrated service organisations do not need to employ someone with a similar professional qualification to lead integrated teams or services. This research study research has found that over time leaders just need to possess the right qualities to gain and be seen as credible. Credible leaders shine through because of their leadership qualities and not because of their qualifications.

Further knowledge emerged from the findings (see Appendix 1) that will add value to the development of integrated services and leaders. Leaders of multi-agency services need to be open to new ideas and knowledge and different ways of working. Social workers placed a great emphasis on leaders who were strong and confident decision makers, whereas health staff perceived leaders who listened and demonstrated conviction to be more credible as leaders.

This research study has extended the theory of leadership and credibility.as the findings revealed that leaders of integrated services or systems tin order to gain credibility, need to possess knowledge of the organisational and political environment they are located (Hartley & Fletcher, 2008), The need to be cognisant of the large group of diverse professionals and to acknowledge the challenges that this presents in terms of marginalisation. This is particular to those professionals who may be managed by a person from a different professional background. The opportunity to reduce isolation of an individual or groups of professional staff can be reduced by the integrated service leader by creating a culture that positions the professional voice at the centre of strategic decision making and development (Wesorick, 2002). This will need to be facilitated by the service or team leader ensuring that there are robust governance arrangements in place and strategies to engage professionals in service development opportunities at service predesign stages. This will ensure that any reshaping of patient/service user related services have a professional perspective. This strategic approach to firming the arrangements around the professional involvement in strategic decision making will reduce professional marginalisation and dilution of the professional voice. This can be achieved by Integrated Service Leaders creating a culture that positions the professional voice at the centre of organisational decision making.

A multi- layered approach can be adopted to facilitate the cultural shift at every level in the organisations.

- *Strategic level*: championing the need for a professional representation at NHS Trust Board and Council Executive / Corporate level.
- *Departmental level*: introduce protocols to reflect evidence that professional advice on any case for change has been engaged in processes.

- *Individual level:* establish a professional forum with a cross section of representatives from the whole range of professional groups to generate and share ideas and new ways of working.

6.6.1 Summary of the key research messages

Prior to this research study there was no evidence of professional identity and credibility as a combined theory. The evidential authority relating to leadership credibility and its relevance in integrated health and social care organisations did not exist. This research study involved an in-depth investigation into the perceptions of professional and non-professionally qualified staff working in a newly established integrated health and social care service. The findings offer an opportunity to ascertain the unique perceptions of staff in relation to the role as an influencing factor that professional identity had on leadership credibility. The key messages from the research participants that informed the new knowledge in this thesis are: -

- That professional Identity as a term was found not to be a standalone concept but instead it represented as a range of skills, qualities and traits e.g., possessing knowledge, having expertise, providing professional presence.
- When considering leadership and management as a theoretical concept or roles from an intellectual or a staff development perspective, this research found that the participants considered each of them as being distinct from each other.
- Leadership being a trait focused role whilst management being more skill orientated.
- To be a credible leader, this research study found that leaders needed to ensure that they gained a full understanding of the roles of each professional working in the multi-agency services.
- This is to ensure that there is professional identity advocacy at a strategic level within the integrated organisations.
- The other key message emerging from the findings was for leaders to ensure that professionals are encouraged and supported to have a strong voice within the integrated service at every level within the organisation.

- An important message gained from social worker staff who participated in the study, was the overwhelming need for leaders to have strong decision-making skills. This offers an opportunity for integrated service leaders to ensure that robust safeguarding supervision is accessible to support the social workers public law responsibilities.
- The importance of possessing a professional qualification was found not to be an important factor to influence the credibility of leaders, instead a greater importance was placed on the qualities of a leader, in particular trust and honesty.
- Professional qualifications and professional knowledge were perceived as two separate entities and the research participants did not consider them to be interdependent. This is an interesting finding as it presents a conundrum of how a leader can achieve professional knowledge without attaining the professional qualification. This emerging finding may warrant further investigation.

6.7 Limitations of the Study

The researcher acknowledges there are limitations to this study due to the time lapse since completing the research and collecting data. The findings remain relevant with the establishment of statutory Integrated Care Systems (ICS) in July 2022. The ICS will be integrated health and social care services across the country.

A further limitation of the study is the omission of service users as research participants. The research study didn't set out to gain the perceptions of service users as to what they considered what makes leaders credible as the integrated service. To achieve meaningful involvement of service users as participants in this study research this would have required the researcher to have a particular skill set as the service users of TCYPS (the research study site location) are children and young people and the involvement of as research subjects would entail the researcher to have a specific skill set (Lockey et al., 2004). McLaughlin (2009), suggests that to merely give the illusion of service user participation just to tick a box, is tokenistic and can result in unethical research. The other challenge for the inclusion of Service users in the study was researcher capacity in terms of time.

The opportunity to involve service users in future research is extremely important, as Baxter et.al., (2018), identified the paucity in research that evaluates the quality outcomes of service integration in particular children, as most service evaluation research is focused on adult service provision.

The learning from this research is transferable, and there is generalisation can be achieved. The researcher being an employee and a senior leader within the study location was cognisant of the 'insider' and outsider positionality and the power issues between being 'researched' by a researcher. The nuance of being an insider and outsider was managed through reflexivity and objectivity during the research process. Being an insider afforded the researcher access to and an understanding of the history of the development of the service reform and the challenges that the staff (study participants) faced during the evolution of the organisational change and the trust relationship that existed. Also being an 'outsider' enhanced the researchers understanding of the wider issues that emerged from the study. Crossley et al., (2015), argues that the researcher's positionality is fluid and it is pointless to suggest that a researcher is a subjective insider or to consider an outsider as objective and completely detached. I went to great lengths to reduce insider bias by introducing rigorous reflexivity and objectivity into the research processes. Based on my critical reflections and constantly undertaking self-scrutiny I made a concerted effort to ensure that the research participants voices came through loudly and not what they wanted me to hear.

6.8 Practitioner Researcher Reflections

As the research study forms part of Professional Doctorate award, it is important to reflect on the research journey I've experienced. After completing the taught element of the D.Prof. I was assigned a university supervisor; we were in the throes of discussing and formulating the research study when they left to join another university. After a few months another supervisor was allocated. We had two supervision meetings and we were again exploring the research study, when they advised me, t that they were being made redundant. I attempted to secure another supervisor but due to capacity issues at the university none were available. I waited for almost 12 months before my current supervisor contacted me to advise me, I had now been reassigned one. We have been together ever since.

The balance between conducting the research and being committed to a fulltime senior position working across both organisations was challenging, I also experienced personal loss that tested my resilience, I contemplated terminating the research. I was feeling overwhelmed, but I have such a passion for public sector services that I wanted to complete the research, as given all the difficulties experienced to achieve service integration in Trafford, through managing professional relationships, securing the confidence from the Council Executive, the CCG and the Trust Boards, to take such a risk from a governance perspective to be one of the first fully integrated services in the country, it just had to be seen through to the end. It's all been worthwhile as the findings, I believe will now add to the knowledge of future service leaders. There is a practice reflection of the journey to establish CYPS (see Appendix 12).

6.9 Recommendations for Practice

There are several recommendations that will inform future practice, these are listed below:

- Leaders of integrated services do not need a professional qualification to be considered credible leaders, but they require a supporting professional governance framework to ensure access to professional supervision and expertise for the workforce

- Professionally qualified leaders require leadership training to ensure impartiality across professional groups

- Where non-professionally qualified leaders are employed there needs to be arrangements that gives presence to the professional voice at an operational, strategic and executive level.

- Multi-professional staff require continual training and development to understand the different leadership qualities brought by non-professional and professional leaders to improve their self-belief and credibility.

- Attention is needed to sustain integrated working by improving the satisfaction of health service staff within the teams.

- All new Integrated Service or Team Leaders needs to receive leadership development that includes the qualities, and values that improve their credibility.
- Staff of integrated teams need preparing and educating appropriately to understand and value leadership and understand that it is not confined to or bound by professional knowledge and qualifications.

6.10 Conclusion

In Trafford we took a risk and we decided to appoint some leaders without a professional qualification matching professional groups they were leading. Overtime the research demonstrated and reinforced that key leadership qualities such as integrity, honesty, trust, effective communication, exposed already throughout the leadership theories (Grint, 2011; McKimm & Phillips, 2009; Northouse, 2016), are more important than a professional qualification. Before this research this interplay of concepts that influenced credibility was an unknown regarding integrated team leadership, and this study is one of the first to explore this notion. Moreover, those leaders with a professional qualification who failed to demonstrate key leadership qualities of integrity and honesty, by showing favouritism to their own profession, were considered weak leaders with little credibility. When considering leaders for integrated teams this study identified that an awareness and assurance of policies and governance for the different professional groups you are leading was essential to improve the credibility of an integrated leader and this training needs to be incorporated within a leader's induction or demonstrated at interview.

The research evidence exploring the influence of professional identity on the credibility of integrated service leaders built on existing theory and practice. The study discovered that professional qualifications are not necessary to be a credible leader of integrated services, but in-depth knowledge of pollical environments and policies are key influencers to leadership credibility. Expertise and experience were also factors which informed decision making and are seen as crucial to successful

leadership. The challenge to understand how leaders gain professional expertise and experience without undertaking professional training or attaining a professional qualification, is unclear and may warrant further research. The success of integrated services is yet be proven as the best model of service to deliver the aspirations of governments and strategic partners (Scobie, 2021). Leaders of integrated services need to be open to new ideas and knowledge and different ways of working. This research identified that social care staff placed a greater emphasis on leaders who demonstrated strength in professional decision making whereas health staff perceived leaders who listened and demonstrated conviction to be more credible. Leaders originating from non-professional backgrounds need to demonstrate strong professional governance to provide the required assurance to lead disparate professional groups. Leaders with professional qualifications were found to exhibit a bias such as favouritism towards their own professional group therefore, identifying additional development tor leaders to ensure they provide impartial leadership. The existing evidence of leadership qualities relating to credibility were reinforced, with communication, honesty, trust and integrity being seen to be more important as credibility factors than a leader's level of competence.

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Appendices

Appendix 1 - Contribution to new Knowledge

New knowledge to contribute to DProf:

- This study provides the first evidence exploring the influence of professional identity on the credibility of integrated service leaders building on current theory and practice
- The study indicated that you do not need a professional qualification to be a credible integrated health and social care service leader, but experience and expertise which inform decision making is seen as crucial to successful leadership
- How leaders gain expertise and experience without a professional qualification is unclear and the success of integrated services needs to yet be proven as the best model of service delivery
- Managers of multi-agency services needed to be open to new ideas and knowledge and different ways of working
- Social care staff placed a greater emphasis on leaders who demonstrated strength in professional decision making whereas health staff perceived leaders who listened and demonstrated conviction to be more credible.
- Health staff appeared less satisfied with the integrated service model than those from Local Authority
- Leaders originating from non-professional backgrounds need to demonstrate strong professional governance to provide the required assurance to lead the disparate professional groups
- Leaders with a professional qualification were found to exhibit negative leadership qualities such as favouritism towards their own professional group; identifying additional training and development needs for this group of leaders to provide impartial leadership of integrated services
- Existing evidence is reinforced as integrity was seen to be more important for leaders' credibility than their ability or competence

- **Recommendations for Practice:**
- Leaders of integrated services do not need a professional qualification to be considered credible leaders – but require a supporting governance framework to ensure access to professional supervision and expertise for the workforce
- Professionally qualified leaders require leadership training to ensure impartiality across the professional groups
- Where non-professional leaders are employed there needs to be a mechanism to ensure the professional voice is present at a strategic and executive level
- Multi-professional staff require continual training and development to understand the different leadership qualities brought by non-professional leaders and professional leaders to believe their credibility
- Attention is needed to sustain integrated working by improving the satisfaction of health service staff within the team

Appendix 2 - Literature Review Extraction/Inclusion Table

No	Author and Title	Methodology	Sample	Findings/Other
1	Avolio, B. J. (2004). Examining the full range model of leadership: Looking back to transform forward. *Leader development for transforming organizations: Growing leaders for tomorrow*, 71-98.	Literature Review	N/A	Developed Full Range leadership development Model for individual, team and Strategic development Develop others not self
2	Barr, J., & Dowding, L. (2019). *Leadership in health care*.	Literature Review	N/A	critical literature review examines how leaders of interprofessional teams are functioning identifies a framework of factors that contribute to good leadership practice
3	Binney, G., Williams, C., & Wilke, G. (2012). *Living leadership: a practical guide for ordinary heroes*. Pearson UK.	Qualitative	Living with colleagues	Leaders need to take risk Leaders need to get real Leaders need to get the work done through others
4	Bowman, J. S., West, J. P., Berman, E. M., & Van Wart, M. (2016). *The professional edge: Competencies in public service*. Routledge.	Literature Review	N/A	The new context and character of public service-shifting values, entrepreneurship, information technology, multi-sector careers-require enhanced technical, ethical, and leadership skills
5	Crawford, P., Brown, B., & Majomi, P. (2008). Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies*, *45*(7), 1055-1063.	Qualitative	34	The metaphor of nurses searching for recognition has demonstrated its usefulness as a means of illuminating the quest undertaken by CMHNs to establish the legitimacy of their work and achieve acknowledgment and appreciation. This underlies the search for professional identity in community mental health nursing.

No	Author and Title	Methodology	Sample	Findings/Other
6	Czabanowska, K., Malho, A., Schröder-Bäck, P., Popa, D., & Burazeri, G. (2014). Do we develop public health leaders? - association between public health competencies and emotional intelligence: a cross-sectional study. *BMC medical education*, *14*(1), 1-7.	A cross-sectional study	33	The study shows a positive correlation between public health specific competencies and EI attributes.
7	Daly, J., Speedy, S., & Jackson, D. (2014). *Leadership and nursing: Contemporary perspectives*.	Literature Review	N/A	Managers need to learn continuously Have tools to adapt to emerging change Be courageous
8	Denis, J. L., Langley, A., & Pineault, M. (2000). Becoming a leader in a complex organization. *Journal of Management Studies*, *37*(8), 1063-1100.	Literature Review	N/A	Reveals that leader integration processes may be differentiated between different activity domains,
9	Dinh, J. E., Lord, R. G., Gardner, W. L., Meuser, J. D., Liden, R. C., & Hu, J. (2014). Leadership theory and research in the new millennium: Current theoretical trends and changing perspectives. *The Leadership Quarterly*, *25*(1), 36-62.	Literature Review	N/A	Used 17 themes to critically analyse leadership theories
10	Edgren, L., & Barnard, K. (2012). Complex adaptive systems for management of integrated care. *Leadership in Health Services*.	Literature Review	N/A	complex adaptive systems (CAS) approach to manage integrated care services
11	Edmonstone, J. D. (2020). Beyond healthcare leadership? The imperative for health and social care systems. *Leadership in Health Services*.	Literature Review	N/A	Treat health and social care as a system Don't focus on organisations. Future model is collective multi-agency team

No	Author and Title	Methodology	Sample	Findings/Other
12	Elliott, I. C., Sinclair, C., & Hesselgreaves, H. (2020). Leadership of integrated health and social care services. *Scottish Affairs*, *29*(2), 198-222.	Qualitative	Qualitative survey of front-line managers of integrated health and social care services Purposive Sampling	Co-ordinated support Joint Training Shared source for accessing integrated service information and policies
13	Fisher, W. P. (2017). Provoking professional identity development: The legacy of Benjamin Drake Wright. In *Psychological and Social Measurement* (pp. 135-162). Springer, Cham.	Literature Review	N/A	Developing your own identity Life story identity
14	Fitzgerald, A. (2020, July). Professional identity: A concept analysis. In *Nursing Forum* (Vol. 55, No. 3, pp. 447-472).	Literature Review	N/A	clearer definition of professional identity goal.
15	Fragale, A. R., & Heath, C. (2004). Evolving informational credentials: The (mis) attribution of believable facts to credible sources. Personality and social psychology bulletin, 30(2), 225-236.	Case Studies	3	true beliefs come from credible sources; when participants were given feedback that their beliefs were incorrect, the relationship between beliefs and source inferences did not occur.
16	George, B., Sims, P., McLean, A. N., & Mayer, D. (2007). Discovering your authentic leadership. *Harvard business review*, *85*(2), 129.	Qualitative Semi structured interviews	n=125 Leaders	Findings were identifying qualities and capabilities of leaders an listed the key factors The most important capability for leaders to develop, their answer was self-awareness. can be used for leadership development

No	Author and Title	Methodology	Sample	Findings/Other
17	Goleman, D. (2020). *Emotional intelligence*.	Literature Review	N/A	Emotional intelligence a major role in thought, decision-making and individual success. Self-awareness, impulse control, persistence, motivation, empathy and social deftness-all are qualities
18	Grint, K. (2011). A history of leadership. The SAGE handbook of leadership, 14(1), 3-14.	Literature Review	N/A	Follower leadership theories
19	Hudson, B., (2002). Interprofessionality in health and social care: the Achilles' heel of partnership? *Journal of interprofessional care*, *16*(1), pp.7-17.	Qualitative Study	N = 81 Interviews Focus groups	Multi-professional relationships between in health and social care working {professional Identity There are opportunities to have a more positive approach to interprofessional working 18mths to establish service ***(Researcher met with Prof Hudson re research study)***
23	Joynes V. (2018). Defining and understanding the relationship between professional identity and interprofessional responsibility: implications for educating health and social care students. *Advances in health sciences education: theory and practice*,	Qualitative Study Semi structured interviews	(n=33)	Senior professionals more comfortable with their own professional identity, and with working across professional boundaries, than junior colleagues.
20	Judge, T. A., Piccolo, R. F., & Kosalka, T. (2009). The bright and dark sides of leader traits: A review and theoretical extension of the leader trait paradigm. *The leadership quarterly*, *20*(6), 855-875.	Literature Review	N/A	Big Five traits, core self-evaluations, intelligence, and charisma. We also consider the positive and negative effects of "dark side" leader traits: Narcissism, hubris, dominance, and Machiavellianism.

No	Author and Title	Methodology	Sample	Findings/Other
21	Kaiser, R. B., Hogan, R. & Craig, S. B. (2008). Leadership and the Fate of Organizations. *American Psychologist, 63* (2), 96-110.	Literature Review	1,124 samples 10 meta-analytic studies reviewed	leadership effectiveness should be defined and evaluated in terms of the performance of the group or team for which a leader is responsible. leadership research concerns how managers are perceived and therefore provides limited insight into leadership effectiveness. Literature tends to focus more on follower, team, and organizational processes than on organisational outcomes
22	Kouzes and Posner Leadership in the eye of the follower (2007)	MMI Convergent over 5 years	100,00 managers	majority of leaders who are honest, competent, forward-looking, inspiring, are credible.
24	Kouzes, J. M., & Posner, B. Z. (2011). *Credibility: How leaders gain and lose it, why people demand it* (Vol. 203).	MMI Convergent study over 5 yrs Focus groups Case studies In-depth interviews Questionnaires	Global study of 15,000 Managers	Identified specific actions that made managers credible Created checklist 'characteristics of admired leaders' Replicated study –with 800 sample same results find the qualities of admired leaders Honesty, forward looking, inspiring Competent
25	Leavy, B, (2003), "Understanding the triad of great leadership - context, conviction and credibility", *Strategy & Leadership*, Vol. 31 No. 1	Literature Review Personal lived experience	N/A	context, conviction and credibility the triad of leadership success

No	Author and Title	Methodology	Sample	Findings/Other
26	Marsh, S., & Dibben, M. R. (2003). The role of trust in information science and technology. *Annual Review of Information Science and Technology*, *37*(1), 465 - 498.	Literature Review	N/A	Mistrust, and Distrust, how they interlink and how they affect what goes on around us and within the systems we create. introduce the phenomenon of 'Untrust,' which resides in the space between trusting and distrusting. consider how untrust, distrust and mistrust work, why they can be useful in and of themselves, and where they can shine.
27	Matuson, R. C. (2011). Suddenly in Charge: Managing Up, Managing Down, Succeeding All Around.	Qualitative	Personal Lived experience no sample	Credibility based on words and behaviour Leaders need the ability to select talent Learning organisation cultures Importance of aligning values organisation and followers
28	McInnes, A., & Lawson-Brown, V. (2007). God 'and Other Do-Gooders' A Comparison of the Regulation of Services Provided by General Practitioners and Social Workers in England. *Journal of Social Work*, *7*(3), 341-354.	Literature Review	N/A McInnes, A., & Lawson-Brown, V. (2007). God 'and Other Do-Gooders' A Comparison of the Regulation of Services Provided by General Practitioners and Social Workers	professionalisation of the role of GPs and social workers The perception of the public towards the two professions interprofessional perceptions are explored. Balance of power issues
29	McKimm, J., & Phillips, K. (Eds.). (2009). *Leadership and management in integrated services*. SAGE Publications.	Literature Review	N/A	Leading in different ways Experts are patients/service users not Leaders Not the most senior leaders are the most effective

No	Author and Title	Methodology	Sample	Findings/Other
30	McNeil, K. A., Mitchell, R. J., & Parker, V. (2013). Interprofessional practice and professional identity threat. *Health Sociology Review*, *22*(3), 291-307.	Literature Review	N/A	interprofessional practice (IPP) within healthcare appears to be fraught with difficulties, despite the attention it has received in the literature. Although there are examples where IPP has reaped significant benefits, it has also been shown to impede team performance. We demonstrate that a key cause of failure in IPP can be attributed to interprofessional conflicts based on threats to professional identity
31	Mullins, L. J. (2008). Essentials of organisational behaviour.	Literature Review	N/A	Leadership Theory needs to be integrated Balance and power in organisations and leadership issues (consider re integrated services two orgs coming together)
32	Northouse, P. G. (2016). *Introduction to leadership: Concepts and practice*. Sage Publications.	Literature Review	N/A	Leadership theories from traditional to contemporary
33	Peck E, Dickinson H. (2008) *Managing and leading in inter-agency settings.* Bristol: Policy Press;	Literature Review	N/A	The distinction is overstated; there are also significant overlaps in the types of tasks and challenges that both sets of leaders and managers will face and these should not be underestimated.
34	Penny, S. M. (2017). Serving, following, and leading in health care. *Radiologic technology*, *88*(6), 603-617.	Literature Review	N/A	individuals should be prepared to improve patient care and to function as a servant, follower, and leader for the overall success of the organization. This article examines those roles, emphasizing servantship.
35	Pirrie, A., Hamilton, S., & Wilson, V. (1999). Multidisciplinary education: some issues and concerns. *Educational Research*, *41*(3), 301-314.	Literature Review	N/A	'Multidisciplinary by definition, a 'good thing'. The fact that this is so widely assumed to be the case is, it is suggested, linked in part to the considerable conceptual confusion surrounding the use of terms.

No	Author and Title	Methodology	Sample	Findings/Other
36	Quist, A. H. (2009). A credible leader for turbulent times: Examining the qualities necessary for leading into the future. *Journal of strategic leadership*, *2*(1), 1-12.	Literature Review	N/A	Qualities of credible leaders identified Competency, Honourable Culturally aware Committed to learning. Ability in predicating future scenarios Capability and creative
37	Rodgers, C. R., & Scott, K. H. (2008). 40 The development of the personal self and professional identity in learning to teach. *Handbook of research on teacher education*, 732.	Literature Review	N/A	Prof Identity Constructing own identity Self-identity
38	Roe L. (2013) Leadership and management in integrated services. International Journal of Integrated Care.	Literature Review	N/A	Reflexive, sensitive and smart skills are required to successfully deliver an integrated service
39	Roe, K. (2020). Leadership: practice and perspectives. Oxford University Press.	Literature Review	N/A	Leadership theories Traditional vs contemporary Practice guidance
40	Scully, N. J. (2015). Leadership in nursing: The importance of recognising inherent values and attributes to secure a positive future for the profession. *Collegian*, *22*(4), 439-444.	Literature Review	N/A	identification, support and development of future nurse leaders, shifting paradigm of leadership theory informal, negative “leaders” be discouraged and positive leaders, possessing the evidence-based qualities of leadership be identified and nurtured to lead the profession

No	Author and Title	Methodology	Sample	Findings/Other
41	Shamir, B., & Eilam, G. (2005). "What's your story?" A life-stories approach to authentic leadership development. The leadership quarterly, 16(3), 395-417.	Literature review	N/A	Methods have to be devised to distinguish authentic stories from inauthentic stories and authentic leadership from inauthentic leadership
42	Sims S, Fletcher S, Brearley S, Ross F, Manthorpe J, Harris R. (2021) What does Success Look Like for Leaders of Integrated Health and Social Care Systems? a Realist Review. International Journal of Integrated Care,	Literature Review ongoing stakeholder consultation	N/A	Evidence was identified for seven potentially important components of leadership in integrated care teams and systems: 'inspiring intent to work together'; 'creating the conditions'; 'balancing multiple perspectives'; 'working with power'; 'taking a wider view'; 'a commitment to learning and development 'and 'clarifying …
43	Snelgrove, S., & Hughes, D. (2000). Interprofessional relations between doctors and nurses: perspectives from South Wales. *Journal of advanced nursing*, *31*(3), 661-667.	Qualitative Semi structured interviews	28	Doctors and Nurses relationships Issues re professional identity
44	Sullivan, W. M. (2000). Medicine under threat: professionalism and professional identity. *CMAj*, *162*(5), 673-675.	Literature review	N/A	PI re Drs and MDT
45	Timmins, N. (2015). The practice of system leadership. *Being comfortable with chaos*. The Kings Fund Press	Qualitative (Think Tank)	16 people (chairs of Integrated Care Systems)	Local systems are still evolving. A shift from being autonomous to considering success not being based on leader's organisation performance but on integrated orgs Identified different approaches to governance and accountability and transparency. Leaders with knowledge and experience ready for retiring How to get a sustainable supply of future leaders

No	Author and Title	Methodology	Sample	Findings/Other
46	Tseng, S., & Fogg, B. J. (1999). Credibility and computing technology. *Communications of the ACM*, *42*(5), 39-44.	Literature review	N/A	Credibility conceptual framework developed To capture 4 key areas of credibility (relevant to believing)
47	Turner, P. (2019). Leadership in healthcare: Delivering organisational transformation and operational excellence.	Literature Review	N/A	Professional Credibility Leadership
48	Van Wart, M. (2013). Lessons from Leadership Theory and the Contemporary Challenges of Leaders. *Public Administration Review*, *73*(4), 553–565. http://www.jstor.org/stable/42003076	Literature Review	N/A	Considers contemporary leadership theories and their strategic fit with the public sector and reforms
49	Watson, T. (2002). Professions and Professionalism-Should We Jump Off the Bandwagon, Better to Study Where It Is Going? *International Studies of Management & Organization*, *32*(2), 93-105.	Literature Review	16 papers	abandoning the concepts of "profession" and "professionalism" as analytical resources for the study of occupations and occupational strategies.
50	West, M. A., Eckert, R., Steward, K., & Pasmore, W. A. (2014). *Developing collective leadership for health care* (Vol. 36). London: King's Fund.	Literature Review (Think Tank)	N/A	Collective leadership everyone's job Leaders create caring supportive environments Create culture of collective leadership, all.

No	Author and Title	Methodology	Sample	Findings/Other
51	Yukl, G. (2009). Leading organizational learning: Reflections on theory and research. *The leadership quarterly*, *20*(1), 49-53.	Literature Review	N/A	Limitations of some well-known leadership theories for explaining this influence Ideas for developing more comprehensive and accurate theories Recommendations how leaders can influence organizational learning

Appendix 3 - Ethics Approval Local Research Ethics Committee

From: Osborne Kath (NHSNW) <Kath.Osborne@northwest.nhs.uk>
To: Baker-Longshaw, Carol
Sent: Mon Jan 30 12:34:16 2012
Subject: RE: Ethics Approval

Dear Carol

The Chair has advised that this does not fall within the remit of the NHS ethics committee under the current GAfREC – it is a non-interventional study which involves NHS staff but no patients or information relating to patients.

Given that this is going to be the basis of a doctorate at Salford University, it should be submitted to the University Ethics Committee.

Kind regards

Kath

Kath Osborne | NRES (REC) Co-ordinator

NRES Committee Northwest - Greater Manchester Central

and Acting Co-ordinator - Yorkshire Independent Research Ethics Committee

Health Research Authority

National Research Ethics Service (NRES)

Direct line 0161 625 7825 | Line 2 0161 625 7831 | Fax no. 0161 625 7299

Research Ethics Committee (North West) Centre

3rd Floor, Barlow House, 4 Minshull Street, Manchester M1 3DZ

Email: kath.osborne@northwest.nhs.uk | www.hra.nhs.uk | www.nres.nhs.uk

Appendix 4 - Ethics Approval Trafford Metropolitan Borough Council

Compliance and
Governance Team
Trafford Town Hall
Talbot Road
Stretford uk **M32 0TH** Minicom 0161 912

Telephone 0161 912 1240
Fax 0161 912
Email research.governance@trafford.gov.

When phoning ask for: Michelle Peel

Your ref: Carol Baker-Longshaw

Our ref: c/o Trafford Town Hall

Talbot Road

Date: 24 May 2013

Stretford

Manchester

M32 0TH

Dear Carol,

Many thanks for your application to undertake your research project entitled “The influence that professional identity has in respect to the credibility of Leaders of Integrated Services”, involving staff from Trafford Council.

I can confirm that the Research Governance Committee have reviewed your application, and are happy to provide their approval for you to undertake the research as designed and outlined in your University Proposal.

Best wishes,

Michelle Peel

CYPS Information Governance Officer (in capacity as Research Governance Coordinator)

Appendix 5 - Ethics Approval Pennine Care NHS Foundation Trust

Research & Development Department

Trust Headquarters

225 Old Street

Ashton-under-Lyne

OL6 7SR

Tel: 0161 716 3086

Fax: 0161 716 3143

Email: researchdevelopment.penninecare@nhs.net

Carol Baker-Longshaw
Joint Director
(Strategic and Professional Lead for Healthcare and Early Years)
Children and Young People Services
Trafford Town Hall
Ground Floor Extension
Talbot Road
Stretford M32 0TH

Date: 17th May 2013

Dear Carol

Research and Development approval letter

Re: The Influence that professional identity has in respect to the credibility of Leaders of Integrated Services

Pennine Care reference: 13-A-04-A

Thank you for submitting your research project for consideration by the Research and Development (R&D) Department. The project was reviewed by the R&D Panel in line with the 'Research Governance Framework for Health and Social Care' and in regards to its impact on resources for the Trust and its suitability within our research portfolio.

We have also verified the relevant documentation and approvals from all necessary regulatory agencies. These may include, but are not limited to, the National Research Ethics Service (NRES), the Medicines and Healthcare products Regulatory Agency (MHRA), and the Administration of Radioactive Substances Advisory Committee (ARSAC).

On this basis, we are now able to grant approval for your project at Pennine Care NHS Foundation Trust, subject to the terms and conditions listed below.

- The currently approved protocol/info briefing sheet is **Version 4 dated 9th May 2013** and the approved documents, including the Participant Information Sheet and Informed Consent Form, are those provided in support of your application: V4 Questionnaire, V4 Participants Invitation, V4 Interview Schedule, V1 Consent all dated **9th May, 2013.** These must be the only versions in use.
- In the event of any amendment (substantial or minor) to the protocol or documentation, approval must be sought from the necessary regulatory agencies. Approval for the amendment must also be obtained from the Research and Development Department before implementation.
- Any significant deviation from the approved protocol/info briefing sheet or documentation must be notified to the R&D Department as soon as the issue is discovered.
- The Chief Investigator, local Principal Investigator and all other researchers working on the project must abide by and adhere to their specific responsibilities as detailed in the 'Research Governance Framework for Health and Social Care'. They must also meet all UK statutory requirements, with particular significance, where applicable, to: the 'Data Protection Act 1998', 'The Medicines for Human Use (Clinical Trials) Regulations 2004', the 'Mental Health Act 2007', the 'Human Tissue Act 2004' and all subsequent amendments to these.
- The only researchers approved to perform the research activities for this project at any Pennine Care site or involving any staff, service users or other persons under our duty of care are those listed on the SSI form and/or delegation log for Pennine Care.

continued on page 2…

continued from page 1…

- All personnel listed on the SSI form and/or delegation log for Pennine Care must undertake and provide evidence of Good Clinical Practice (GCP) training at least once every two years.
- Recruitment figures for Pennine Care participants in relation to this project must be sent to the R&D Department on a minimum of a six-monthly basis.
- If applicable, the Sponsor or Chief Investigator must notify the R&D Department of any Serious Adverse Events (SAEs) that occur during the conduct of the trial.
- The R&D Department must be notified about any suspension and upon completion of the project, and must be sent a copy of any final report and/or findings.
- Pennine Care reserves the right to suspend or terminate approval for this project with immediate effect if any of these conditions are breached or in any other circumstances it deems necessary.
- Any further project specific conditions as detailed below:

- This letter must be countersigned by the Sponsor's Representative, Chief Investigator and Principal Investigator or Local Collaborator as proof of their agreement to the terms and conditions described above.

Thank you again for submitting your project to Pennine Care. We wish you good luck with recruitment and with the progress of your project. If you need any further assistance, then please feel free to contact the R&D Department via the contact details at the top of this letter.

Research Approval Granted: Study title: The Influence that professional identity has in respect to the credibility of Leaders of Integrated Services Pennine Care reference: 13-A04-A

Name: Reagan Blyth **Signature:** 

Role: Associate Director of Quality Assurance and Research, Pennine Care NHS Foundation Trust

We, the undersigned, hereby agree to all of the terms and conditions as specified by the approval letter above.

Name: _____ **Signature:** _____

Date: _____ **Role:** Sponsor's Representative

Name: _____ **Signature:** _____

Date: _____ **Role:** Chief Investigator

Name: _____ **Signature:** _____

Date: _____ **Role:** Principal Investigator/Local

*****delete as applicable

Please return one original signed copy of this letter to the R&D Department immediately and retain the other copy for your own project file.

Appendix 6 - Ethics Approval University of Salford

Research, Innovation and Academic

Engagement Ethical Approval Panel

College of Health & Social Care
AD 101 Allerton Building
University of Salford
M6 6PU

T +44(0)161 295 7016
r.shuttleworth@salford.ac.uk

www.salford.ac.uk/

12 July 2013

Dear Carol,

RE: ETHICS APPLICATION HSCR13/36 – The influence that professional identity has in respect to the credibility of leaders of integrated services

Based on the information you provided, I am pleased to inform you that application HSCR13/36 has now been approved.

The Panel have asked me to pass on a couple of comments for consideration:

- Appendix 4: The draft interview should contain an item prompting the researcher to reassure the participant of the objectivity and reflexivity aspects of the interview as set out in section 10
- Appendix 1: Q11 wording appears a bit tricky to understand – could it be reworded? Has this questionnaire been piloted with anyone to see if it elicits the best responses?

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth
College Support Officer (R&I)

Appendix 7 - Participant Information Briefing Sheet

INFORMATION BRIEFING SHEET

Research Study:

The Influence that professional identity has in respect to the Credibility of Leaders of Integrated Services

You are being invited to take part in a Professional Doctorate research study that I am undertaking to explore what makes leaders credible and whether coming from a different professional background matters to, or influences leaders or the staff they work with.

Before you decide to be involved, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

What is the purpose of the study?

The research will examine the concept of credibility of Leaders who lead across the health, Social Care and Learning & Development Sectors, in Trafford Children and Young People Services. The focus of the research is to explore if credibility is perceived differently for those leaders from different professional backgrounds to those professionals in the sectors that they lead. The study focus is not about performance or management, but it is about leadership.

Why have you been asked to participate?

You have been invited to take part in this research because you work in CYPS which is a multi –agency service with staff who have a range of different professional qualifications and backgrounds. Your experience of working in an integrated service with different professional staff at practitioner and management level is invaluable to add knowledge to help leaders understand what makes them credible.

What will happen to you if you take part?

As a staff member in Trafford CYPS, (Council/CMFT/Pennine Care Foundation Trust) your views and opinions of leadership are important. Therefore, all staff (approximately 300), involving participants from all the different professions across the organisation, will be invited to respond to an electronic questionnaire sent by email using a secure link. The questionnaire has 20 questions and should take approximately 15 minutes to complete.

A further 25 staff, a smaller sample of the different professional groups, will be randomly selected and invited to take part in a semi-structured interview. The semi-structured interview undertaken by the researcher will last approximately 90 minutes, at a time and place that is convenient to you. If you agree to participate as one of the 25 people to be interviewed then you will be asked to sign a consent form prior to the interview.

Will your time be reimbursed?

It has been agreed with your manager that you can be provided with time during your working hours to take part and contribute to this research study, therefore you should not experience any out-of-pocket expenses and there will be no payment for your involvement.

Will your individual responses be shared with others, in particular managers or Directors in the organisations?

You have my complete assurance that all the information which you share with me will be dealt with in complete confidence and your participation in the research will be completely confidential. Any responses gathered during the research will be used to explore the concept of credibility and professional identity within the context of leadership. No managers or staff within CYPS or the employing organisation will receive any individual responses and nor will the information be used against any leader or participant in the research. The research is in relation to your views on the influence that professional identity has in respect to the credibility of leaders of integrated services and not about your performance, however, if there are any issues expressed that reveals a risk or potential risk of harm to patients, clients or service users, I will have to discharge my professional duty of care to the patient/service/user/client and inform the appropriate personnel.

The research participants will receive complete anonymity. Any quotes will not be attributed and will be unidentifiable.

How will the information I provide be kept confidential?

Your participation in the research will be completely confidential. The data collected from the questionnaires and the one-to-one interviews will be assigned codes which will only be known to the researcher and will be non-identifiable and completely anonymous. The interview materials and any digital recordings will be password protected and securely stored in a locked filing cabinet. All electronic files will also be password protected and subject to safe storage regulations.

The responses collected in the interview will be analysed along with all the other participants' responses to identify emerging themes that will inform the research findings. The researcher will ensure total anonymity when reporting at no time will any responses either from the questionnaires or the individual interviews be attributed to any named individual.

Do I have to take part?

No, you are not required to take part, it is important your involvement is completely voluntary. Even if you do agree to participate in the semi-structured interview, you will be free to withdraw at any time, without giving a reason. The decision to withdraw at any time, or a decision not to take part, will not affect your position in CYPS or personally in any adverse way.,

How will this study benefit me?

I cannot promise the study will help you personally in your professional practice, but the information you provide may help improve the way that services are led in the future and identify important professional and structural factors to consider when leading change to develop integrated models of

service provision. It is important to remember this is not research into any individual leader's performance but the focus is to explore the concept of what makes a leader credible.

What will happen to the data collected?

The data collected will be used for this specific research study and not used for any further studies, and will only be accessible by myself and/or my Professional Doctorate supervisor appointed by the University of Salford, it may also be looked at by representatives of regulatory authorities to check that the study is being carried out correctly.
All personnel viewing the data will have a duty of confidentiality to you as a research participant and nothing that could reveal your identity will be disclosed outside the research site. The data will be retained until 2016 when the Doctorate is awarded; the data will then be destroyed and disposed of confidentially. As a participant you will have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

The research contributes to the award of a Professional Doctorate written up into a thesis. There will also be an intention to publish the results and share the findings within peer reviewed publications and through conference presentations.

Within the dissemination and publication of the research in whatever format, you as an individual will not be identified and will remain anonymous. Findings will be reported predominantly as the perspectives of a group, not an individual, and where individual quotes are used, they will be non-identifiable (in that neither you nor your manager will be identified from the text used).

Who is organising and funding this research?

The research is being funded through the NHS as part of the professional doctorate studies programme; however, the partner organisations are supporting the research by offering access to employees and internal resources to facilitate the research.
This study was given ethical approval by the University of Salford Research Governance and Ethics Committee. It has also been supported by internal Research and Development processes in Trafford Council and Pennine Care Foundation Trust.

Contact Details:

If you require further information in respect of the study –please contact the following

Carol Baker-Longshaw on 0161 912 4468 or carol.baker-longshaw@trafford.nhs.uk

If you have a concern about any aspect of this study, please contact the research supervisor, Professor Paula Ormandy, School of Nursing, Midwifery and Social Care University of Salford on 0161 2950453 or p.ormandy@salford.ac.uk

Thank you for considering to take part and taking the time to read this information.

Appendix 8 - Participants Invitation Letter / Email

Letter and Email to Participant to complete questionnaire and also if selected to participate in semi-structured interviews

Carol Longshaw

Tel No xxxxxx

Dear Participant,

I am currently undertaking Professional Doctorate studies, which requires me to complete a research study to explore what makes leaders credible and whether coming from a different professional background matters to, or influences leaders or the staff they work with.

To enable me to complete the thesis, I should be grateful if you would agree to participate in the research I am conducting.

I am wishing to conduct an electronic survey which I would like you to complete online anonymously; I will also be inviting a number of you to participate in a semi-structured interview on a one-to-one basis with myself.

I have attached for your consideration an information briefing sheet explaining in more detail what the study entails and what your involvement would be.

For those who have been selected for the semi-structured interview, I will send to you in a separate email a consent form for you to consider and return to me signed via email if you agree to participate in the study.

If you do decide to participate in the study, I can reassure you that any information you share with me, as a researcher will be completely confidential and all data collected will be secured and non-attributable to you therefore, your identity will be confidential.

If you wish to discuss any issues with me then please do not hesitate to contact me at the above address or on the telephone numbers contained within the information briefing sheet.

I would like to thank you for taking the time to read the information briefing sheet and considering participating in the research.

Yours Sincerely

Carol Longshaw

Appendix 9 – Participant Invitation and Consent Form

Dear Participant,

A Research Study:

WHAT INFLUENCE THAT PROFESSIONAL IDENTITY HAS IN RESPECT TO THE CREDIBILITY OF LEADERS OF INTEGRATED TEAMS

You are being invited to take part in a Professional Doctorate research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part One

What is the purpose of the study?

The research will review the concept of credibility of Leaders who lead change across the Health and Social Care Sectors, in Trafford Children and Young People Services, and who do not possess the same professional background as that of the professionals working within the sectors.

Why have I been chosen?

I have invited you to take part in this research study, as your professional background and experience will provide the study with a level of knowledge that could contribute to changes in future service design and change management practice. You were selected randomly from your level within your organisation.

All employees' names were given to me by the Managers and I selected 2 from each tier in the professional groupings from each organisation.

How many participants are there taking part?

There are a total of 50 participants from CYPS/THT/Bridgewater Community Trust (3 organisations) taking part in the research

100 participants have been invited to complete the questionnaire

It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of management and professional support you receive.

What will happen to me if I take part?

If you decide to participate in the study, it will require you to participate in completing a questionnaire, which should take approximately 30 minutes.

If you agree to give consent to participate in all the methods i.e., questionnaires, although you may not be selected to take part in all of these activities.

Expenses and payments:

As an employee of the participating agencies, I have secured an agreement from the participating agencies that you can be released from your workload to participate in the study,

Part Two

What do I have to do?

As a participant in the study, you will be expected to complete the questionnaire

What are the possible benefits of taking part?

I cannot promise the study will help you personally in your professional practice, but the information might help improve the way that services are led to achieve integration and what factors need to be

considered when leading change to develop integrated models of service provision, in relation to professional issues and structures.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed'. The detailed information on this is given in Part 2. If you have any particular concerns that you wish to express you can contact my supervisor; Dr Paula Ormandy, Faculty of Health and Social Care, University of Salford, Salford, Greater Manchester, M6 6PU or e-mail her at paula.ormandy@salford.ac.uk

Complaints:

If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions (0161 748 4022). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure or the University of Salford Faculty of Health and Social Care, University of Salford, Salford, Greater Manchester M6 6PU

Will my taking part in this study be kept confidential?

As the researcher, I am responsible for ensuring that when collecting, handling, storing, using or destroying data, I am not contravening any legal or regulatory requirements in any part of the UK, and I am compliant with the Data Protection Act 1998 The data will be collected from questionnaire analysis.

This data will be anonymous and securely stored in a locked filing cabinet within my office.

Contact Details:

If you require further information in respect of the study –please contact the following the Faculty of Health and Social Care, University of Salford, Salford, Greater Manchester M6 6PU

The data collected will be used for this specific research study and not used for any further studies, and will only be accessible by myself and/or my Professional Doctorate supervisor appointed by the University of Salford, it may also be looked at by representatives of regulatory authorities and by authorised people from (the Trust, other partner bodies) to check that the study is being carried out correctly.

All will have a duty of confidentiality to you as a research participant and nothing that could reveal your identity will be disclosed outside the research site.

The data will be retained until 2014 when the Professional Doctorate is awarded; the data will then be destroyed and disposed of confidentially.

As a participant you will have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

The research is intended to contribute to the award of a Professional Doctorate, however, there will also be an intention to publish the results and share the findings with other participants. I can assure you; however, that you will not be identified in any report/publication, if you are quoted verbatim this will only be done with your prior consent. You will have access to a copy of the research study for your own personal use.

Who is organising and funding the research?

The research is being self-financed by the researcher as part of the professional doctorate studies programme; however, the partner organisations are supporting the research by offering access to employees and internal resources to facilitate the research.

Who has reviewed the study?

This study was given a favourable ethical opinion for conduct in the Ethics Committee at University of Salford.

I would like to take this opportunity to thank you for considering taking part or taking time to read this sheet.

Study Number:

CONSENT FORM

Title of Research:

WHAT INFLUENCE THAT PROFESSIONAL IDENTITY HAS IN RESPECT TO THE CREDIBILITY OF LEADERS OF INTEGRATED TEAMS

Name of Researcher: Carol Longshaw

Please initial boxes after each statement

1. I confirm that I have read and understand the information sheet dated _ for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, professional/employment or legal rights being affected. ☐

3. I understand that relevant sections of any data collected during the study, may be looked at by responsible individuals from the partner organisations CYPS/THT/Bridgewater Trust from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research.

I give permission for these individuals to have access to the data collected ☐

4 I agree to my manager being informed of my participation in the study. ☐

5. I agree to take part in the above study. ☐

Name of Participant:

Signature: Date

Name of Person taking consent: Date

Signature:

(If different from researcher)

Researcher: Date

Signature:

when completed, 1 copy of consent form for participant; 1 for researcher site file.

Appendix 10 - Research Questionnaire

Credibility of Leaders Questionnaire

This survey is designed to get an understanding of what you think makes leaders of multi-agency services credible

1. Are you Male or Female? *

- Male
- Female

2. What age group are you in? * Please tick relevant age band

- 18-25 yrs
- 26-33yrs
- 34-43yrs
- 44-51yrs
- 52-59yrs
- 60-67yrs
- other please specify

3. Do you work in a multi-Agency Team? *

- No -go to Q4
- Yes, please tick the box the sector/agency you are employed
- Health Service
- Council
- Police
- Voluntary Sector
- Independent
- Probation
- Housing
- Other- Please Specify

4. Do you lead a team? * Please tick the box that reflects your position

- No - please skip to the next question
- Yes, please tick in the box below the sector you belong to
- Director
- Head of Service

- Operations Manager
- Team Leader
- Senior Practitioner
- Senior Clinician
- Clinical Lead
- Practitioner
- Head of Unit/Centre
- Deputy Ops Manger
- Other -Please specify

5. What is the main position you hold? * Please tick as appropriate

- Social Worker
- Nurse
- Health Visitor
- Management
- Team Leader
- Mental Health Worker
- Medical Staff
- Educational Welfare Officer
- Youth Worker
- Teacher
- Administrator/Secretarial
- Connexions/Career Adviser
- Nursery Nurse
- Health Care Assistant
- SALT
- Physiotherapist
- Orthoptist
- Occupational Therapist
- Psychotherapist
- Play Therapist
- Probation Officer
- IT Officer

- ☐ Commissioner
- ☐ Customer Services Officer
- ☐ School Improvement Officer
- ☐ SEN Adviser
- ☐ Educational Psychologist
- ☐ Family Therapist
- ☐ Clinician
- ☐ Children Centre Worker
- ☐ Head of Unit/Centre
- ☐ Clinical Psychologist
- ☐ Therapist
- ☐ Other please specify

☐ Other:

6. Which of the following do you think are the most important qualities of a good leader * please tick the 4 most important

- ☐ Personal Experience
- ☐ Professional Experience
- ☐ Following up on what is promised
- ☐ Listening
- ☐ Accepting challenges
- ☐ Managing resources effectively
- ☐ Academic Qualifications
- ☐ Professional qualifications
- ☐ Having good ideas
- ☐ Being able to communicate effectively
- ☐ Other: _____

7. In your opinion what makes a leader credible? * Please tick the 4 most important factors

- ☐ Experience
- ☐ Professional Qualifications
- ☐ Communication
- ☐ Listening
- ☐ Trust
- ☐ Confidence
- ☐ Making decisions
- ☐ Managing relationships
- ☐ Political awareness

12. Would type of management structure and support do you prefer? *

Managed within a structure where the managers are from a different professional background to the staff, they re managing

- Seeing ideas through to the end
- Honesty
-
- Other:

8. Describe an experience of good leadership and what it was that made your experience good. * think about someone who may have managed you now or in the past and what it was that gave you confidence in them as leaders

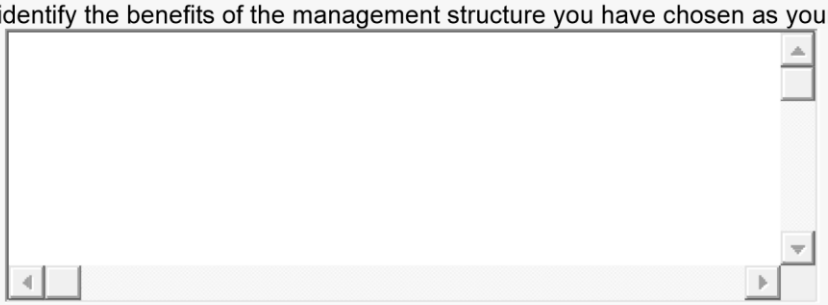
9. Describe an experience of poor leadership and what it was that made your experience poor *

10. On a scale of 1 to 4 how satisfied are you with the current management structure in your service? * 1= poor 2 = good 3= satisfied 4= very satisfied

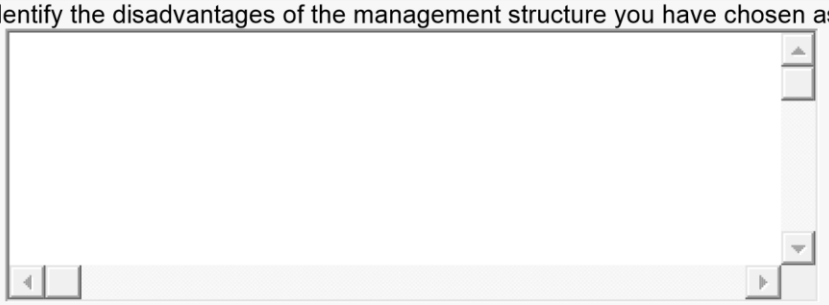
	1	2	3	4	
not satisfied	○	○	○	○	very satisfied

11. Please explain what makes the current structure poor/good/satisfactory/very satisfactory? * What in particular makes the experience poor- very satisfactory?

13. Please identify the benefits of the management structure you have chosen as your preferred option *



14. Please identify the disadvantages of the management structure you have chosen as your preferred option? *



Please add any other comments as required

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Appendix 11 - Example of Thematic analysis from Interviews

Data Extract	Coded Relevance/Meaning
One person who I think has really good leadership skills is xx. The thing that impresses me about xx the most she is a really good delegator and communicator. It is a really difficult balance to have I think because sometimes you can feel a bit distant from people if you are left to get on with it, so it is important to check back in from time to time and keep juggling your priorities. I think she demonstrates a lot of trust in people who work with her, and she can give credit where it is due, making people feel valuable and contributing to something that exists beyond their personal career boundaries. A lot of that comes from trust. When she sends emails, she will say I trust you to deal with it, but the door is always open. She is not heavy handed as a leader and that works really well.	Positive perception /credible Leadership qualities or /management skills Perceived challenging skill Disengaged or is it professional autonomy Management expectation or self-monitoring values staff 'With' not 'for': valuing staff- team work Acknowledging contribution/valuing Trust/delegation Fair

Appendix 12 - Journey of establishing CYPS 1999-2010 (Personal reflections and Evidence)

	Event /Issues	Researcher Reflections	Evidence
1999	Complaints regarding duplication of services; unmet needs due to some professionals thinking that the other had delivered the service to meet needs of children with complex needs	Considered how to manage services more efficiently; from a quality perspective but also from an efficiency perspective too; researched other service models for suitability and considered	Verbal and written complaints
October 2000	Informal discussion paper composed by researcher to consider closer working with council services shared with Director of Education	It was quite cathartic as previous Directors of Education hadn't engaged with health and could not move beyond the educational needs of children, but this DCS really understood the rationale	Informal discussion paper
Dec 2000	Engagement and Visioning workshop event held with stakeholders	Over 150 stakeholders including staff attended the workshop and were enthused by the idea of reducing duplication; but some staff feedback that there was a need to remain 'as is'; the researcher considered how to develop the evidence to support the pending challenges	Stakeholder feedback
2001	Childrens and Young People Partnership Board was formed including members from all key agencies, Health, Social Care, Police, Education, Councillors, Third Sector	As the researcher was the NHS Trust representative on the Board this provided some level of influence in shaping the future offer. At the time although there was a need to bring together all key partners to inform the future strategic direction of childrens services; the lack of strategic understanding by some partners introduced some frustration.	CYP Partnership minutes (archived by TMBC off site)
April 2002	Trafford's Directors of Children and Social Care and Education were merged into one post	Having one Director of Children Services covering both Education and Social Care offered a consistent leadership approach and provided clear direction from a council perspective into shaping childrens services	
June 2002	The Partnership Board became a legal entity and was known as Trafford Children and Young Peoples Service Ltd;	The establishment of the Ltd Company was to enable the delivery of Connexions Services through the integrated service; this was an exciting departure and helped to focus the business of the Board; this was new experience for the researcher.	Legal documents: minutes of meetings (archived by TMBC off site)

	Event /Issues	Researcher Reflections	Evidence
March 2003 June 2003	All key partners i.e.: Trafford Council; Trafford PCT and Trafford Healthcare NHS Trust signed an expression of interest to become a pathfinder childrens Trust Pathfinder status was awarded for three years accompanied with a grant for £60Kpa	This was a comprehensive strategic piece of work to pull a bid together ; the researcher was involved as a key agent in steering the completion of the bid; and engagement with the three key organisations to persuade the respective Boards to have confidence in the bid going forward ; these were interesting times as it required managing relationships between commissioners and providers; the researcher was also invited to attend the DoH in London to present the bid for consideration; a sense of achievement for the researcher and others when the pathfinder was awarded; and Trafford was the only area nationally other than Hove and Brighton who were attempting a whole systems integration and not just a departmental integration.	CYPS Pathfinder Bid (2003) Evaluation of Children's Trust Pathfinders Final Report; University of East Anglia in association with the National Children's Bureau (DFSE 2007)
April 2004 July 2004 Dec 2004	The Childrens Act (2004) created the statutory post of Director of Childrens Services (a local authority appointment) Trafford CYPS Ltd was dissolved, due to the requirements of the Childrens Act (2004) and the company's inability to recover VAT TMBC and Trafford PCT commissioned a consultant Prof. Sinead Brophy (SB) to propose service models to support the integration of children and young people services	This was aligned to the current Director of Education and Childrens Social Care personal specification; therefore, from the researcher's perspective, it meant continuity of the strategic direction. The dissolution of the company was a significant event, as the credibility of the development of the integrated services could have been derailed, as the three partner organisations could have lost confidence in the direction of travel that was being proposed by the researcher and the Director of Education and Social Care The researcher worked closely with SB to develop and generate service model options; the learning was immense from an engagement perspective.	Childrens Act (2014)
June 2005	The Brophy Report was published, and the recommendations accepted by Trafford PCT Trust Board; Trafford Healthcare NHS Trust Board and Trafford Council Executive Committee	The researcher as a member of Trafford Healthcare NHS Trust Board and received an invite to the Trafford PCT Board to present the report, therefore the researcher played a key role in receiving Board approval for the recommendations.	Brophy Report (2005). PCT and Trafford Healthcare NHS Trust Board minutes (2005) (archived). Trafford's CYPP (2006)
2006			

	Event /Issues	Researcher Reflections	Evidence
	The Children and Young Peoples Plan 2006-11 was published setting out the strategic objectives for the next 5 years. A Project Board was established to implement the recommendations from the Brophy Report (2004)	The researcher became a member of the Project Board and played a key role in engaging staff through a series of road shows to share the vision, the new service delivery model and new ways of working, there were vociferous verbal and written responses, particularly from health professionals regarding them being managed by someone from a different professional background; indeed a group of Speech and language Therapists wrote to their local MP who in turn submit a letter of complaint; Health Visitors and Medical staff were equally negative regarding the proposals , suggesting the model was unsafe	Feedback from road show events (archived); notes from personal/professional journals (field notes)
2007	Final report on the evaluation of the pathfinder Childrens Trust	The evaluation findings in respect to Health and local authority partners in pathfinders who took a whole system approach had developed expertise in joint commissioning of services for children. They were effective in making progress with local delivery of joined-up services and commissioning services for specific groups. This mirrored the researchers reflections of the process to date; conversely the evaluation also found Directors representing the health sector in pathfinders that focused on specific groups of children such as disabled children, or those in a specific locality, described themselves as having a service 'provider' role rather than a 'commissioner' role and as such reported that they had a different contribution to make to interagency governance; the pathfinder project definitely expanded the knowledge and experience of the researcher sometimes the researcher struggled with fully understanding the governance arrangements for the pathfinder; implementation of the project but on reflection this has enhanced the strategic knowledge and skill set of the researcher.	Children's Trust Pathfinders: Innovative Partnerships for Improving the Well-being of Children and Young People National Evaluation of Children's Trust Pathfinders Final Report University of East Anglia in association with the National Children's Bureau DFSE 2007

	Event /Issues	Researcher Reflections	Evidence
June – Sept 2007	Following extensive staff consultation during early 2007 key Directors and Senior management posts from Health, Social Care and Education were disestablished and new posts to reflect the new integrated management structures to support the multi-agency service model were formally recruited to. (32 posts that were in the old single agency structures were disestablished and only 18 remained to cover a service with a combined workforce of 2600 (in 2007).	The Researcher was successfully appointed to the Joint Director CYPS post with the professional leadership portfolio for healthcare. This was through a cross agency selection process with all three CEOs from PCT, Council and Healthcare NHS Trust and Non-Exec Directors and Councillors. The appointment served the researcher with a level of assurance and confidence in their leadership qualities and skills. The researcher interpreted the appointment as a mandate to claim the leadership role and forge ahead with the implementation and co-location of services to achieve the project objectives	Staff consultation documents
2008	Three of the six multi agency teams were established and co-located (Children in Care; MARAS; Complex and Additional Needs Services) Trafford PCT had a change of Leadership Team and required further assurance in respect to the delegated authority and professional governance arrangements, therefore Prof Liz Fradd was commissioned to consider the integrated governance arrangements; Fradd supported the governance arrangements and the project continued:" a *mechanism needs to be found to evaluate progress and the eventual success of the new CYPS"* (Fradd, 2008:17)	The researcher had the overall leadership for the Complex and Additional Needs Service (the biggest team of approx. 160 staff with approximately 13 different professional staff groups being co-located from three different areas, Health Social Care and Education, including the S&LT who had been resistant to the change, therefore the researcher had to consider appropriate strategies to engage staff in the new ways of working. This was another point in the journey when the researcher took stock and reflected on the fragility of the project in terms of its sustainability if it was solely dependent on an individual's confidence in the process and the systems, then the way to successfully manage the project was to manage the relationships whilst attempting to develop robust governance arrangements for the future service model to enable the 'buy in' to the project to be sustained	Fradd, L (2008) *Review of Integrated Governance Arrangements for Trafford CYPS*, Report to Trafford CYPS and Trafford NHS Primary Care Trust

	Event /Issues	Researcher Reflections	Evidence
2009	Trafford CYPS commissioned the University of Salford to evaluate the introduction of the Multi Agency Family Support Team	The evaluation findings delivered a challenge for partners to identify accommodation to support the co-location of the multi-agency teams	McLaughlin H., Livesley J and Scholar H (2009) Evaluation of Trafford (West Area) Multi-Agency Family Support Team
2010	3 x Multi agency teams were established in shadow form and were soon co-located	This was the last piece of the jigsaw; al 6 teams now co-located, the researcher felt a sense of achievement and knew the real work was just about to begin; in terms of embedding new ways of working, managing interprofessional management structures	

Appendix 13 – Consent Form: Semi-structured Interview

Consent form: semi-structured interview

Date:

Participants ID Number:

Study Title: The Influence that professional identity has in respect to the Credibility of Leaders of Integrated Services

Researcher Name: Carol Longshaw

Please Tick Box

I confirm that I have read and understand the information sheet (V4 9.5.13) for the above study and have had the opportunity to ask questions	
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected	
I understand that my name and involvement in the study will remain confidential	
I understand that any personal information about me such as my email contact address will not be shared outside of the study team and will only be used for this research (unless I have given instructions to be placed on a separate mailing list)	
I understand that the information I provide could be used as part of the final study report or journal publications, but any comments used will not be identifiable to me	
I understand that the interviews will be tape recorded and transcribed	
I agree to take part in the above study	

Name of Participant Date Signature

Name of Researcher Date Signature

Appendix 14 – Interview Schedule and Questions

Interview Schedule and Questions

Date:

Venue:

Time:

Introduction:
Discuss the purpose of the study with the interviewee, gain consent and signature
Offer reassurance regarding confidentiality and objectivity and reflexivity

Preliminary Questions:
Introduce self and inform the participant the interview will be confidential; explain the process for data collection, analysis and storage of data

Conduct interview / Main questions:

Question areas for semi –structured Interview

1. Can you describe to me what you believe to be the core set of leadership skills that you think are essential?

2 Do you think it is possible to be an effective leader but a poor manager; and if so, can you explain what you understand is the difference if any?

3 Can you be a good manager but not necessarily a good leader?

4 Is leadership about using certain techniques, can you list some and explain why they are important?

5 How do you think a person's values and beliefs affect their leadership behaviours?

6 Where does trust fit into effective leadership? Can you explain why this makes someone an effective leader?

7 Do you believe that leaders need to be liked in order to be effective leaders if so, why? If not, why not?

8 What do you think being a powerful leader means?

9 Do leaders need to be qualified in a particular professional field to be an effective leader?

10 what professional qualification or area of expertise if any is needed to ensure that a leader possessed the right qualities to lead?

11 Do you think there is a difference between having a professional experience and having professional qualifications

12 What model of service do you think delivers the best outcomes for children and young people?

13 What are the development opportunities, if any are there from working in that service model?

14, Can you explain why you think that particular model works more effectively?

15 What do you think are the advantages of working in an integrated service model from a leadership perspective... And the disadvantages?

16 What do you see as the future of integrated service teams?

17 If you could re-structure service now, what would you do to change it if anything?

18 Why would you re-structure in that particular way?

Conclusion:

Debrief participant, ascertain if there is anything else they would like to add and asking are they happy with the interview.

Answer any questions and ensure the participant understands the purpose of the study and what will happen with the data and the findings.

Thank you for your time and participation.

Appendix 15 – Participant Information and Briefing Sheet

INFORMATION BRIEFING SHEET

Research Study:

Does Professional Identity Influence the Credibility of Leaders of Integrated Health and Social Care Services?

You are being invited to take part in a Professional Doctorate research study that I am undertaking to explore what makes leaders credible and whether coming from a different professional background matters to, or influences leaders or the staff they work with.

Before you decide to be involved, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

What is the purpose of the study?

The research will examine the concept of credibility of Leaders who lead across the Health, Social Care and Learning & Development Sectors, in Trafford Children and Young People Services. The focus of the research is to explore if credibility is perceived differently for those leaders from different professional backgrounds to those professionals in the sectors that they lead. The study focus is not about performance or management, but it is about leadership.

Why have you been asked to participate?

You have been invited to take part in this research because you work in CYPS which is a multi –agency service with staff who have a range of different professional qualifications and backgrounds. Your experience of working in an integrated service with different professional staff at practitioner and management level is invaluable to add knowledge to help leaders understand what makes them credible.

What will happen to you if you take part?

As a staff member in Trafford CYPS, (Council/CMFT/Pennine Care Foundation Trust) your views and opinions of leadership are important. Therefore, all staff (approximately 300), involving participants from all the different professions across the organisation, will be invited to respond to an electronic questionnaire sent by email using a secure link. The questionnaire has 20 questions and should take approximately 15 minutes to complete.

A further 25 staff, a smaller sample of the different professional groups, will be randomly selected and invited to take part in a semi-structured interview. The semi-structured interview undertaken by the researcher will last approximately 90 minutes, at a time and

place that is convenient to you. If you agree to participate as one of the 25 people to be interviewed, then you will be asked to sign a consent form prior to the interview.

Will your time be reimbursed?

It has been agreed with your manager that you can be provided with time during your working hours to take part and contribute to this research study, therefore you should not experience any out-of-pocket expenses and there will be no payment for your involvement.

Will your individual responses be shared with others, in particular managers or Directors in the organisations?

You have my complete assurance that all the information which you share with me will be dealt with in complete confidence and your participation in the research will be completely confidential. Any responses gathered during the research will be used to explore the concept of credibility and professional identity within the context of leadership. No managers or staff within CYPS or the employing organisation will receive any individual responses and nor will the information be used against any leader or participant in the research. The research is in relation to your views on the influence that professional identity has in respect to the credibility of leaders of integrated services and not about your performance, however, if there are any issues expressed that reveals a risk or potential risk of harm to patients, clients or service users, I will have to discharge my professional duty of care to the patient/service/user/client and inform the appropriate personnel.

The research participants will receive complete anonymity. Any quotes will not be attributed and will be unidentifiable.

How will the information I provide be kept confidential?

Your participation in the research will be completely confidential. The data collected from the questionnaires and the one-to-one interviews will be assigned codes which will only be known to the researcher and will be non-identifiable and completely anonymous. The interview materials and any digital recordings will be password protected and securely stored in a locked filing cabinet. All electronic files will also be password protected and subject to safe storage regulations.

The responses collected in the interview will be analysed along with all the other participants' responses to identify emerging themes that will inform the research findings. The researcher will ensure total anonymity when reporting at no time will any responses either from the questionnaires or the individual interviews be attributed to any named individual.

Do I have to take part?

No, you are not required to take part, it is important your involvement is completely voluntary. Even if you do agree to participate in the semi-structured interview, you will be free to withdraw at any time, without giving a reason. The decision to withdraw at any time, or a decision not to take part, will not affect your position in CYPS or personally in any adverse way.,

How will this study benefit me?

I cannot promise the study will help you personally in your professional practice, but the information you provide may help improve the way that services are led in the future and identify important professional and structural factors to consider when leading change to develop integrated models of service provision. It is important to remember this is not research into any individual leader's performance, but the focus is to explore the concept of what makes a leader credible.

What will happen to the data collected?

The data collected will be used for this specific research study and not used for any further studies and will only be accessible by myself and/or my Professional Doctorate supervisor appointed by the University of Salford, it may also be looked at by representatives of regulatory authorities to check that the study is being carried out correctly.
All personnel viewing the data will have a duty of confidentiality to you as a research participant and nothing that could reveal your identity will be disclosed outside the research site. The data will be retained until 2016 when the Doctorate is awarded; the data will then be destroyed and disposed of confidentially. As a participant you will have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

The research contributes to the award of a Professional Doctorate written up into a thesis. There will also be an intention to publish the results and share the findings within peer-reviewed publications and through conference presentations.

Within the dissemination and publication of the research in whatever format, you as an individual will not be identified and will remain anonymous. Findings will be reported predominantly as the perspectives of a group, not an individual, and where individual quotes are used, they will be non-identifiable (in that neither you nor your manager will be identified from the text used).

Who is organising and funding this research?

The research is being funded through the NHS as part of the professional doctorate studies programme; however, the partner organisations are supporting the research by offering access to employees and internal resources to facilitate the research.
This study was given ethical approval by the University of Salford Research Governance and Ethics Committee. It has also been supported by internal Research and Development processes in Trafford Council and Pennine Care Foundation Trust.

Contact Details:

If you require further information in respect of the study –please contact the following

Carol Baker-Longshaw on 0161 912 4468 or carol.baker-longshaw@trafford.nhs.uk

If you have a concern about any aspect of this study, please contact the research supervisor, Professor Paula Ormandy, School of Nursing, Midwifery and Social Care University of Salford on 0161 2950453 or p.ormandy@salford.ac.uk

Thank you for considering taking part and taking the time to read this information.