LOOKING BACK, LOOKING FORWARD: PERSPECTIVES ON CLINICAL LEADERSHIP IN OCCUPATIONAL THERAPY

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ABSTRACT

Background

Occupational therapists are one of 14 allied health professional groups: health care professionals that make up six per cent of the National Health Service. Occupational therapists work across a range of settings, supporting people whose health prevents them doing the activities that are meaningful and important to them, with the aim being to maximise independence in these activities. Occupational therapists may work in a variety of roles, with some having increased responsibility for leading clinical teams and services. However, little is known about occupational therapists' views of clinical leadership in professional practice.

Aims and objectives of the study

The study aimed to gather and summarise occupational therapists' perceptions and experiences of clinical leadership, and to investigate the influence and impact of education, situational factors and social influences upon these perceptions and experiences, in order to provide recommendations for future training, development and practice

The objectives of the study were:

1 To map the current roles, education, training and leadership experience of occupational therapists practising in the UK.

2) To explore the key attributes of an effective clinical leader from the perspective of occupational therapists.

3) To examine the impact of training and development on clinical leadership positions held by occupational therapists.

4) To develop an understanding of the perceived barriers and facilitators influencing occupational therapists' leadership development.

5) To use findings to generate recommendations for leadership training, development and practice.

Methods

The research used mixed methods, comprising two phases. Phase one utilised a quantitative approach and comprised a survey which gathered information about occupational therapists' professional education and employment. Views were also sought on effective clinical leadership and leadership development needs. 720 questionnaires were distributed to occupational therapists in the United Kingdom. Phase two used qualitative methods and comprised interviews with thirteen occupational therapists that had participated in the survey. Interviews sought to explore key themes emerging from the survey in greater depth. Phase two constituted the major part of the study.

Findings

The study found that whilst some occupational therapists have attained leadership positions, senior leadership is still nursing dominated. The impact of multidisciplinary leadership was highlighted, with findings suggesting that where leadership of occupational therapists is via a different profession, this may have a detrimental impact on their leadership development. Furthermore, integrated working has diluted the potential and scope of occupational therapy practice. The study also found that occupational therapists were concerned about the profile of the profession; fearing a loss of identity, professional standing and professional pride. It was identified that that opportunities for development were not readily available and that support and guidance is needed to prepare occupational therapists to be leaders both now and in the future.

Conclusions

The study concluded that occupational therapists need to work with their professional body to proactively seek opportunities to demonstrate the profession's scope and potential. There is also a need to advocate for the profession, support learning, and use best evidence and research to promote and profile the profession.

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TABLE OF CONTENTS

ABSTRACT ..... **i**

ACKNOWLEDGMENTS ..... **iii**

TABLE OF CONTENTS ..... **iv**

LIST OF FIGURES ..... **vii**

LIST OF TABLES ..... **viii**

CHAPTER 1: INTRODUCTION **1**

1.1 Occupational therapy 2
1.2 Defining leadership 4
1.3 Clinical Leadership 6

CHAPTER 2: LITERATURE REVIEW **9**

2.1 Introduction 9
2.2 Part one: Theoretical perspective 9
2.3 Part two: The Policy Context 16
2.4 Part three: Scoping review of research evidence 25
    2.4.1 Quality appraisal of research papers 28
2.5 A review of related research 35
2.6 Gaps in the available evidence relating to clinical leadership in occupational therapy 42
2.7 Overall aim of the study 43
    2.7.1 Objectives 43
2.8 Summary 43

CHAPTER 3: METHODS AND METHODOLOGY **44**

3.1 Introduction 44
3.2 Methodology 44
3.3 Methods of Data Collection 51
    3.3.1 Study Design 51
    3.3.2 Phase 1 – Survey 51
    3.3.3 Planned Survey Method 58
    3.3.4 Actual Survey Method 59
    3.3.5 Data analysis 62
    3.4 Phase 2 – Interviews 62
    3.5 Interview analysis 70

3.5.1 Analytical strategy 70
3.5.2 Analysis of data 78
3.6 Reflexivity 81

CHAPTER 4: SURVEY RESULTS 86

4.1 Profile of participants 87
4.2 Key attributes of an effective clinical leader 94
4.3 Leadership development 99
4.4 Barriers and facilitators to clinical leadership development 102
4.5 Summary and brief discussion 108
4.6 Limitations of the survey 110
4.7 Conclusion 112

INTRODUCTION TO INTERVIEW PARTICIPANTS 115

CHAPTER 5: INTERVIEW FINDINGS 119

5.1 Constructing leadership 119
5.1.2 Knowledge and understanding 120
5.1.3 Characteristics 123
5.1.4 Perceptions 128
5.2 Identity and presence 133
5.2.1 Professional profile 134
5.2.2 Promoting the profession 137
5.2.3 Organisational structure 139
5.2.4 Evidence base 141
5.3 Access 143
5.3.1 Training and education 144
5.3.2 Support 147

CHAPTER 6: SYNTHESIS AND DISCUSSION OF FINDINGS..... 149
6.1 Introduction 149
6.2 Synthesis of Findings 149
6.2.1 Defining clinical leadership 149
6.2.2 Importance of clinical leadership 150
6.2.3 Clinical leadership effectiveness 150
6.2.4 Developing clinical leaders 151
6.2.5 The profile of occupational therapists as clinical leaders 152
6.3 A model of clinical leadership in occupational therapy..... 153
6.4 Discussion..... 156
6.4.1 The key attributes of an effective clinical leader 158
6.4.2 Occupational therapists' attainment of leadership positions 159
6.4.3 Supporting the development of clinical leaders 161

6.4.4 Professional profile 163
6.4.5 The role of the Royal College of Occupational Therapists..... 164
6.5 Limitations of the study 166
6.6 Summary 168
6.7 Contribution of the research to the body of knowledge 168
6.8 Implications of the research for policy 170
6.9 Implications of the research for practice and future leadership 172

REFLECTIONS **174**

CONCLUSION **176**

REFERENCES **178**

APPENDICES **197**

Appendix 1 Narrative overview of research 198
Appendix 2 Survey 207
Appendix 3 Survey covering letter 212
Appendix 4 Ethical approval letter 213
Appendix 5 Pre notification letter 217
Appendix 6 Interview guide 218
Appendix 7 Participant information sheet 220
Appendix 8 Consent form 223

LIST OF FIGURES

Figure 1 Domains of the NHS Leadership Framework 14

Figure 2 PRISMA Flow Chart showing the identification of related research 27

Figure 3 Thematic map illustrating final themes generated from the Analysis 81

Figure 4 Participants Main Employing Organisation 90

Figure 5 Profession of Immediate Line Manager 94

Figure 6 Importance of Clinical Leadership to Career 95

Figure 7 Most Important Leadership Quality 97

Figure 8 Most important Leadership Behaviour 98

Figure 9 Most Important Leadership Skill 99

Figure 10 Importance of on the Job Training to Clinical Leader Development 100

Figure 11 Importance of Mentorship to Clinical Leader Development 101

Figure 12 Importance of Formal Leadership Training to Clinical Leader Development 101

Figure 13 Key issues from survey requiring further exploration in interviews 112

Figure 14 Key elements of clinical leadership 120

Figure 15 A model of clinical leadership in occupational therapy..... 154

LIST OF TABLES

Table 1 Classifications of leadership 10

Table 2 Quality appraisal of related research papers 29

Table 3 A 15 point checklist of good thematic analysis..... 77

Table 4 Examples of extracts from the data with codes applied..... 79

Table 5 Research objectives 86

Table 6 Qualification period 87

Table 7 Place of training 88

Table 8 Professional occupational therapy qualification 89

Table 9 Postgraduate qualification 89

Table 10 Highest postgraduate qualification 89

Table 11 Participant roles 92

Table 12 Participant grades 93

Table 13 Qualities that Characterise an Effective Clinical Leader 96

Table 14 Behaviours that Characterise an Effective Clinical Leader 97

Table 15 Skills that Characterise an Effective Clinical Leader 98

Table 16 Barriers to the Development of Clinical Leaders 102

Table 17 Facilitators to the Development of Clinical Leaders 103

Table 18 Themes developed following content analysis of comments in response to the final survey question 105

Table 19 Interview themes..... 119

CHAPTER 1: INTRODUCTION

This thesis presents research exploring occupational therapists' views on clinical leadership in professional practice. This was a mixed methods study, undertaken with occupational therapists based in the United Kingdom (UK). A review of the literature, together with a systematic review of related empirical research were undertaken to inform development of the research. The research sought to explore what had influenced and shaped occupational therapists' leadership development with a view to providing recommendations for future training, development and practice.

My interest in this topic emanates from a curiosity to understand what occupational therapists value in a good leader and what qualities, skill and behaviours constitute effective leadership. I am passionate about promoting clinical leadership in occupational therapy and committed to supporting the future development of occupational therapy practice both in the workplace and through student education. However, personal experience and anecdotal feedback highlighted a frustration amongst some occupational therapists that the true value, potential and scope of occupational therapy is not being recognised. Hearing these concerns and discovering there was limited written information about clinical leadership in occupational therapy ignited my interest and motivation to undertake this research.

The thesis comprises six chapters, an introduction to interview participants and eight appendices. The first chapter provides the background and context to the study. The second chapter reviews the available literature and research evidence related to clinical leadership; and identifies the gaps which highlighted the issues this study sought to explore. Chapter 3 outlines the methodology and methods employed to conduct the research. Chapter 4 presents the results of the survey and includes a brief discussion of these results. An introduction to interview participants precedes Chapter 5, which presents the interview findings. Chapter 6 discusses the key findings of my

study, their contribution to the available knowledge and their implications for policy and practice. This is followed by my reflections on the study and final conclusions.

The following sections provide an introduction to the profession of occupational therapy and offers background information on the occupational therapy workforce both in the UK and worldwide. Next, information is presented about the meanings applied to leadership. Finally, the term 'clinical leadership' is introduced in order to set the background and context to study.

1.1 Occupational Therapy

Occupational therapy is a healthcare profession that focuses on developing, recovering, or maintaining the daily living and working skills of people with physical, mental, or cognitive impairments (Royal College of Occupational Therapists Specialist Section, 2019). Occupational therapists support people whose health prevents them doing the activities that are meaningful and important to them, with the aim being to maximise independence in these activities. Occupational therapists may work within the NHS, social care services, housing, schools, prisons, voluntary sector, independent sectors, vocational and employment rehabilitation, education and research. Occupational therapists work with individuals to build self-reliance rather than dependency on services (Scott, 2017) and have a key role to play in providing care closer to home and keeping people out of hospital. The Improving, Lives Saving Money series (College of Occupational Therapists, 2016, Royal College of Occupational Therapists, 2019a) demonstrates how occupational therapy expertise can be used to maximum effect by using best practice examples. Taking a wider view, The Guardian has featured several articles acknowledging the role of occupational therapists in admission avoidance and reducing length of stay (Brindle, 2015, Jackson, 2016 and Murray, 2016). Brindle (2015) suggested that although no single group of professionals holds the key to the future of health and social care, occupational therapists may have more influence than most. He stated that occupational therapy

has the potential to play a pivotal role in meeting the challenges of 21st century health and social care, a position supported by Jackson (2016) who stated that occupational therapists may offer a solution to the challenges of delayed hospital discharges. Jackson (2016) pointed to increased numbers of occupational therapists assessing patients requiring urgent care and supporting them to remain in their own homes; describing this as a quiet revolution that was pushing occupational therapists to the forefront of healthcare. Similarly, Murray (2016) described how occupational therapists have adopted new ways of working within primary care to reduce hospital admissions for older people and keep them in their own home. Finally, Scott (2017) described how occupational therapy has been shown to reduce emergency department admissions and reduce delayed transfers of care.

Occupational therapists are one of 14 allied health professionals (AHPs); a group of health care professionals that make up six per cent of the National Health Service (NHS) workforce (Davis and Lovegrove, 2017). AHPs are the third largest clinical workforce after doctors and nurses (Chief Allied Health Professions Officer's Team, 2017). When looking at the breakdown of professions within this group, occupational therapists are the third largest professional group after social workers and physiotherapists (HCPC, 2019). Occupational therapists in the UK must be registered with the Health and Care Professions Council (HCPC), the regulatory body for allied health professionals. In 2005, 28,333 occupational therapists were registered with HCPC. By 2017 the figure had risen to 38,240. (HCPC, 2019)

Internationally, occupational therapists make up a significant proportion of the healthcare workforce. Between 2006 and 2014, there was a 56% growth in the occupational therapy workforce worldwide (Ledgerd, 2013), with occupational therapists increasingly seen in clinical leadership roles with responsibility for the planning and delivery of services. The World Federation of Occupational Therapists (WFOT) asserts that occupational therapists are committed to the improvement,

development and promotion of the profession both nationally and internationally (WFOT, 2005). This clearly requires leadership, a position reinforced by Clark (2010) who asserts that "powerful professions have the capacity to obtain leadership positions, advocate successfully in the policy arena and secure the resources necessary to achieve their professional goals" (Clark, 2010, p264).

1.2 Defining leadership

Leadership has been described as "a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2007, p3). This is just one of many definitions and was the overarching definition used to frame this study. The definition succinctly describes the essence of leadership within health and care services, as achieving a common goal is vital to ensure the provision of high quality patient care. Leadership requires that a vision is clearly communicated, understood and embraced by individuals within a team. Moreover, through the use of influencing skills, the leader is able to flexibly guide and direct team members as required, motivating and empowering individuals to follow the vision, implement new ideas and embrace change in order to drive forward service developments and meet organisational goals.

Leadership means different things to different people and the terms leadership and management are often used interchangeably (Murphy, Quillinan and Carolan, 2009). Turner-Warwick (2011) argues that using the terms interchangeably causes confusion and whilst she acknowledges that there are overlapping attributes, she maintains that leadership and management are not synonymous. There has been much debate on the difference between management and leadership and whether a manager can be a leader and vice versa. Based on their interpretation of the debate Owen, Hodgson and Gazzard (2004) provide a useful differentiation of management and leadership, highlighting that:

- The manager maintains whilst the leader cultivates
- The manager focuses on process and organisation whilst the leader focuses on people
- The manager regulates whilst the leader innovates
- The manager accepts the current state whilst the leader questions it
- The manager controls while the leader instils trust
- The manager replicates whilst the leader initiates
- The manager has a short term outlook while the leader holds a long term view
- The manager complies whilst the leader is driven by his/her values
- The manager is interested in how and when, whilst the leader focuses on what and why

They thus argue that leadership and management are distinctive yet complementary each with its own function and capabilities; a position also taken by others (Kotter, 1999, Booth, 2008). Crucially, what seems to be important is that leadership requires that a vision is clearly communicated and understood; and that through the use of influencing skills the leader is able to motivate and empower individuals to follow the vision, implement new ideas and embrace change in order to achieve the desired outcome.

The importance of leadership for managing people, managing services and driving change is well documented (Storey, 2004, Barr and Dowding, 2012, Hayes, 2000, Goodwin, 2000, Botting, 2011). Historically, leadership within health and social care was associated with level of seniority. However in recent years there has been recognition that leadership occurs at all levels within an organisation, with clinical leaders playing a vital role in clinical developments, innovation and change (Department of Health, 2008, Stanley, 2012). Responsibilities may include leading

teams, leading projects, teaching, undertaking clinical specialist and consultant therapist roles, writing influential books or papers, speaking at conferences or carrying out high quality research (College of Occupational Therapist, 2012) in order to improve the quality of care and services provided.

1.3 Clinical Leadership

Clinical leadership is a term used to "encapsulate the concept of clinical healthcare staff undertaking the roles of leadership: setting, inspiring and promoting values and vision, and using their clinical experience and skills to ensure the needs of the patient are the central focus in the organisation's aims and delivery" (Jonas, McCay and Keogh, 2011, p1). Clinical leadership is high on the healthcare agenda and is seen as the method to provide high quality, responsive and sustainable services (Department of Health, 2008). Clinical leadership extends across a broad range of professions including medical, nursing and allied health professionals (AHPs) who will use their skills and expertise to develop services and shape change. In essence clinical leadership is focused on using leadership knowledge, skills and abilities within clinical settings to achieve organisational goals. The Department of Health (2008) highlighted the important contribution of AHPs to clinical leadership, however relatively little has been written about clinical leadership from an AHP or more importantly occupational therapy perspective. Wylie and Gallagher (2008) highlighted that building leadership capacity and capability are seen as essential to facilitating allied health professionals (AHPs) to embrace opportunities presented by the redesign of services. However, a review of the evidence (West, Armit, Loewenthal, Eckert, West and Lee, 2015) highlighted that greater attention has been given to medical and nursing professions than to other clinical and non-clinical leadership roles in health care. A case in point is a report by Ezziane (2012), examining the importance of clinical leadership in the delivery of 21st century healthcare. The report highlighted the importance of leaders having the ability to lead themselves as well as lead others. It also describes the ingredients for successful leadership, focusing on individual attributes, competencies,

leadership outcomes and networking. Whilst referring specifically to medical students, Ezziane (2012) recommended that leadership programmes should be introduced at undergraduate level and that health-care organisations should encourage clinicians to enroll in professional development programs. These recommendations could equally be applied to other health and care staff.

A review of the literature specific to occupational therapy leadership from an international perspective was undertaken. The review emphasised the importance of leadership, with a focus on the profession realising its potential (Townsend, 1998), the survival and future growth of the profession (Reimer, 2000), achieving the centennial vision (Moyers, 2007 and Copolillo, Shepherd, Anzalone and Lane, 2010), meeting the challenges of the 21st century (Duncan and Bannigan, 2009) and the relationship between leadership and gender (Davidson, 2012). To achieve the centennial vision, Moyers (2007) emphasised the need to build occupational therapy's professional visibility by creating leaders who demonstrate the ability to effect change. Copolillo et al (2010) emphasise the importance of the development of professionals with leadership skills and describe the development of an occupational therapy professional doctorate programme, specifically designed to develop leaders. Rodger (2012) considered the key qualities of leadership through an occupational lens, encouraging individuals to identify themselves as leaders wherever they are positioned within organisations or in their professional lives. She highlighted that the philosophy of occupational therapy, together with the profession's theoretical and practical knowledge can assist leaders in their current and emerging leadership roles. She urged occupational therapists to embrace leadership opportunities so that leadership is recognised and celebrated as being very much a part of the profession's territory. Finally, Lapointe, Baptiste, von Zweck, and Craik (2013) highlighted the need for effective leadership and mentorship strategies to develop the profession and increase leadership capacity. In addition, Ziviani (2017) highlighted the importance of leaders valuing, respecting and nurturing staff in order to achieve successful outcomes.

More recently, the College of Occupational Therapists suggested in its position statement that the concept of leadership is an important topic for members and the profession as a whole and considers clinical leadership necessary for integrated team work in health and social care services (College of Occupational Therapists, 2012). Hunter (2013) emphasised the need for more occupational therapy leaders, stating:

> *"We need occupational therapists with vision, who are innovative and able to collaborate with policy makers, members of the community and leaders in other professions. Occupational therapy leaders such as these will enable us to create and implement solutions for the many challenges facing services at present and in the future." (Hunter, 2013, p.346)*

Similarly, Jones (2019) highlights the importance of having strong professional leadership. Reflecting on her experience of being seconded into head occupational therapist role, she explained that she had spoken to occupational therapists who reported feeling "*out of the loop, the bottom of the pile or invisible" (Jones, 2019, p.33).* Furthermore, occupational therapists that were emerging as strong leaders reported that they were struggling to influence through the tiers of management. Turner and Knight (2015) assert that where a strong identity is lacking amongst occupational therapists, this can lead to a lack of ability to think strategically and result in the profession being over influenced by other professions and feeling undervalued. Jones (2019) witnessed despondency, frustration and powerlessness amongst occupational therapists and spoke of a desire to see occupational therapy leaders that were passionate about the profession and understood the role of professional leadership. Tempest and Dancza (2019) assert that it is important for the profession to discuss how it values and cultivates leadership principles in order to advance occupational therapy in the future; stating that effective leadership ensures the professions' purpose is preserved and progressed.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

A review of the literature in relation to clinical leadership was undertaken from three perspectives, which I will present and examine in turn. Part one focuses on the theoretical perspective, part two the policy context and part three the research perspective. For parts one and two I adopted a narrative review technique (Baumeister and Leary, 1997) and for part three I undertook a systematic review of published empirical research.

2.2 Part one: Theoretical perspective

A review of the literature has highlighted that theories of leadership are categorised into seven major classifications: Great Man, Trait, Behaviourist, Situational, Contingency, Transactional and Transformational (Handy, 1999; Bolden, Gosling, Marturano, and Dennison 2003), summarised in Table 1. Transactional and transformational theories have perhaps received greater attention more recently. Transactional leadership is generally concerned with day to day processes and is based on a system of rewards and sanctions (Bass, 1985), whilst transformational leadership is interested in the relationship between leaders and followers and focuses on how the leader motivates and inspires individuals within a group to recognise the importance of achieving their goal and maximising their potential (Burns, 1978). Reiss (2000) asserts that an increased understanding of transformational leadership skills will promote increased effectiveness in occupational therapy service delivery, teaching and research. She suggests that transformational leadership theory should form the framework of course content in the leadership development of occupational therapy students; thereby ensuring the transfer of these skills to future leaders.

Table 1: Classifications of leadership

Great Man Theory	Based on the belief that leaders are born and have innate qualities that render them destined to lead.
Trait Theory	Emerged as a result of the male dominant influences of great man theory, focusing on traits and qualities associated with leadership.
Behaviourist Theory	Focuses on what leaders actually do rather than their qualities. Patterns of behaviour are categorised into styles of leadership.
Situational Leadership	Leadership is specific to the situation. For example some situations may require autocratic style of leadership, while others require a more participative approach.
Contingency Theory	This is a refinement of situational leadership which focuses on identifying the situational variables that best predict the most appropriate leadership to fit a particular circumstance.
Transactional Theory	Transactional leadership emphasises the importance of the relationship between leaders and followers, focusing on the mutual benefits gained by way of rewards and recognition in return for loyalty and commitment. Transactional leaders have positions of responsibility in an organisation. This type of leader is responsible for maintaining routine by managing individual performance and facilitating group performance.
Transformational Theory	Transformational leadership focuses on the role of leaders in creating a vision, implementing change and improving organisational performance. Transformational leaders inspire and motivate individuals to be innovative and creative in shaping the future success of the organisation.

It could well be argued that there is a cross over between transactional and transformational theories; and it is this interplay that has predominantly informed the

development of this study, as leading teams requires an element of getting the job done but doing so in a way that will motivate and inspire the team to actively work towards their goals. Reiss (2000) suggests that occupational therapists would benefit from being more aware of their own transformational and transactional leadership styles and use this knowledge to facilitate their professional development, support career decisions and develop the profession.

The theoretical literature not only looks at the classifications of leadership but also considers how styles of leadership direct and influence individuals and teams. Goleman (2000) proposed that effective leaders use a combination of six styles of leadership; coercive, authoritative, affiliative, democratic, pacesetting and coaching. Coercive leadership demands immediate compliance and can be effective in particularly challenging situations where specific instructions are required, such as a natural disaster. However, this approach limits flexibility within an organisation and reduces employees' motivation. Authoritative leaders bring people along with them on the journey, sharing the vision but giving people the choice on how they achieve it. They work well in situations lacking focus but are less effective when working with a team of more experienced people. Affiliative leaders create emotional bonds and harmony. This style of leadership improves morale but its focus on praise can result in poor performance not being addressed. Democratic leaders create flexibility and responsibility by giving workers a voice in decision making. However, this can result in people feeling confused and leaderless. Pacesetting leaders expect excellence and self-direction. This works well for the self-motivated but can be overwhelming for others. Finally, coaching leaders focus on developing people for the future. This style of leadership works well when employees have an awareness of their development needs but is less effective when they are resistant to change. Coercive and pacesetting are considered to be negative styles of leadership. However, it is acknowledged that they are effective if used sparingly and at the right moment (Owen, Hodgson and Gazzard, 2004).

Goleman (2000) contends that the six leadership styles derive from different components of emotional intelligence, a phenomenon which refers to one's capacity to motivate self and others through recognition and management of one's emotions and the acknowledgement of the feelings of others. Emotional intelligence requires self-awareness, self-management, social awareness and social skill. To be effective, leaders must have an understanding of how their emotions and actions affect the people around them. Essentially, the better a leader relates to and works with others, the more successful they will be.

In a similar vein, George, Sims, McLean and Mayer, et al (2007) asserts that the capacity to inspire and empower others is within us but we must first be willing to devote ourselves to our personal growth and development as leaders. This is the essence of authentic leadership, a leadership style popularised by George (2003). Authentic leaders are passionate about their purpose, committed to their values and consistently lead with their hearts as well as their heads. Authentic leaders have meaningful and lasting relationships and have the self-discipline to get results. Like emotional intelligence, authentic leadership emphasises the importance of self-awareness, social awareness and social skill. Authentic leaders recognise that leadership is not about their own success but rather empowering leadership at all levels. Thus, authentic leaders not only inspire those around them but empower those individuals to step up and lead.

The King's Fund (2014) considers leadership to be the most influential factor shaping organisational culture and emphasises the importance of developing leadership behaviours, strategies and qualities. It also points to the importance of staff engagement for effective leadership (The King's Fund, 2015). West, Eckert, Stewart and Passmore (2014) advocate collective leadership, which they describe as the key to unlocking cultural change in the NHS. Collective leadership requires each member of an organisation to not just focus on their area of work but to take responsibility for the organisation's success as a whole. In essence collective leadership involves a culture of

constant learning and continuous dialogue and debate, which will ultimately lead to improved patient care. West and Bailey (2019) also point to the importance of leaders in healthcare systems being compassionate and inclusive, seeing this as a core value of the NHS at all levels. They advocate that compassionate leadership ensures that the voices of all staff are heard and that there is a shared understanding of the challenges health and care staff face. This will enable decision makers to take appropriate action to support them in delivering and improving care. Whilst this is desirable one would question whether this approach is always possible in a pressured NHS.

The Health Foundation supports those in leadership roles to lead and deliver better health and health care through fellowships and other development opportunities including: Leaders for Change, Leadership Fellows, Leading Practice through Research, Quality Improvement Fellowships, Clinician Scientist Fellowship and the Harkness Fellowships in Health Care Policy and Practice. In essence, their aim is to support individuals to develop the knowledge, technical skills and leadership capacity to secure lasting improvements to healthcare (The Health Foundation, 2011).

The Health Foundation (2011) reported on a commissioned review of their leadership programmes undertaken in 2007. The review highlighted the importance of good relationships and collaborative working as key strengths in leading the delivery of service improvements. Some key points of note were that:

- Engagement and relationship skills are fundamentally important in leading improvement.
- Enabling and facilitating others to make their contribution is central to leading improvement in the NHS.
- The complexity and novelty of initiatives reportedly led to greater use of certain aspects of leadership.
- Participants found the most helpful programme content to be the academic input, informal networking, action learning and coaching.

Leadership has been an important feature of health and social care reforms, and the development of effective leaders is considered central to the process of NHS modernisation. The Leadership Framework (NHS Leadership Academy, 2011), presents a model of the leadership development for health and care staff. The framework (Figure 1) comprises seven domains, drawing on the earlier Leadership Qualities Framework (NHS Institute for Innovation and Improvement, 2005) and sharing the five domains of the Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010) and the Clinical Leadership Competency Framework (Department of Health, 2011) to create one overarching framework. It is anticipated that staff will demonstrate a range of leadership behaviours across all domains dependent on the context in which they operate.

Figure 1: Domains of the NHS Leadership Framework



Demonstrating personal qualities, working with others, managing services, improving services and setting direction are the five core domains of the framework. These core domains are deemed essential for effective leadership; and all health and care staff are expected to demonstrate competence in these domains regardless of their role or positon. Creating the vision and delivering the strategy are two additional domains, deemed more applicable to individuals in senior leadership positions. Here the focus is on demonstrating effective leadership by developing and influencing the vision and developing, implementing and embedding the strategy.

Whilst leadership frameworks have been well utilised in NHS services and more recently applied to Social Care (Department of Health, 2012), Bolden, Wood and Gosling (2006) are critical of their applicability. They argue that competency frameworks do not provide a realistic picture of management/leadership roles and may actually confuse the very issue they aim to resolve. They propose a shift in focus from competencies to the lived experience and suggest that the key to successful leadership development is to achieve a balance between knowledge exchange, action and reflection, and alignment between the needs and wants of the individual and those of the organisation. West et al (2015) support this position, highlighting that there is little evidence that the use of competency frameworks results in improved leader effectiveness. Instead, evidence highlights the importance of collective leadership and advocates a balance between individual skill-enhancement and building organisational capacity, a position reflected in more recent leadership frameworks.

Developing People Improving Care (NHS Improvement, 2016) is a national framework to develop leadership and improvement capability in the health and social care. It aims to create the right conditions to enable all staff and organisations involved in NHS funded activity to continually improve their local health and care systems. The framework focuses on supporting NHS and social care staff to develop four critical capabilities:

- Systems leadership for staff who work with partners in other local services to ensure 'joined up' local health and care systems for communities
- Established quality improvement methods that utilise staff and service user knowledge and experience to improve service quality and efficiency
- Inclusive and compassionate leadership, so that all staff are listened to, understood and supported, and that leaders at all levels truly reflect the talents and diversity of people working in the system and the communities they serve
- Talent management to support NHS-funded services to fill current and future senior leadership vacancies with diverse and appropriately developed people

Arguably, competencies set a benchmark or standard from which one is able to measure their leadership development but a key question for this study was whether competencies or situational factors influence occupational therapists leadership development. In addition, the quality improvement and change agenda raises questions about how occupational therapists market and position themselves as clinical leaders.

Given the theoretical positions presented, the study needed to consider what successful leadership looked like and explore what influenced styles of leadership and the leadership experiences of occupational therapists in the UK. Moreover, it needed to compare theoretical models with leadership practice as reported by occupational therapists.

2.3 Part two: The Policy Context

Within the UK leadership has been an important feature of health and social care reforms, and the development of effective leaders is considered central to the modernisation of the NHS. Much of UK policy has focused on developing and strengthening the NHS, highlighting where the focus should be in relation to leadership. The NHS plan identified that there was a need for more focus to be placed on developing leadership skills in doctors, nurses and other professional staff because

leadership development within the NHS had been ad hoc with very few clinicians in leadership roles (Department of Health, 2000). Clinical leadership has remained high on the National Health Service (NHS) agenda, with the Department of Health (2008) emphasising the importance of leadership at all levels. Importantly the 2008 paper proposed that the future success of the National Health Service (NHS) lies with clinicians acting as both partners and leaders in the delivery of care. The paper states that clinicians are expected to provide leadership and where appropriately qualified take senior leadership and management positions. The knowledge, skills and experience of allied health professionals were deemed crucial for the transformation and sustainability of health and social care services (Department of Health, 2008). However, there was recognition that a limited understanding of the knowledge, skills and abilities of allied health professionals had resulted in their scope and potential in delivering patient-centred care not being maximised. Almost ten years later the Department of Health Workforce Directorate (2009) restated the need to improve leadership within the NHS.

Karen Middleton, the then Chief Health Professions Officer emphasised the importance of leadership for driving forward change (College of Occupational Therapists Briefing, 2010). For the NHS this has never been more important, with increased demands and limited resources. Equity and Excellence: Liberating the NHS (Department of Health 2010) set out a long term strategy for the future delivery of care by the NHS. The paper outlined a set of challenging and far-reaching reforms to drive cultural change within the NHS; and deliver quality services with optimal efficiency. The realisation of these changes is already apparent with budgets being significantly reduced and services reconfigured or decommissioned. This level of challenge and change is unprecedented and strong professional leadership is vital to ensure occupational therapy's future. Failings within the NHS have further highlighted the need for effective clinical leadership. The Mid Staffordshire NHS Foundation Trust Inquiry report by Francis (2013) highlighted a catalogue of concerns and made recommendations to bring about improvement including a review of management and

leadership structures ensuring that views are fully represented at all levels. The King's Fund (2012) supports this position, advocating that leaders need to cultivate a strong culture of engagement.

The Five Year Forward View (NHS England, 2014) set out a vision for an improved NHS; an NHS equipped to meet the increasing challenges associated with the impact of changing healthcare needs. The plan highlighted the need for a step change in the future provision of health care, emphasising a greater focus on prevention, wellbeing and public health. It also highlighted the need for improved partnerships with the local community and voluntary organisations, provision of care closer to home, the delivery of services in specialist centres and investment in new care models. Growing and sustaining the workforce was deemed crucial for the implementation of the plan, with an acknowledgment that all health care staff including therapists had a role in its delivery. The value and contribution of AHPs in the implementation of the Five Year Forward View was highlighted in the AHP national strategy document 'AHPs into Action' (Chief Allied Health Professions Officer's Team, 2017). The strategy describes and demonstrates that AHPs are both ready and have the skills to support and transform health and social care; a position reinforced by the NHS Long Term Plan (NHS England, 2019). AHPs have a vital role to play in the prevention agenda through early intervention, making every contact count, promoting self-management and promoting healthy environments (Public Health England, 2015 and 2019). It is therefore important that the AHP workforce is utilised to best effect to address the challenges facing health and social care.

Whilst it is acknowledged that AHPs have a key role in shaping the future delivery of health care there remains a recognised need for greater diversity in NHS leadership. A report by the Faculty of Medical Leadership and Management (2018) focusing on barriers and enablers for clinicians moving into senior leadership roles, suggested that the leadership potential of AHPs could be better utilised. The report highlighted a concern that board structures, requiring a nurse director and medical director,

preclude AHPs accessing opportunities to develop and demonstrate board-level skills. However, the report also recognised the role of AHPs in effecting change, suggesting that AHPs need to take a more strategic view in order to promote participation in leadership activity and progress.

In February 2019, an Allied Health Professions Federation (AHPF) press notice reported on a motion tabled in Parliament by Norman Lamb (MP), urging a change in the law to enable greater diversity of talent and leadership at the top of the NHS for physiotherapists, occupational therapists, radiographers and other therapists. He stressed that current rules around NHS senior leadership roles were outdated and that greater diversity of talent in leadership posts in hospitals can boost multi-disciplinary working, reduce pressure on emergency departments and thus improve patient outcomes. Similarly, a King's Fund report (Anandaciva, Ward, Randhawa and Edge, 2018) noted that there was no clear route for AHPs to attain senior leadership positions, unless they became chief operating officers. The report, based on interviews with senior leaders, acknowledged the wealth and experience that AHPs could bring as leaders, with one chief executive suggesting that the NHS could be more versatile in their approach to using non-voting board roles.

The drive to develop AHP senior leadership roles has gained considerable momentum. A report commissioned by NHS Improvement (2018) shared the findings from a project which evaluated leadership arrangements for AHPs. The project was developed to provide an evidence-based approach to reviewing and improving AHP leadership in provider organisations. The evaluation concentrated on formal professional AHP leadership; focussing on established senior leadership positions aligned to higher agenda for change bandings (8 and above). This was not to ignore that leadership occurs at all levels but to provide specific insights relating to senior strategic leadership for AHPs. The evaluation addressed two key issues regarding AHPs' leadership across the NHS in England:

1) What organisational leadership structures exist for AHP service provision, and what is the impact of them for quality and productivity of care delivery in NHS provider organisations in England?

2) What are the characteristics, key skills and attributes of effective AHP leaders and how are these gained through professional development during an AHP's career?

The report found significant variation in AHP leadership arrangements across NHS providers in England. This was perhaps most noticeably reflected in the range of job titles for the most senior AHP lead (41 titles across 43 job descriptions), meaning that in most cases there is not a readily identifiable 'go-to' AHP leader as in other professions - for example, the Chief Nurse. The report also found that Board-level accountability for AHP matters is ultimately via the Chief Nurse/Director of Nursing. However, the scale of the nursing agenda may leave the Chief Nurse feeling unable to adequately represent AHPs at board level. The report highlighted that higher banded AHP posts increase AHP visibility. In addition, findings indicated that the most senior roles influence the AHP workforce and increase its engagement in improving services. The report concluded that AHPs will be most effective in delivering and improving healthcare if there is sufficient strategic, professional, clinical and operational leadership to maximise their contribution to quality and productivity.

The NHS Long Term Plan (NHS England, 2019) highlights the importance of diverse clinical leadership to ensure high quality patient care and commits to identifying, developing and supporting future leaders. The plan acknowledges that AHPs can significantly support the demands the NHS faces and commits to doing more to develop and embed cultures of compassion, inclusion, and collaboration across the NHS.

The Interim NHS People Plan (NHS Improvement, 2019a) is the first phase of the implementation of the NHS Long Term Plan and highlights the importance of transforming the way that health and care staff work together to deliver high quality patient care. The interim plan emphasises the need to ensure that there is a sufficient

supply of staff to deliver new service models set out in the NHS Long Term Plan. Furthermore, it foresees the need for additional AHPs including occupational therapists and commits to increasing applications to undergraduate AHP education. This will be supported by AHP faculties who will play a key role in helping to shape the next generation of AHPs, supporting continuous professional development and developing advanced practice roles. Further support and guidance is available through use of the Clinical Leadership Framework for Action (NHS Improvement, 2019b). The framework acknowledges that there is a growing interest in clinical leadership, with a desire to know how more clinicians at the board can support organisations to be more effective. The framework seeks to support leaders working on clinical leadership gain new perspectives on what might be standing in the way of progress and sets out the key legal and policy considerations. The framework seeks to support senior leaders in recognising the diverse skills of AHPs and their potential to undertake senior leadership roles. Using case study examples, the framework highlights successes and demonstrates how challenges were overcome, thus giving future clinical leaders a vision, of what their journey to senior leadership positions could be.

Trust executives have provided valuable insights on investing in chief allied health professional roles (NHS Improvement, 2019c). The guide highlighted that the AHP workforce's visibility and voice were greatly improved by the introduction of a chief AHP (NHS Improvement 2019c). Board members reported that having a chief AHP in post had raised the profile of the AHP workforce, increasing its engagement and therefore its contribution to trust priorities. However, it was acknowledged that further work is required in order to challenge historical practices that have limited the strategic contributions of AHPs' to health and social care. The report concluded that trust boards looking to strengthen AHP leadership arrangements should:

- Appoint a substantive chief AHP with a strategic focus
- Challenge historical practices on traditional roles and support the organisation to identify opportunities for a richer skill mix

- Review governance arrangements and use the chief AHP role to reduce fragmentation and bring the AHP workforce together to improve safety and productivity.
- Recognise the AHP contribution in meeting organisational priorities
- Support AHP leadership development and career pathways

Finally, NHS Improvement (2019d) has produced an interactive guide for use by trust boards and clinicians to support the professional and leadership development of AHPs. Drawing on insights and evidence from trust chief executives and chief AHPs, the Developing Allied Health Professional Leaders Guide (NHS Improvement, 2019d) provides a framework for AHPs that are considering their leadership career path. The guide which may be used to facilitate appraisals, career coaching and mentoring conversations, highlights the importance of demonstrating the strategic behaviours and characteristics sought by executives. It also highlights the importance of combining formal learning with mentorship and guidance. Finally, the guide emphasises the importance of taking 'leap of faith' opportunities to broaden knowledge and skills development and highlights the importance of demonstrating a track record of leading change and delivering on projects.

Turning specifically to occupational therapy guidance, the Royal College of Occupational Therapists (RCOT) Strategic Intentions 2018 - 2023 emphasises its role in strategic leadership to ensure members enhance the profile and value of the profession, and operate effectively within a changing political and economic landscape (RCOT, 2018). The strategic intentions emphasise the importance of occupational therapy in contributing to the health and wellbeing of UK citizens, and provides a framework for how the RCOT will support its staff, members and the wider profession.

The strategic intentions aim to position the profession and its members for the 21st century, enhance the profile of the profession to a range of audiences and ensure that RCOT is a thriving membership organisation within which members flourish.

This will be achieved by:

- Empowering members to develop and lead through research, education and continuous professional development (CPD)
- Lobbying and influencing Governments and decision makers to recognise the value of occupational therapy
- Securing a sustainable and effective workforce for the future by empowering young people to choose occupational therapy as a career
- Enabling members to work with RCOT to promote the profession
- Using effective and impactful communications to enable the general public to have a better understanding of occupational therapy
- Preserving the foundations of the profession and embracing technology to develop professional practice

Notably, leadership in occupational therapy was the subject of a recent podcast (Why is leadership such a hot topic for occupational therapists right now (RCOT, 2019b)? The podcast involving conversations with occupational therapists working in different practice settings and at different levels in their careers, highlighted that recognising yourself as a leader can take you by surprise and that sometimes there is a need to sit back and reflect in order to acknowledge your accomplishments. Similarly, stepping out of your comfort zone will help you to develop the confidence and skills to take on more challenging roles. At an organisational level, it was suggested that a lack of understanding of what occupational therapists do can negatively impact on the value placed on the profession. Participants spoke of the need for greater confidence in the value of the profession, suggesting that clear targeted communication was required to

prove that value. However, they also highlighted that RCOT resources have been helpful in evidencing the value of occupational therapy practice.

One such resource is the RCOT Career Development Framework (RCOT, 2017), a practical resource offering a structured approach to guide and support professional development for individuals, services and the occupational therapy profession. The framework is intended for staff practicing at all levels within the profession and comprises four pillars. The first pillar focuses on professional practice, the second has a focus on facilitation of learning, the third is concerned with leadership, whilst the forth has a focus on evidence, research and development. Each pillar comprises nine levels that identify the knowledge, skills and mind-set for professional development whilst also highlighting the range of opportunities available. The framework also provides guiding principles on application of the nine levels within each pillar for service users, employers and commissioners. These guiding principles provide assurance with regards occupational therapists' knowledge and skills and can be used by managers to identify and support development. As well as supporting professional development, the RCOT (2017) asserts that the Career Development Framework will raise the profile of occupational therapy by emphasising the range of knowledge, skills and mind-set across the four Pillars of Practice. This is important for the profession, as policy and guidance has either focused on AHPs as a collective or the wider health and care services.

In a similar vein, the latest RCOT Research and Development Strategy (RCOT, 2019c) acknowledges the ongoing need to build enthusiasm, confidence, capability and capacity for research. The strategy is underpinned by ten key principles that inform, guide and direct the development of occupational therapy research in the UK. There is an expectation that advancing the strategy is a shared commitment, and that involvement in research will involve all occupational therapists, albeit to differing degrees. RCOT's vision is that there will be a culture of occupational therapists in the UK that embrace engaging in and with research, and that this becomes embedded

within the profession (RCOT, 2019c). The strategy highlights that building research capacity and using evidence to demonstrate the value and impact of occupational therapy on improving people's lives is in the interests of all occupational therapists. Furthermore, the strategy highlights that building research capacity:

- Ensures that individuals, groups and communities receive the best possible input from the profession
- Enables services to be developed and delivered in the most effective way
- Enables occupational therapists to thrive and develop their careers.
- Raises the profile of the profession.
- Positions the profession to deal with the uncertainties and complexities of health and social care.

2.4 Part three: Scoping review of research evidence

A scoping review of published empirical research was undertaken to identify research relevant to clinical leadership in occupational therapy. Scoping reviews identify and map the available evidence in relation to a research topic (Arksey and O'Malley, 2005). Scoping reviews are useful for examining emerging evidence and when trying to determine more specific questions that can be posed and addressed by a more precise systematic review. They can report on the types of evidence that address and inform practice in the field and the way the research has been conducted (Munn, Peters, Stern, Catalin, McArthur and Aromataris, 2018).

Using Medline, CINAHL, ASSIA, AMED, PubMed and Web of Science databases, an initial literature search was conducted using the key search terms 'leadership in occupational therapy' and 'clinical leadership in occupational therapy'. This initial search was limited to UK research published between 2000 and 2019, as the aim was review related research undertaken in the UK. The search returned zero results therefore I revised my search criteria removing the limit of UK and extending the

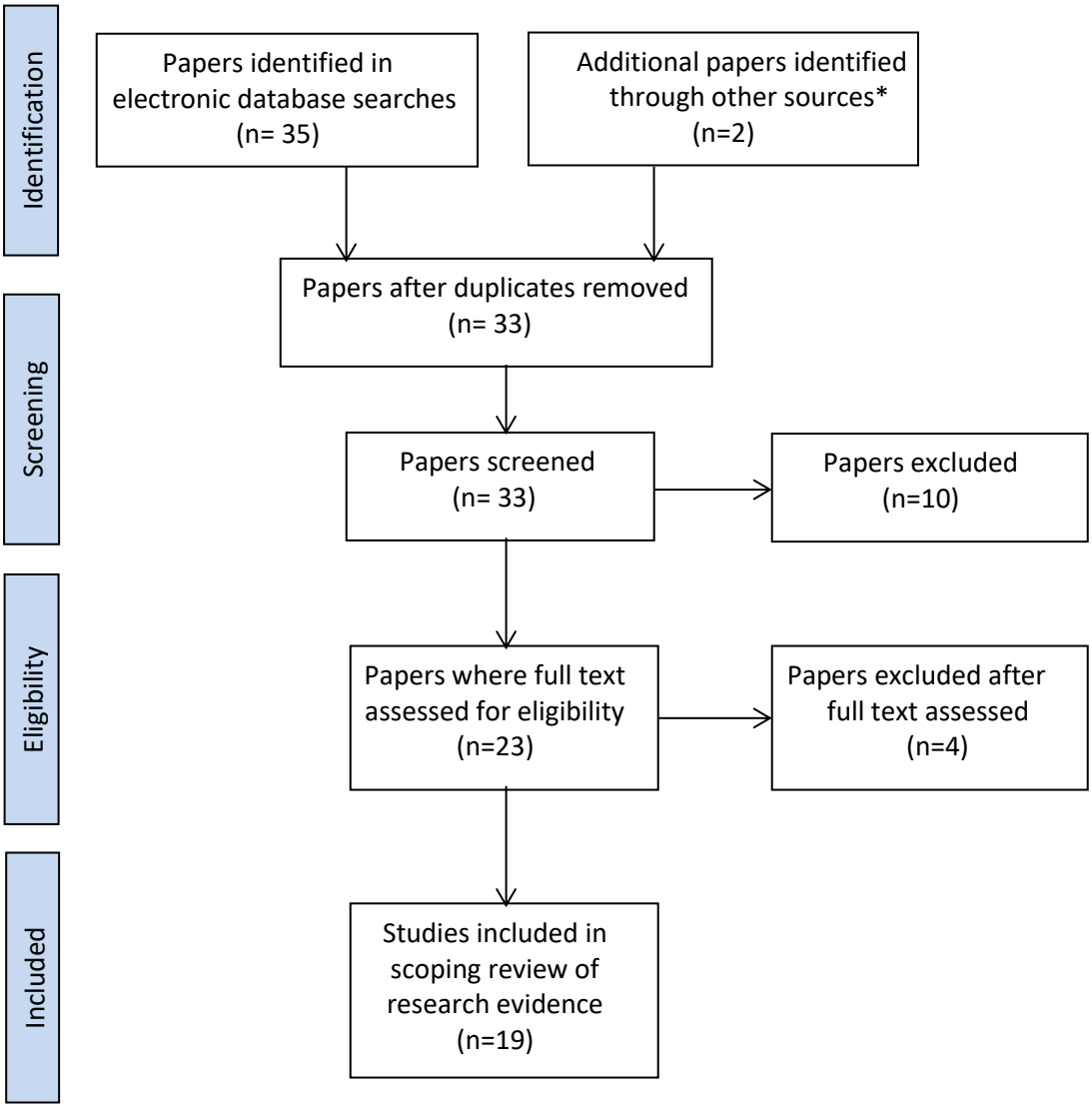
search to include published research from 1985. A hand search of key occupational therapy journals was also undertaken. On completion of the initial literature searches, alerts were set using the search criteria 'leadership in occupational therapy' and 'clinical leadership in occupational therapy'. A total of 35 studies were identified but this was revised to 33 following the removal of duplicate papers. The inclusion criteria for the selection of related research considered published research with a focus on leadership in occupational therapy clinical practice, occupational therapy leadership development, occupational therapy leadership training and education, and occupational therapy leadership and management. Abstracts and the full text of research papers were screened against the criteria for inclusion. Research related to other health care professions including nursing, physiotherapy and other allied health professions were initially excluded.

A total of 23 studies relevant to clinical leadership in occupational therapy were found; of these eleven were based on research with occupational therapy practitioners in the UK (n=2), USA (n=7) and Australia (n=2). Four of the studies were qualitative, whilst seven were quantitative. Following the initial search, a further two searches using the terms 'clinical leadership in allied health professionals' and 'clinical leadership in nursing' were undertaken using the same limits. This search identified a further ten studies related to clinical leadership.

Two studies from the USA researched leadership in Physiotherapy, a Canadian study focused on leadership in nursing, a UK study highlighted the leadership skills of healthcare managers and the remaining studies provided a UK perspective of clinical leadership in Nursing, focusing on clinical leadership qualities and the impact of specific clinical leadership training on professional practice. With regard to research design ten studies were quantitative, utilising survey research, two studies employed mixed methods, with the remainder utilizing qualitative methodology; including case studies, depth interviewing and focus groups. A narrative overview of the research is presented in Appendix 1. However, whilst it was useful to review related research

from other health care professions, these studies were not included in the scoping review as the aim was to scope research specific to leadership in occupational therapy. Thus, 23 papers were assessed for eligibility for inclusion in the scoping review. Four of these papers were excluded, as the studies were not related to clinical leadership in occupational therapy. The exclusion of these papers left a total of 19 papers for inclusion in the scoping review. A PRISMA flow chart showing the identification of related research is presented in Figure 2.

Figure 2: PRISMA flow diagram showing the identification of related research



*Hand search of journals

2.4.1 Quality appraisal of research papers

The 19 studies identified for inclusion in the scoping review were quality appraised to assess the relevance and trustworthiness of the research, utilising a tool adapted from Hawker, Payne, Kerr, Hardey and Powell, J (2002). Other tools including CASP and JBI checklists were considered, however these tools were either more appropriate for systematic reviews or required the use of more than one check list to quality appraise a range of qualitative, quantitative and mixed methods research papers. In contrast, the tool developed by Hawker et al (2002) was designed for quality appraisal of qualitative, quantitative and mixed methods papers. Therefore, this tool was deemed more appropriate for the quality appraisal of the research relevant to this study. Table 2 provides an illustration of the quality appraisal process.

Table 2: Quality Appraisal of Related Research Papers

(Adapted from Hawker et al, 2002)

Study	Does the title and abstract provide a clear description of the study?	Is here a clear statement of research aim/s?	Is the research method appropriate and clearly explained?	Was sampling appropriate to address the research aims?	Is there a clear description of the data analysis process?	Have ethical considerations, (including ethical approval, consent, bias and reflexivity) been addressed?	Is there a clear statement of findings	Are research findings generalisable or transferable to a wider population?	Do findings suggest implications for policy/practice
Gill, T. (1982) Administrative Competencies in Occupational Therapy: A Pilot Study. **British Journal of Occupational Therapy**. 45(1): pp. 323-327.	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes
Gill, T. (1984) Administrative Competencies in Occupational Therapy: A Follow-up Study. **British Journal of Occupational Therapy**. 47(10): pp. 321-324.	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes
Scott, W. E. (1985) Variables That Contribute to Leadership Among Female Occupational Therapists. **The American Journal of Occupational Therapy.** 39 (6):pp. 379-385.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Burke, J.P. and DePoy, E. (1991) An Emerging View of Mastery, Excellence and Leadership in Occupational	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Study	Does the title and abstract provide a clear description of the study?	Is here a clear statement of research aim/s?	Is the research method appropriate and clearly explained?	Was sampling appropriate to address the research aims?	Is there a clear description of the data analysis process?	Have ethical considerations, (including ethical approval, consent, bias and reflexivity) been addressed?	Is there a clear statement of findings	Are research findings generalisable or transferable to a wider population?	Do findings suggest implications for policy/practice
Therapy Practice. **American Journal of Occupational Therapy**. 45 (11): 1027-32.									
Schemm, R. L. and Bross, T. (1995) Mentorship Experiences in a Group of Occupational Therapy Leaders. **American Journal of Occupational Therapy.** 49(1): pp.32-7.	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Dudek-Shriber, L. (1997) Leadership Qualities of Occupational Therapy Department Programme Directors and the Organisational Health of their Departments. **American Journal of Occupational Therapy**. 51(5): pp. 369-77.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Lloyd-Smith, W. (1997) Moving to Trust Status: The Experiences of staff of Occupational Therapy Departments. **British Journal of Occupational Therapy**. 60(7): pp. 309-314.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Study	Does the title and abstract provide a clear description of the study?	Is here a clear statement of research aim/s?	Is the research method appropriate and clearly explained?	Was sampling appropriate to address the research aims?	Is there a clear description of the data analysis process?	Have ethical considerations, (including ethical approval, consent, bias and reflexivity) been addressed?	Is there a clear statement of findings	Are research findings generalisable or transferable to a wider population?	Do findings suggest implications for policy/practice
Craik, C., Austin, C. and Schell, D. (1999) A National Survey of Occupational Therapy Managers in Mental Health. **British Journal of Occupational Therapy**. 62(5): pp. 220-228.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adamson, B. J., Cant, R. V. and Hummell, J. (2001) What Managerial Skills do Newly Graduated Occupational Therapists Need? A View from their Managers. **British Journal of Occupational Therapy**. 64(4): pp. 184-192.	Yes	Yes	Yes	Yes	yes	No	Yes	Yes	Yes
Dillon, T. H. (2001) Authenticity in Occupational Therapy Leadership: A Case Study of a Servant Leader**. American Journal of Occupational Therapy**. 55 (4): pp. 441-8	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Bondoc, S., Kroll, C. and Herz, N. (2008) Managerial competencies for the occupational therapy practitioner, part 1**. Administration & Management**	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes

Study	Does the title and abstract provide a clear description of the study?	Is here a clear statement of research aim/s?	Is the research method appropriate and clearly explained?	Was sampling appropriate to address the research aims?	Is there a clear description of the data analysis process?	Have ethical considerations, (including ethical approval, consent, bias and reflexivity) been addressed?	Is there a clear statement of findings	Are research findings generalisable or transferable to a wider population?	Do findings suggest implications for policy/practice
Special Interest Section Quarterly. 24(3): pp.1-4.									
Kroll, C., Bondoc, S. and Herz, N. (2008) Managerial competencies for the occupational therapy practitioner, part II. **Administration & Management Special Interest Section Quarterly.** 24(4): pp. 1-4.	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes
Snodgrass, J. and Shachar, M. (2008) Faculty Perceptions of Occupational Therapy Programme Directors' Leadership Styles and Outcomes of Leadership. **Journal of Allied Health**. 37(4): pp. 225-35.	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Burtner, P.A., Crowe, T.K. and Lopez, A. (2009) A Model of Mentorship in Occupational Therapy: The Leadership of A. Jean Ayres. **Occupational Therapy in Health Care.** 23(3): pp226-243.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Study	Does the title and abstract provide a clear description of the study?	Is here a clear statement of research aim/s?	Is the research method appropriate and clearly explained?	Was sampling appropriate to address the research aims?	Is there a clear description of the data analysis process?	Have ethical considerations, (including ethical approval, consent, bias and reflexivity) been addressed?	Is there a clear statement of findings	Are research findings generalisable or transferable to a wider population?	Do findings suggest implications for policy/practice
Gamble, J. E., Lincoln, M. and Adamson, B (2009) A Case Study of Occupational Therapy Managers in NSW: Roles, Responsibilities and Work Satisfaction. **Australian Journal of Occupational Therapy.** 56: pp. 122-131.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Fleming-Castaldy, R. P. and Patro, J. (2012) Leadership in Occupational Therapy: Self-Perceptions of Occupational Therapy Managers. **Occupational Therapy in Health Care.** 26(2-3): pp. 187-202.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Heard, C. P. (2014) Choosing the Path of Leadership in Occupational Therapy**. The Open Journal of Occupational Therapy**. 2 (1): pp. 1-18.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Lachter, L.G. and Ruland, J. (2018) Enhancing leadership and relationships by implementing a peer mentoring	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Study	Does the title and abstract provide a clear description of the study?	Is here a clear statement of research aim/s?	Is the research method appropriate and clearly explained?	Was sampling appropriate to address the research aims?	Is there a clear description of the data analysis process?	Have ethical considerations, (including ethical approval, consent, bias and reflexivity) been addressed?	Is there a clear statement of findings	Are research findings generalisable or transferable to a wider population?	Do findings suggest implications for policy/practice
program. **Australian Occupational Therapy Journal**. 65(4): pp. 276-284.									
Hendricks, F. and Troth-Cohen, S. (2018) Perceptions about Authentic Leadership Development: South African Occupational Therapy Students' Camp Experience. **Occupational Therapy International.** Volume 2018, Article ID 1587906, 9 pages https://doi.org/10.1155/2018/1587906	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Heard, C. P., Scott, J., McGinn, T., Van Der Kamp, E. and Yahia, A. (2018) Informal Leadership in the Clinical Setting: Occupational Therapists Perspectives. **The Open Journal of Occupational Therapy.** 6(2): Article 8. Available at: https//doi.org/10.15453/2168-6408.1427	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

2.5 A review of related research

UK based research has primarily focused on nurse leadership, for example Fielden, Davidson and Sutherland, 2009 and Alleyne and Jumaa, 2007. UK research specific to occupational therapy leadership predates 2000. Lloyd-Smith (1997) investigated the impact of NHS staff moving to Trust status, highlighting the important role of departmental leadership during a period of transition and change. Craik, Austin and Schell (1999) surveyed occupational therapy managers to find out about the services they managed. The survey highlighted the importance of supervision and training for professional development and identified the need for improved marketing and promotion of occupational therapy as a profession.

International studies, undertaken in USA, Australia, Canada and South Africa have explored management and leadership in a wider context. Gill (1982) used interviews and a survey to explore the administrative competencies of directors of occupational therapy departments in one region of Ontario, Canada; with questions focusing on current skills and the level of support and training required to fulfil their management responsibilities. The pilot study found varying levels of skill and need amongst study participants; and highlighted the need for training in personnel issues. The study concluded that the directors of occupational therapy had not received sufficient training, in the area of administration in order to practice their roles comfortably. In a follow-up survey with occupational therapy administrators that extended across Canada (Gill 1984), results corroborated the need for training in personnel issues but no other associations were found. Adamson, Kant and Hummell (2001) investigated what occupational therapy managers perceived as important management skills for newly qualified occupational therapists. The research, which was part of a larger study undertaken with allied health professionals in Australia, utilised a questionnaire design to establish the level of importance that occupational therapy practitioners placed on a range of managerial skills and competencies for new graduates. It also sought to ascertain who should be responsible for introducing managerial skills to occupational

therapists and when this should occur. Ninety-four occupational therapy managers participated in the study, representing a response rate of 59%. Participants identified future planning skills such as time management, prioritisation of work and setting goals for the work team as the most important team managerial skills. Developing skills to support organisational practice and advocating for services was considered second most importance whilst skills development to facilitate team leadership was ranked third. Notably, Adamson, et al (2001) state that the occupational therapists surveyed rated team leadership skills more importantly than the larger sample. With reference to when managerial skills should be introduced, just over half of the occupational therapy managers (55%) agreed that this should occur at undergraduate level and that curriculum development needs to consider how managerial skills development will be incorporated into training programmes. Bondoc, Kroll and Herz (2008) and Kroll, Bondoc, and Herz (2008) conducted a mixed methods study, comprising a survey and interviews with occupational therapy managers and administrators, to ascertain the knowledge, skills, competencies and personal attributes required to succeed in management roles. The study highlighted that interpersonal communication, organisational skills, time management and problem solving skills are essential management and leadership competencies. Moreover, the study suggested that further support is required to prepare occupational therapists as leaders, managers and administrators. Gamble, Lincoln and Adamson, 2009 used a case study approach to investigate the differences between clinical managers and administrative managers roles and responsibilities in order to provide a deeper understanding of the work of occupational therapy managers. The study found no clear difference between the two types of manager but pointed to the importance of balancing priorities. Whilst these studies focused on management, useful insights can be drawn with regards to leading teams and services.

Research specifically focused on leadership has employed a number of approaches to investigate perceptions of leadership, leadership characteristics, leadership behaviours and strategies to enable effective leadership. Research has investigated leadership at

practice level, manager/leader level and from an educational perspective. At the practice level, Scott (1985) used validated survey instruments as well as self-developed questions to investigate factors contributing to leadership among female occupational therapists. Comparisons were drawn between occupational therapy leaders and those who had not occupied leadership position. The study discovered no difference between leaders and non-leaders demographically, and found that leaders saw themselves as leaders and desired leadership. The study highlights the need to consider the influence of personal experiences on the development of leadership skills. Similarly, Burke and DePoy (1991) employed semi-structured interviews to determine the characteristics of occupational therapists' mastery and excellence in practice and explore the degree to which they engaged in leadership behaviour. The study concluded that mastery, excellence and leadership are independent of one another but some characteristics are common to each of these phenomena. As such, it is important for occupational therapists to understand the developmental steps involved in mastery, excellence and leadership and this should inform curriculum development. Heard, Scott, McGinn, Van Der Kamp and Yahia (2018) examined occupational therapists' perspectives of informal leadership in clinical settings, using qualitative methodology. The study undertaken in Canada, drew on the experiences of ten occupational therapists, identified as informal occupational therapy leaders via a peer identification process. Through the use of semi-structured interviews, occupational therapists were asked how they perceived themselves in their informal leadership roles, how their role informed occupational therapy practice and how occupational therapy informal leaders might best be supported. Interview findings highlighted that informal leaders were knowledgeable, accessible and inspirational. They were viewed as collaborative workers and considered the 'go to' staff within teams. Informal leaders were also considered to be both creative and inspirational, building capacity and strength through supportive mentoring and coaching. Heard et al (2018) concluded that the role of informal leaders needs to be validated by giving informal leaders the freedom to realise their vision. They also suggested that recognition also

needs to be given to the time commitment of such roles which often extend beyond core working hours without acknowledgement. Finally, Heard et al (2018) advocate that curriculum material and professional guidance should consider the role and function of informal leadership in professional practice.

Studies focusing on managers/leaders have highlighted the need for powerful leadership to influence development and change. Fleming-Castaldy and Patro (2012) drew on the Leadership Practices Inventory (LPI) to investigate the self- perceptions of leadership in occupational therapy clinical managers. Their survey collected data on leadership practices and concluded strong leadership capabilities are influential in times of change/ reform. Schemm and Bross (1995) drew on two pre-existing survey tools to investigate the impact of mentorship experiences of a group of occupational therapy leaders. The study found little evidence that respondents were mentored by high powered individuals that helped launch their careers. Thus, it was recommended that plans to initiate mentorship programmes should include activities that promote powerful leaders beyond the status and position of their mentors.

The importance of educational influence has featured in previous research (Dudek-Shriber, 1997, Dillon, 2001 Snodgrass and Shachar, 2008 and Burtner, Crowe and Lopez, 2009). These studies investigated the leadership qualities of occupational therapy programme directors using surveys and self-assessment questionnaires to determine leadership styles, influence and impact on others. The research by Snodgrass and Shachar focused on styles of leadership and concluded that the most effective leaders in academia combine transformational and transactional leadership styles. Dudek-Scriber found a strong relationship between leadership and organisational health and Dillon concluded that an effective, authentic and accomplished leader's success was attributed to enabling others, collaborative visioning and leadership through caring. Dillon's 2001 study of education faculty members focused on the leadership and educational influence of occupational therapist, Dr A. Jean Ayres. A subsequent study by Burtner, Crowe and Lopez (2009)

also examined the leadership of Dr Ayres. The survey of faculty members highlighted the importance of inspirational leadership as well as the influence of effective role modelling and mentorship for the continued growth of occupational therapy as a profession.

In a shift from examining the influence of educational leaders in development of occupational therapy leaders, Lachter and Ruland (2018) evaluated the outcomes of a peer-mentoring program designed for graduate occupational therapy students. Second-year student volunteers were randomly assigned to individually mentor first-year students in a year-long program focusing on everyday student issues. The effectiveness of the programme was measured using the Multi-factor Leadership Questionnaire (Avolio and Bass, 2004) and an open-ended feedback survey. Questionnaire analysis indicated significant improvement in several leadership skills, whilst qualitative data from feedback surveys indicated that students valued and benefited from the structure and support provided from their peer-mentoring experience. Lachter and Ruland concluded that peer-mentoring programs can facilitate the development of essential professional skills and promote leadership development. They therefore recommended that peer-mentoring should be considered as a vehicle to empower students to practice and advance essential career skills from an early stage in their professional development.

Hendricks and Troth-Cohen (2018) have also examined the experiential impact of undergraduate education on leadership development. They explored the perceptions of authentic leadership in occupational therapy with a purposive sample of predominantly Black occupational therapy students in South Africa. The study undertaken with students from universities across South Africa, attending a pilot of a national student leadership camp, set out to ascertain participants' perceptions of leadership and leadership development. The aim was to inform the development of strategies to help Black South African occupational therapy students further develop their leadership capacity and contribute their knowledge and experience to support

leadership in what was seen to be a slowly progressing profession with regards diversity and inclusion.

Hendricks and Troth-Cohen (2018) explain that authentic leadership comprises key elements including self-awareness, self-knowledge, self-regulation and personal values that can be utilised by students who have a desire to effect change. They describe how they developed an interview guide based on these elements, to explore aspects of authentic leadership through the use of in-depth interviews with participants attending a national student leadership camp. Interview data were analysed using content analysis and findings highlighted that participants' perceptions of leadership were reflective of their internalised beliefs and their expectations of leaders. Four themes were identified and these were broken down into four categories. The first was perceptions of 'self' based on participants' personal narratives of authentic leadership. The second was perceptions of key issues with current leaders with regards moral issues including; continuing inequality, insincerity, greed, corruption and selfishness. The third focused on the pursuit of goals and aspirations for leadership development via student camps whilst the fourth was focused on the effects of leadership on the system through pursuit of these goals. Based on their findings, Hendricks and Troth-Cohen (2018) present a working model of authentic leadership development for students, which highlights that the potential for authentic leadership development is on a continuum that takes into account students' past experiences whilst also considering their perceptions of the future. Hendricks and Troth-Cohen (2018) conclude that the model can benefit occupational therapy by providing a better understanding of the leadership development needs of emerging young Black leaders whilst contributing to the wider knowledge and understanding of theories of leadership. Furthermore, they advocate focused investment in camps that develop student leadership skills and build authentic leadership knowledge.

This scoping review of research evidence concludes with a qualitative study by Heard (2014) who examined why occupational therapists chose to pursue a path of

leadership. The study comprising semi-structured interviews with ten occupational therapy leaders in Canada found that occupational therapists choosing the leadership path were motivated by a desire to influence professional practice, a need for personal or career development and a need for change. Participants highlighted the importance of embedding leadership concepts into the occupational therapy curriculum and ensuring this continues post qualification. Moreover, participants emphasised the importance of mentorship to support the development of leaders but also pointed to the need for emerging leaders to take responsibility for demonstrating their leadership potential.

The review highlights the paucity of research focusing on clinical leadership in occupational therapy both from a UK perspective and internationally; a position echoed by Heard (2014) who noted that the limited volume of leadership studies presents serious concerns for the profession. Heard (2014) highlights a focus on nursing leadership, citing nursing journals that have placed specific emphasis on leadership as a professional obligation and an area for continued research. Conversely, other health professions including occupational therapy have been markedly limited in the volume of leadership studies and more disparate in focus (Heard 2014). Research has been specific to a particular area of practice and has not incorporated the breadth and scope of practice, i.e. health, social care, independent practice and embraced occupational therapists working across the grade range, thereby providing a limited perspective of occupational therapists' experience. Moreover, the relevance and applicability of older research to current and evolving practice is called into question (Heard 2014).

2.6 Gaps in the available evidence relating to clinical leadership in occupational therapy

The review highlighted that studies undertaken in the UK were limited. One study focused on leadership during a time of transition and change whilst a second focused on the duties and responsibilities of occupational therapy managers. Occupational therapy research undertaken in the USA has investigated the characteristics and qualities of effective leadership but again this has predominantly featured managers and has not embraced occupational therapists working across the grade range, thereby providing a limited perspective of occupational therapists' experience. This is a gap that will be addressed by my research, which aims to sample occupational therapists from a range of work environments and at various grades. In so doing it is anticipated that the research will provide a more complete picture of clinical leadership from the perspective of occupational therapists.

Whilst studies may have explored leadership qualities and characteristics, little attention has been paid to the barriers and facilitators to clinical leadership. This is an important aspect to gaining understanding of the lived experience of occupational therapists and their clinical leadership development. It has been suggested that social influences may impact on how the world is viewed and experienced (Bolden et al, 2006) so a key question for this study was whether competencies or situational factors influence occupational therapists' leadership development.

Finally, previous research has focused on participants self-rating their ability as a leader and exploring leadership qualities and characteristics as discussed earlier. However, research of leadership in occupational therapy has not evaluated which aspects of leadership are most important for leading and developing occupational therapy clinical practice in the UK. Whilst it is helpful to draw insights from our international colleagues it is important to inform clinical leadership from a UK perspective.

2.7 Overall aim of this study

The overall aim of this study was to gather and summarise occupational therapists' perceptions and experiences of clinical leadership, and to investigate the influence and impact of education, situational factors and social influences upon these perceptions and experiences, in order to provide recommendations for future training, development and practice.

2.7.1 Objectives

1) To map the current roles, education, training and leadership experience of occupational therapists practising in the UK.
2) To explore the key attributes of an effective clinical leader from the perspective of occupational therapists.
3) To examine the impact of training and development on clinical leadership positions held by occupational therapists.
4) To develop an understanding of the perceived barriers and facilitators influencing occupational therapists' leadership development.
5) To use findings to generate recommendations for leadership training, development and practice.

2.8 Summary

The review of the literature has provided an historical view of clinical leadership in occupational therapy. The review has considered available evidence in the context of wider healthcare leadership and highlighted some of the gaps that this study aims to address.

CHAPTER 3: METHODOLOGY AND METHODS

3.1 Introduction

This chapter will describe and examine the research methods employed to investigate occupational therapists perceptions and experiences of clinical leadership in professional practice. The chapter begins by outlining the research methodology and the philosophical assumptions underpinning the research; it then goes on to provide an account of the research methods utilised for the study.

3.2 Methodology

The research employed mixed methods to investigate occupational therapists perceptions and experiences of clinical leadership in professional practice. Mixed methods research has been described as research whereby the researcher collects and analyses the data, integrates the findings and makes inferences using qualitative and quantitative measures in a single study (Tashakkorri and Creswell, 2007).

The aim of mixed methods research and the rationale for its use in this study is that it builds upon the strengths of quantitative and qualitative methods in order to gain a deeper understanding of the subject under investigation (Johnson and Onwuegbuzie, 2004). Doyle, Brady and Byrne (2009) assert that mixed methods may be used for hypothesis testing, instrument development testing and data validation. They argue that one approach may be used to explain the findings of another and that quantitative data may be illustrated using qualitative methods. Doyle, Brady and Byrne (2009) contend that the triangulation of data afforded by mixing methods provides greater validity. Furthermore, they argue that combining methods not only offsets the limits of each approach to strengthen overall results but enables the researchers to answer questions that cannot be answered by a single method. Thus a combination of research approaches provides completeness, which was what I set out to achieve in this study.

It could be argued that the sole use of quantitative or qualitative methods may well address the research aim; however Morse (2003) argues that combining and increasing the number of research strategies within a given project will broaden the dimensions and scope of the study and provide a more complete picture of human behaviour and experience. Further, Doyle et al (2009) maintain that mixed methods allow and guide the researcher to use a variety of approaches to answer research questions that are not readily addressed through the sole use of qualitative or quantitative methods. Thus, proponents of mixed methods regard it as a natural complement to traditional quantitative and qualitative research (Johnson and Onwuegbuzie, 2004) or a legitimate alternative (Doyle, et al, 2009).

In mixed methods research the relationship between the two approaches is key, with the research process either being predominantly quantitative (QUAN-Qual), predominantly qualitative (QUAL-Quan) or equally weighted (QUAN-QUAL). The design will be very much dependent on the priority given to either quantitative or qualitative data collection, the sequence of collecting quantitative or qualitative data or the data analysis techniques used and how this integrates the study (Morse, 2003). This study was predominantly qualitative, combining a minor quantitative phase with a major qualitative phase (QUAL-Quan). Data collection was undertaken in two phases using a sequential explanatory design (Creswell and Plano Clark, 2011). Stage one utilised quantitative data collection and analysis to profile and evaluate the position of occupational therapists as clinical leaders. Stage two employed qualitative data collection and analysis techniques to undertake an in depth exploration of occupational therapists perspectives and experiences of clinical leadership. The rationale for this approach was that quantitative element provided a general understanding of the research problem, whilst the qualitative component refined, developed and explained the quantitative results by exploring participants' views in more depth (Rossman and Wilson, 1985, Tashakkori and Teddlie, 1998.

Mixed methods research is underpinned by philosophical assumptions that enable the mixing of quantitative and qualitative approaches during the research process (Hanson, Creswell, Plano Clark, Creswell, 2005). Quantitative and qualitative research operates from differing philosophical perspectives; with quantitative research being influenced by positivism and qualitative research influenced by phenomenology and interpretive approaches. Positivism draws on scientific enquiry and asserts that social phenomenon can be measured using the principles of the natural scientist to establish a reliable and valid body of knowledge (Bowling, 1997). Common tools of measurement include experiments and surveys that can be controlled or measured in a scientific and objective manner (Bryman, 1998). For positivists, any knowledge is testable by experience and the researcher is value neutral. Benton and Craib (2001) summarise the core beliefs of a positivist approach. They suggest that for positivists there is an acceptance of the empiricist view of the natural sciences and for most empiricists science is considered the only legitimate form of knowledge. Positivists also contend that scientific methods can and should be applied to life and societal studies to establish them as social sciences. Finally, Benton and Craib (2001) argue that positivists accept that once reliable social and scientific knowledge is established, one can influence the behaviour of individuals or groups in society; resolving social problems and conflicts in the same way that technical and engineering matters would be resolved. Like the natural sciences positivism seeks understanding of cause and effect and draws on the laws of the natural sciences to establish their position within the social sciences.

Positivism has been criticised by a number of social scientists as being misleading through its emphasis on knowledge verification without understanding the experiences of individuals, or the meanings attached to this (Bowling, 1997). Critics also question the application of scientific principles to the study of individuals in the social world and Grbich (1999) comments that nineteenth century philosophers argued that the truth of knowledge relating to human action was relative, dependent on

changing relationships and bound by context and time. A further critique is that by the very nature of the research process social science researchers cannot be value neutral. These concerns are addressed by the post positivist movement that takes into account the potential biases of the researcher and the research process.

In contrast to positivism, interpretivism is a methodological approach concerned with the meanings and understanding that individuals attach to their social world (Bowling, 1997). The historical roots of interpretivism derive from the ideas of Immanuael Kant (1929) who believed that our thoughts contribute to the construction of knowledge of the social world thus enabling a better understanding of the experiences of individuals and groups. Interpretivism is based on a belief that reality is socially constructed or is given meaning through an 'actors' understandings and interpretations of events (Berger and Luckmann, 1966). Meanings refer to how actors make sense of their experiences and the impact this has on their organisational lives whilst interpretations refers to the process of making inferences about organisational phenomena (Putnam and Banghart, 2017). Thus, for interpretivists the existence and foundation of an organisation stems from our actions, social interactions and the interpretations that form communication (Prasad and Prasad, 2002).

Interpretivists focus on symbols, language use and social interactions. The interpretivist's relationship with participants in the research process is open and transparent and the relationship with the researcher is considered an empowering partnership (Frey, 1994). The focus is on comprehensiveness and rigour rather than reliability and generalisability thus multiple methods of data collection may be used to gain insights about the meanings that participants attach to their social worlds (Bantz, 1983). Thus, the interpretivist approach was the methodological approach underpinning this research.

Qualitative research aims to gain depth of understanding and richness of information using a variety of methods including participant observation, case studies, focus groups and one-to-one interviews. The emphasis is on meaning and context rather than numerical data; and there is an acceptance that the research provides more than one meaning rather than a single answer (Braun and Clarke, 2013). Grbich (1999) asserts that within qualitative research there are those that believe the researcher can participate in research with minimal disturbance whilst others believe that the perceptions of the researcher and research participants are socially constructed and interlinked. Thus, knowing your position and influence as a researcher is an important consideration in the design, development and analysis phase of any research project.

When considering the approach for the qualitative phase of the study, a constructivist grounded theory approach (Charmaz 2006), drawing on the principles of grounded theory (Glaser and Strauss, 1967) was an initial consideration. However, thematic analysis Braun and Clarke (2006) was considered a more appropriate method for framing qualitative data collection and analysis. Braun and Clarke (2006) describe thematic analysis as an umbrella term for a range of approaches that identify, describe, analyse and organise patterns within datasets. Braun, Clarke, Hayfield and Terry (2019) credit the discovery of thematic analysis to the work of Gerard Holton (1973) but note that its roots date back to the early 1930s. They suggest that thematic analysis may have evolved from quantitative content analysis and that the two have a shared history. Whilst used extensively for qualitative analysis, there are differing views with regards what thematic analysis is and its application. Boyatzis (1998) regards thematic analysis as a tool that may be applied across different research methods whilst Ryan and Bernard (2000) view thematic coding as a method used in analytic traditions rather than being a specific approach in its own right. In a similar vein, Holloway and Todres (2003) describe the classification of meanings into themes as a skill that is shared across qualitative analysis. Moreover, Braun and Clarke (2006)

point to a number of papers documenting themes emerging from data without an established methodological approach, which led them to describe thematic analysis as:

> "A *poorly demarcated and rarely acknowledged, yet widely used qualitative analytic method" (Braun and Clarke 2006, p77).*

However, Braun et al (2019) highlight that over the years some of the previously held positions regarding this have changed and that thematic analysis should be viewed as a distinct method of qualitative analysis in its own right. Importantly, for Braun and Clarke (2006) the issue of importance is that researchers are clear about process and method when undertaking qualitative analysis, which they clearly set out.

Like grounded theory, thematic analysis identifies patterns or themes within qualitative data sets. However, Braun and Clarke (2006) claim that whilst there are some similarities between the two methods, by adopting thematic analysis "researchers need not subscribe to the implicit theoretical commitments of grounded theory if they do not wish to produce a fully worked up grounded theory analysis" (Braun and Clarke, 2006, p. 81). They further argue that the topics addressed are diverse and may include understanding perceptions, experiences, understanding, practices and factors underlying a phenomenon (Braun & Clarke, 2013). This resonates with the plan for developing my research, as I sought to explore occupational therapists' perceptions and experiences of clinical leadership in professional practice. Thus, this offers justification for the use of thematic analysis for the qualitative phase of this study.

There has been much debate regarding the use of mixed methods in research, with writers debating whether it is possible to combine world views or paradigms. Holmes (2006) questioned whether it was possible to combine two opposing world views in a single study and was interested in how competing discourses would be integrated. This purist stance, described by Rossman and Wilson (1985) was the position held by Guba (1985) who rejected the use of mixed methods, arguing that attempts to

combine the two approaches fail to distinguish between a paradigm and method. However, this position was later revised by Guba and Lincoln, 2005 who contend that elements of different paradigms may be combined within a single study. This position is Further supported by Greene and Caracelli (1997) and Creswell and Plano Clark, 2007, 2011) who advocate the use of multiple paradigms for the different phases of a research design. This study aimed to investigate the occupational therapists' perceptions and experiences of clinical leadership in professional practice, with a view to making recommendations for future practice. Whilst positivist principles were important for the initial phase of data collection, it was necessary to obtain in depth information in the qualitative phase in order to illuminate findings. Hence, for this study there was not one single philosophical position providing the basis and framework under which the study was conducted. Rather, the issue of importance was the application of research methods and how these methods enhanced the quality of the research in order to add to the body of knowledge. This point is substantiated by Bowling (1997) who stated:

> *"The question to be addressed should not be quantitative versus qualitative methodology, but how to identify innovative strategies for combining different perspectives and quantitative and qualitative methodologies in a single study, while at the same time respecting the distinct branches of philosophical thought from which they are derived." (Bowling A, 1997, p114)*

3.3 Methods of Data Collection

3.3.1 Study Design

The study was designed in two phases using a sequential exploratory design (Creswell and Plano Clark, 2011). The study combined a minor quantitative phase with a major qualitative phase, referred to as QUAL-Quan (Morse, 2003). The quantitative phase comprised a survey that collected baseline data in relation to the first research objective, with the plan being to use survey results to inform development of the qualitative phase of the study. The qualitative phase comprised in-depth interviews that aimed to build on and explore emergent key issues from the survey. Qualitative interviews sought to address objectives two, three and four. Interviews were based on an interview guide developed from an analysis of survey findings. The desired outcome was that a synthesis of survey and interview findings would add to the body of knowledge and use occupational therapists perceptions and experiences of clinical leadership to make recommendations for future practice and leadership.

3.3.2 Phase 1 - Survey

Phase 1 of the study employed quantitative data collection and analysis techniques to address the research aims and objectives. A cross sectional survey design (Moser and Kalton, 1971) was employed to primarily address the first objective and collect baseline data in relation to objectives two, three and four. Cross sectional surveys seek to gather information from a sample of the population of interest using descriptive measures. They are undertaken at a specific point in time and describe the characteristics of a population but do not provide evidence about cause and effect relationships between different variables (Oppenheim 1992, Bowling 1997).
Surveys may be administered in a variety of formats including face-to-face, telephone and postal questionnaires. In this study survey data was collected using postal questionnaires. The rationale for the using postal questionnaires was its potential to gain access to the target population relatively quickly. Postal questionnaires are

known to have low response rates (Bowling, 1997) however follow-up procedures including letters, post cards and phone calls can contribute to increasing the response rate (Cook, Dickinson and Eccles, 2009). Consideration was given to using other survey methods including telephone, email and web-based surveys. Use of a telephone questionnaire was ruled out due to cost and time constraints. Additionally, the use of email surveys was rejected due to the potential for incorrect demographic information and technical problems (Friker and Rand, 2002); but of greater significance is the outcome of comparative studies of email and postal surveys that found that the response rate for posted questionnaires can be as much as twice that for emailed questionnaires (Sheehan, 2001, James, 2007). Shih and Fan (2009) in a meta-analysis of 35 studies over a ten year period found email surveys to have a 20 percent lower response than mail surveys, therefore concluding mail surveys to be superior to email surveys with regards to eliciting a higher response. More recently, combining email and postal surveys has been suggested as a mechanism to increase the overall response rate from survey research. Kroth, McPerson, Leverence, Pace, Daniels, Rhyne and Williams (2009) found that following up email surveys with mail surveys yielded a higher response rate. Again this approach was ruled out and the decision taken to proceed with postal surveys, as the studies cited indicate that postal surveys generate a higher response rate than email. In addition, a further study by McDonald and Adam (2003) found that respondents answered survey questions differently online than via postal methods, suggesting that online surveys should not be viewed as a substitute for postal surveys in all cases. Finally the use of web-based surveys which can access large populations and provide instant feedback (Dillman, 2000) was rejected based on anecdotal evidence that many clinicians have limited internet access within their work environments.

Background to the development of the survey

Development of the survey was informed by the earlier systematic review reported in chapter two. The review highlighted that previous research was speciality specific, focused on managers and concerned with self-rating qualities and abilities. Furthermore, the review highlighted that previous research incorporating a questionnaire design was either self-developed or drew elements from existing instruments. In light of the above, a survey addressing the critical issues identified in the literature review and aimed at exploring occupational therapists' perceptions and experiences of clinical leadership in professional practice was designed and developed.

The questionnaire was presented as an eight page A5 booklet (two sheets of A4). The motivation for using a booklet format was its compact design, which it was hoped respondents would not view as unwieldy or lengthy; thereby increasing the potential for completion. The questionnaire was divided into four sections, comprising 30 questions with an additional space for comments. The questionnaire opened with an introductory page explaining that the survey was about Clinical Leadership in occupational therapy and confirming that the questionnaire should be completed by qualified, Health and Care Professions Council (HCPC) registered occupational therapists. The introductory page also provided instructions for completion and return of the questionnaire and provided a named contact in the event of any queries (see Appendix 2). The questionnaire was accompanied by a single page covering letter outlining in more detail that the survey aimed to seek occupational therapists' views on clinical leadership in professional practice and investigate what factors influence clinical leadership development (see Appendix 3). The letter confirmed that participation was completely voluntary and that responses would be kept confidential. The questionnaire comprised four sections, which posed questions to enable:

- Profiling of current employment/position of participants
- Mapping participants experience of leadership training and development
- Mapping the career paths of participants

- Ranking perceived factors of importance for effective occupational therapy clinical leadership
- Mapping perceived barriers and facilitators to leadership development

The questionnaire employed a combination of closed questions requiring a short defined response e.g. yes, no, age, ethnicity, open questions that allowed the respondent to think, reflect and elaborate on a response, questions requiring a response using a numeric rating scale and questions offering a choice of responses to address the research aims and objectives. Questions that presented a choice of responses included "other" as an option to enable participants to record a response that accurately reflected their perceptions and experiences and minimise the potential for researcher bias. The literature documents advantages and disadvantages to each method of questioning however there is consensus that when constructing a survey the questions need to be clear, unambiguous, ordered and easily coded for subsequent analysis (Bowling, 1997, Grbich, 1999, Sapsford, 1999).

Section 1 asked participants about their professional education and training; and was concerned with establishing year and place of qualification, highest post graduate qualification if any and membership of professional bodies or groups if any. Section 1 also sought to establish what level of support had been made available to participants for post graduate education and/ or leadership training within their current role. Section 2 sought to ascertain participants' perceptions of clinical leadership. Using a numeric scale, participants were asked to rank how important clinical leadership was to them in their career. In addition, participants were asked to indicate the qualities that characterise an effective clinical leader from a menu of responses; then indicate which characteristic was most important in their opinion. This pattern of questioning was then repeated for behaviours and skills that characterise an effective clinical leader. Section 3 focused on participants' current employment and sought to establish their main employing organisation, job title and grade, as this information would inform sample selection for phase two of the study. Questions also sought to establish

the profession of participants' line managers, as well as determining the nature, level and frequency of support received and from whom. Section 3 ended with a series of questions to determine whom participants managed, and establish the level and frequency of support provided. Section 4 sought to establish what was important to participants with regards to their own leadership development. Participants were asked to rank the importance of 'on the job training, mentorship and formal leadership training to their own development as clinical leaders. Participants were also asked whether they had encountered barriers to their development as clinical leaders; and if so to indicate what the barriers were from a menu of choices. Finally, participants were asked to indicate from a list of options what would support the development of clinical leaders in occupational therapy. The questionnaire ended with a free text comments box for participants to comment on any aspect of the questionnaire; and an invitation to participate in a complementary interview to explore clinical leadership in greater depth.

Piloting

The questionnaire and covering letter were piloted with a convenience sample of six occupational therapists to check for clarity of information, as well as relevance and ordering of questions. The questionnaire and covering letter were posted to the occupational therapists and feedback was received in writing, with follow-up via telephone where respondents wished to elaborate on comments on written feedback.

The pilot presented the opportunity to highlight potential issues or ambiguities that required refining prior to printing and dissemination (Bowling, 1997). Overall the questionnaire received positive feedback; with comments that included it was well presented, well ordered and concise. However, the pilot highlighted questions requiring review and recommended two key changes to improve clarity and avoid ambiguity. The first followed a suggestion that it would be helpful to establish whether or not participants held a post graduate qualification before asking the

question; what is your highest post graduate qualification and in what subject? Based on this feedback the final version of the questionnaire asked the question; do you hold a post-graduate qualification, which required a yes or no response. The second change was based on feedback suggesting that three consecutive questions asking participants to indicate the qualities, behaviours and skills that characterise an effective clinical leader did not stand out clearly. It was suggested that there was a need to draw attention to the descriptor in each of the questions and make it stand out. Thus, in the final version of the questionnaire the words qualities, behaviours and skills were underlined in each of the questions to emphasise the different focus.

In addition to feedback received on question structure, further feedback was received in relation to the inclusion of a definition of clinical leadership that preceded Section 2 questions. One respondent questioned why the researcher had not used a referenced definition of clinical leadership and further queried whether a definition was required at all, as the survey sought to establish participants' perceptions of clinical leadership. Whilst this feedback was well-founded the researcher's definition of clinical leadership remained in the final version of the questionnaire. The rationale for inclusion was that it could not be assumed that all participants would be familiar with the term clinical leadership thus inclusion would enable respondents to start from the same premise.

The final version of the questionnaire was presented as an A5 booklet, printed on cream paper. No changes were made to the covering letter, which was also printed on cream paper. The rationale for using coloured paper was the questionnaire would stand out from other post which is normally on white paper and may increase the possibility of the questionnaire being seen and completed. This position is supported by Berdie, Anderson and Neibuhr (1986) who suggest that color might make the survey more appealing. However, Sharma and Singh (1967) found that the color of the paper (yellow, pink, and white) did not have an effect on response rate.

Ethics

Ethical approval was obtained from The University of Nottingham, Faculty of Medicine and Health Sciences Research Ethics Committee (Appendix 4). Formal written consent was not a requirement for undertaking the survey, as completion and return of questionnaires indicated respondents' willingness to participate.

Eligibility criteria

Qualified occupational therapists registered with the Health and Care Professions Council (HCPC) and employed within the UK were eligible to participate in the study. Participants were employed within any practice setting including NHS, Social Care, Higher Education and Private Practice; and worked across the grade spectrum. Occupational therapy students were excluded from the study.

Sampling

Study participants were selected using purposive sampling; an intentional, non-random method of sampling (Bowling, 1997). This method of sampling was chosen because the study sought the opinions of a specific population, namely occupational therapists. The sample comprised HCPC registered occupational therapists based in the United Kingdom (UK) and employed within the National Health Service (NHS), Social Services, Higher Education, Ministry of Defence and Independent Practice. At the time the survey was undertaken there were 34,026 HCPC registered occupational therapists in the UK, of which 1,758 were employed within the West Midlands. The aim was to recruit up to 350 occupational therapists from the West Midlands region to the survey, as this represented 20% of the West Midlands occupational therapy workforce. It was not practically or financially feasible to survey the whole of the West Midlands occupational therapy population. However, 20% was considered a realistic target to achieve within time and financial limitations. The intention was to then recruit a further 2000 participants via a national occupational therapy conference and

exhibition, with the aim being to gain a national perspective of clinical leadership in occupational therapy.

3.3.3 Planned Survey Method

The original plan was to undertake the survey in two stages using two access points. The proposed first point of access was the West Midlands Occupational Therapy Network, a forum for occupational therapists working in the West Midlands region of England. The plan was to contact the chair of the network to request permission to use the network as the initial access point for distribution of questionnaires to occupational therapists working in the West Midlands region. The intention was that I would access participants via the regional network contact list. In addition, contact would be made with potential participants via networks established through work, education and training in order to maximise recruitment potential. The intended second point of access was the College of Occupational Therapists Annual Conference 2014, a national three day event focused on occupational therapy practice, research and development. Conference organisers were contacted to establish the feasibility of distributing questionnaires at the conference. Conference organisers fed back that it was not permissible to hand out questionnaires to conference delegates. However, there was an option to place the questionnaires in delegate packs (n = 1000), which would be distributed to all conference attendees including students and exhibitors. This option had an associated cost in the amount of £450.00 and required all printed documents including the questionnaire, covering letter and return envelopes to be delivered to the College of Occupational Therapists in advance of the conference date. It was my intention to proceed with the option presented, as it provided an opportunity to access occupational therapists on a national platform. However, the decision was taken not to proceed with this initial plan, as there was only one ethics committee meeting scheduled before the conference date. Planning for the conference was deemed an unrealistic expectation, as it didn't account for potential queries from the Ethics Committee and there was no guarantee that ethical approval

would be granted within the available time frame. Therefore, an alternative national forum to access occupational therapists was scoped. This is outlined in the description of the actual survey method.

3.3.4 Actual Survey Method

Recruitment

Recruitment to the survey was undertaken via two access points; the West Midlands Occupational Therapy Network and the Occupational Therapy Show: a national occupational therapy exhibition and conference. For the West Midlands area a pre-notification letter (Appendix 5) was sent to the Chair of network, outlining the nature and purpose of the study and requesting permission to use the network's forthcoming 'Lifelong Learning Event' as a forum to promote the research and recruit participants to the study. Permission was granted to attend the event and I delivered a short presentation on the proposed research. Event attendees demonstrated a commitment to participate in the research, providing their name and email address to enable arrangements to be made for the distribution of questionnaires once the survey was launched. Data protection legislation (Data Protection Act, 1998 and 2018) precluded the network providing a list of occupational therapists based in the West Midlands. However, the chair of the network agreed to circulate my contact details to the network to allow members to make direct contact should they wish to participate in the study. In addition to recruitment via the West Midlands Occupational Therapy Network, participants were recruited via networks established through work, education and training.

The second point of access to the study was the Occupational Therapy (OT) Show; a national two day event dedicated to occupational therapy practice and development, with an anticipated attendance of 2000 delegates. The event organisers were contacted to establish whether it would be possible to use the OT Show as a forum to recruit occupational therapists to the survey and determine how this might be

achieved. Through a series of email exchanges possible options including the insertion of questionnaires in delegate packs and setting up a stand to promote the research and distribute questionnaires were considered but ruled out. After further consideration, the event organisers agreed to place 400 questionnaires in the Key Note Theatre as a seat drop, to increase the likelihood of questionnaires being picked up, completed and returned. In addition to the placement of questionnaires as a seat drop, conference delegates were approached individually and invited to participate in the survey.

Procedure

The survey was administered in two stages, with the first stage focussing on participants accessed via the West Midlands Occupational Therapy Network. An email was sent to occupational therapists that had provided their contact details at the West Midlands Life Long Learning event or had subsequently made contact following the circulation of my contact details to network members. Participants were asked to provide a mailing address to send out questionnaires. Participants were also asked if they would be willing to distribute questionnaires within their teams. Where this was met with approval an agreed number of questionnaires was dispatched to participants for dissemination and a record kept of the numbers sent. This approach was also employed when contacting participants from networks established through work, education and training.

The questionnaire, covering letter and self-addressed freepost return envelope were inserted into envelopes labelled Clinical Leadership Survey; and addressed to participants. Questionnaires were mailed to participants using first class post. A three week deadline was set for response to questionnaires and participants were asked to return their completed questionnaires by the date specified on the questionnaire and in the covering letter.

A total of 300 questionnaires were sent out to occupational therapists in the West Midlands region, with the aim being to yield a 40% response (n=120). This is consistent with research by Baruch and Holtom (2008) who found that the average response rate for studies utilising data collected from individuals was 52.7 percent with a standard deviation of 20.4, while the average response rate for studies utilising data collected from organisations was 35.7 percent with a standard deviation of 18.8. Since it known that the return potential for surveys is maximised through the use of follow-up procedures including letters, post cards and phone calls (Cook, Dickinson and Eccles, 2009), follow-up procedures were employed with the aim being to improve the overall response. Key contacts were sent reminders by post with a copy of the questionnaire and this was followed up with a telephone call and email reminder.

The second phase of the survey was administered at the Occupational Therapy Show. Again questionnaires, covering letters and self-addressed freepost return envelopes were inserted into envelopes labelled Clinical Leadership Survey and boxed ready for distribution. Four hundred questionnaires were delivered to the event organisers and these were placed on delegates' seats in the Key Note Theatre; with the intention that attendees would take a questionnaire for completion and return. An additional 420 questionnaires were distributed to conference attendees during the two day conference. I approached delegates individually, providing a brief introduction to myself and outlining the nature and purpose of the study. Delegates were then asked if they would be willing to participate in the survey and were also asked if they would be willing to distribute questionnaires to colleagues. Delegates that expressed an interest in the research and indicated their willingness participate in the survey were provided with a copy of the questionnaire, with additional copies provided as indicated by the participant. A deadline of three weeks from the date of the conference was set for the return of questionnaires and a record of the number of questionnaires distributed was kept.

3.3.5 Data analysis

Survey data were entered into SPSS version 22 and analysed using descriptive statistics. Written comments in response to the final survey question were analysed using content analysis (Bowling 1997) and categorised into themes.

3.4 Phase 2 – Interviews

Phase 2 of the study employed qualitative data collection and analysis techniques to address objectives two, three and four in greater depth. In depth semi-structured interviews were conducted with a subset of survey participants to obtain richness of information by exploring key themes emerging from the survey. Qualitative interviews enable an exploration of the perspectives and meanings constructed by individuals regarding events and experiences in their lives (Grbich, 1999). Miller and Glassner (2011) argue that qualitative interviews provide an opportunity to study and speculate about the social world, including the context and cultural frames which people use to make sense of their experiences. In this study, semi-structured interviews were employed to gain an understanding of occupational therapists' lived experience of clinical leadership and how this manifests in their working lives. The use of an interview guide provided an element of structure to the interview without making the process rigid (Braun and Clarke, 2013). I sought to explore in detail participants' experiences of clinical leadership including: personal influences, barriers and facilitators, and how social constructs have shaped their attitudes and beliefs about clinical leaders and their own leadership development. Notably, Grbich (1999) points out that obtaining information from interviews brings with it an assumption that both the interviewer and interviewee understand each other and share a common language. However, this may not be the case as differences of class, status, culture and education may influence how the investigator approaches data collection and analysis. Thus, the credibility of qualitative methods is not only dependent on the skill,

competence and rigour of the researcher but also personal influences that might come into play (Patton, 2002).

Background to development of the interviews

Emergent concepts and themes from the survey informed development of the interview guide used for phase two of the study. Braun and Clarke (2013) emphasise the importance of well-planned questions for generating rich information relevant to the research question. Moreover, Reinharz (1993) asserts that a good interview guide will help to establish trust and rapport with the research participant.

The interview guide comprised a series of questions that sought to explore key issues of importance in greater depth (see Appendix 6).

Questions explored:

- Participants' current roles and responsibilities and factors influencing the move to their current role
- Participants' understanding of the term clinical leadership in occupational therapy
- Participants' thoughts on why little has been written about clinical leadership in occupational therapy
- The characteristics they perceived of an effective leader
- Whether they perceived that anyone can be a leader
- Whether participants' considered themselves to be clinical leaders
- Whether they perceived any differences between leadership and management
- Whether they perceived that a leader can be a manager or vice versa
- Participants' views on what has influenced their leadership development
- Participants thoughts on what needs to be considered for the future development of clinical leaders in occupational therapy

Sampling for qualitative interviews

At the close of the survey, participants were asked to indicate if they were willing to participate in a complementary interview that aimed to explore emergent concepts and themes from the survey in greater depth, by ticking the relevant box. Individuals who expressed an interest in being interviewed were asked to provide their contact details, thereby providing an opportunity for me to make contact upon completion of phase one of the study. The plan was to recruit a maximum of twenty participants to take part in the interviews. Given that Braun and Clarke (2013) suggest between six and ten interviews for small projects and ten to twenty interviews for medium projects, a minimum of 10 and maximum of 20 interviews was deemed appropriate for this study. In addition, it was my intention that participants would represent a cross section of survey respondents. Thus, the survey included an advisory note informing participants that I may not be able to interview everyone who had indicated they would like to take part in an interview.

Sixty-four survey respondents indicated they were willing to take part in the qualitative interviews. Since the aim was to interview a maximum of 20 participants, that were reflective of the broad spectrum of occupational therapists surveyed, I reviewed demographic data to enable purposive sampling of participants using maximum variation (Patton, 2002). Maximum variation involves the selection of a small sample that represents the wider population, in order to gain a diversity of perspectives in relation to the subject under investigation. Patton (2002) asserts that it is the common patterns that emerge as a result of this variation that are of particular interest and value. Thus, my aim was to select occupational therapists that represented the diversity of the profession. When selecting participants for interview I considered their work setting, their level of experience, their specialism and their grade. The NHS is the largest employer of occupational therapists. Services are divided into physical health and mental health services, with a range of specialisms within those services including orthopaedics, stroke, neurology, learning disabilities, paediatrics and mental

health. Occupational therapists also work within social care, independent practice, higher education institutes and specialist services. Thus, when selecting interview participants it was important that, as far as practicable, I aimed for a cohort that was not only representative of the survey sample but reflective of the occupational therapy workforce.

Following this process, I contacted twenty participants who had indicated willingness to participate in the qualitative interviews and asked them if they were still happy to participate in the complementary interviews. Thirteen of these individuals confirmed that they were willing to procced with interviews, three declined and four did not respond to requests. Those who declined stated that they had changed career and were no longer registered as occupational therapists. I sent a participant information sheet (Appendix 7) to those that had confirmed they were happy to participate in the interviews. The information sheet explained the purpose of the research and what it would involve for participants. At this point, I also asked the thirteen individuals to indicate their availability for interview.

Information for participants

The participant information sheet explained that the interviews would seek to gain a more detailed understanding of the person's thoughts, opinions and experiences of clinical leadership in occupational therapy; focusing on what factors they believed support clinical leadership development and which hinder development. The information sheet explained that interviews would take approximately 60 minutes to complete and would take place in a mutually agreed venue. The information sheet also explained that interviews would be digitally recorded, then transcribed; and that it may be necessary to make one further contact following the interview to check accuracy of data.

Ethical Considerations

The information sheet gave consideration to potential risks and benefits of participating in the interview. Participants were advised that taking part in the study should not present any risks or cause distress. However, involvement may require taking time out of their work schedule. Thus, interviews would be arranged at a time and venue convenient to participants. With regards to the benefits of participation, it was highlighted that the study may help identify targeted training and development to enhance the scope and practice of occupational therapy clinical leaders.

I encouraged participants to take their time to review the information and to ask for clarification if there was anything that was not clear to them or if they needed more information; as I wanted them to make an informed decision on whether or not to proceed. I provided participants with my contact details, and those of my project supervisors should they have any queries or concerns. In addition, I advised participants that if they remained unhappy or wished to complain formally, they would then need to contact the Ethics Committee Administrator whose details were included on the information sheet.

The information sheet confirmed that participation in the study was completely voluntary and individuals that were willing to be interviewed would be asked to complete a consent form. The information sheet advised that participants were free to withdraw at any time, without giving a reason. However, in the event of withdrawal it may not be possible to destroy data already collected. The participant information sheet explained that information collected about them during the course of the research would be kept strictly confidential and that any identifiable details would be anonymised. The information sheet further explained that interview transcripts and supplementary information would be stored in a locked cabinet; and that audio recordings and the notes from any discussion would be held in a safe place. In addition, typed interview transcripts would be saved to a computer that was password protected. The participant information sheet explained that participants' personal

data would be kept for two years after the end of the study so that they could be contacted about the findings of the study and possible follow-up studies (unless they advised they did not wish to be contacted). The information sheet confirmed that all other research data would be kept securely for seven years. After this time data would be disposed of securely.

The information sheet explained that the study had been reviewed by the University of Nottingham Faculty of Medicine and Health Sciences Ethics Committee and that the research would be written up as part of my higher degree qualification. In addition, results of the study would be published in a peer reviewed journal, so that learning may be shared widely. Finally, the information sheet provided assurance that participants would not be identifiable in any report or publication, as their details would be anonymised. Participants were reminded that the interviews would be recorded and that the recordings would be transcribed following the interviews. Participants were assured that audio recordings would be held securely then archived once data checking was complete. Participants were also assured that confidentiality and anonymity would be maintained.

Consent

Written informed consent was required in order to enter phase two of the study. Once all participant information had been reviewed and discussed, I asked participants to complete a consent form which confirmed the title of the study, the study reference number and the name of the researcher (see Appendix 8). The consent form comprised a series of statements which required participants to confirm that:

- They had read and understand the information sheet and that they had been given the opportunity to ask questions.
- They understood that participation was voluntary and that they were free to withdraw at any time, without giving any reason.

- They understood that if they withdrew then the information collected to that point could not be erased and may still be used in the project analysis.
- They understand that relevant sections of data collected in the study may be looked at by the research group and regulatory authorities where it was relevant to participation in the study.
- They gave permission for the research group and regulatory authorities to have access to these records and to collect, store, analyse and publish information obtained from their participation in this study.
- They understood that their personal details would be kept confidential.
- They understood that the interview would be recorded and that anonymous direct quotes from the interview may be used in the study reports.
- They understood that information recorded about them during the study would be kept in a secure database.
- They understood that if the data was transferred is would be made anonymous and that data would be kept for seven years after the study has ended.
- They agreed to take part in the study.

Once participants had read through the statements, I asked them to initial each statement to indicate that they understood what the study would entail and to sign the consent form to confirm that they were happy to proceed with the interview. Two copies of the consent form were completed and signed by participants. I countersigned each form, retaining one copy for myself and providing one copy to the interview participant.

Interview Participants

Interview participants were employed across a broad range of practice settings including NHS mental health services, NHS physical health services, social care services and higher education. Interviews did not include representation from occupational therapists employed within the Ministry of Defence or those practising independently.

Whilst occupational therapists within these specialties participated in the national survey, they did not indicate a desire to proceed to the interview phase of the study.

Interview procedure

Interviews were conducted over a six month period and ranged in length from 39 minutes to one hour and 11 minutes. All interviews took place during participants' core working hours and at a venue that was convenient for them. In all but two instances this was the participants' place of work. The remaining interviews took place in a mutually agreed community location. I preceded each interview with introductions and a reminder of the purpose of the study. I also reminded participants of how the interview would be conducted and offered them the opportunity to review the patient information leaflet and ask any final questions. This opening preamble was important in terms of setting the context and establishing rapport. Once participants reaffirmed that they were happy to proceed, I commenced with the interviews. I opened each interview by asking interviewees to describe their current role and followed up by asking them to describe their previous career journey. In asking these questions, I not only wanted to get to know more about the interviewee but wanted them to feel at ease by speaking about a subject that was both familiar and important to them. An interview guide was used to facilitate development of the interview and ensure that key issues were addressed. I was not rigid in the ordering of questions but instead allowed the interviewee to develop their thoughts and ideas, using the interview guide as a prompt to ask questions that may not have been answered as part of the discussion. In my very first interview, I did not ask why little had been written about clinical leadership in occupational therapy; however this was raised as a point of interest by the interviewee. I reflected on this feedback and recognised that this was an important consideration. Thus, the question was added to the interview guide to explore participants' thoughts on possible reasons for this. I concluded interviews by informing participants that once interviews were transcribed, I may need to contact them again to clarify information received.

All interviews were digitally recorded and supplementary notes were taken to document observations and highlight any points of interest or concern on the interview process. This was an important step in the early development of the research, as evidenced by the inclusion of an additional question on the interview guide described above. Following each interview and prior to full data transcription, I listened to interview recording and completed interview summaries, noting the general topics covered during interviews and highlighting key insights. Interview summaries helped to channel my thinking as I progressed with development of the research. In addition, a reflexive journal was completed to record my thoughts and feelings about the interviews and indeed the whole research process. During the interviews I was cognisant of my own beliefs and value systems and their impact on my approach to the interviews. For example, when asking participants about their views on why little had been written about clinical leadership in occupational therapy I suggested that they may hold a different view or disagree with my assertion. Reflexivity is an important consideration in the research process, as it increases one's awareness of self and helps to clarify how one's own beliefs have been socially constructed and how these values may influence the research relationships and interpretation of events within the research setting (Grbich, 1999). This point is further developed by Riessman (1993) who notes that the story may have taken a different form if someone else were the listener.

3.5 Interview analysis

3.5.1 Analytical strategy

Interview analysis was undertaken drawing on the principles thematic analysis, as set out by Braun and Clarke (2006). Braun and Clarke (2006) contend that thematic analysis not only offers theoretical flexibility in qualitative data analysis but also provides the primary skills for other forms of qualitative analysis. They assert that there is no mandate for thematic analysis to be applied to a specific theoretical

framework. Moreover, they argue that the method provides the freedom and flexibility to gain a detailed and rich account of the data. For Braun and Clarke (2006) emphasis is placed on the importance of striking a balance between clearly establishing what thematic analysis is and how it is carried out whilst maintaining the flexibility in how it is used, so that its use does not become restricted. They highlight that it is possible to use different combinations to complete the analysis, noting that the issue of primary importance is producing a final report that offers an account of what was done and why.

Braun and Clarke (2006) present a step by step guide to thematic analysis comprising six phases. They note that the six phases are not a set of rules but should be viewed as a set of principles that do not follow a linear process but can be applied flexibly. Before introducing the six phases it is important to define key terms that Braun and Clark (2006) use to describe the data. 'Data corpus' refers to all data collected for the study. 'Data set' refers to data from the corpus that is used for analysis. 'Data item' refers to the individual pieces of data that are collected to form a data set or corpus. Finally, 'data extract' refers to individually coded chunks of data that have been extracted from a data item. Braun and Clarke (2006) explain that whilst numerous data extracts may be taken from a data set, only a selection will feature in the final analysis.

Phase one of thematic analysis focuses on familiarising yourself with the data by reading and re-reading content in order to generate some initial ideas and note points of interest about the data. Braun and Clarke (2006) suggest researchers may enter this phase having already developed some initial thoughts about analysis but stress the importance of immersing yourself in the data. They recommend reading through the whole data set at least once before commencing coding. When working with verbal data such as interviews, Braun and Clarke (2006) emphasise the importance of data transcription, highlighting that transcripts need to retain the true content and context of the conversation. They further suggest that where data transcription is undertaken

by a third party, researchers should spend more time becoming familiar with the data, as well as checking transcripts against audio recordings for accuracy.

Phase two focuses on the generation of initial codes from the data. Here the aim is to start to identify features of the data that appear interesting and organise these into meaningful groups (Braun and Clarke, 2006). For Braun and Clarke (2006) coding is determined by whether themes are data driven or theory driven. They explain that with data driven coding the themes are determined by the data whilst theory driven coding is approached with specific questions in mind. Other factors determining one's approach to coding relate to whether the aim is to code specific elements of the data set or code the whole data set. For this study coding was data driven and the aim was to code the whole data set.

Coding can be undertaken manually, which involves highlighting text and making notes to identify interesting segments of data (Braun and Clarke (2006) or it can be completed by using coding software applications. For this study data coding was completed manually. When coding data, Braun and Clarke (2006) suggest that one should code for as many potential patterns or themes as possible, as the information may be of interest as the analysis develops. They also note that individual data extracts may be coded many times into many different themes.

Phase three begins once all data has been initially coded and focuses on sorting codes into potential themes (or candidate themes) and gathering relevant data extracts for each theme. A theme captures important information and provides some meaning about data in relation to the phenomenon under investigation. Braun and Clarke (2006) contend that there should be a number of instances of a theme across the data. However, there are no set rules on what proportion of a data set constitutes a theme. Moreover, the prevalence of a theme does not necessarily make one theme more important than another. Thus, for Braun and Clarke (2006) the decision on what constitutes a theme is determined by the researcher's own judgement. Furthermore, consistency in how themes are identified is important within any given analysis.

During phase three, the researcher starts to consider the relationship between codes and themes and how they combine to form an overarching theme. Braun and Clarke (2006) suggest a number of methods to facilitate this process including the use of tables, mind maps or written codes on pieces of paper that can then be organised into theme piles. During this phase of the analysis Braun and Clarke (2006) introduce the use of thematic maps, which not only visualise how themes fit together but also tell the story of the data and serve as a check that themes do not overlap. Braun and Clarke (2006) highlight that initial codes created may go on to form main themes, sub-themes, or may even be discarded. In addition, they emphasise the importance of retaining extracts for further review, as it is unclear whether themes will remain the same, or whether they will need to be combined, separated or discarded.

Phase four focuses on reviewing and refining the candidate themes. During this phase clearly defining each theme helps to clarify the essence and scope of the themes (Braun et al, 2019). Themes may be discounted due to lack of supporting data or they may be combined to form a single theme. Braun and Clarke (2006) describe two levels of reviewing and refining themes. Level one comprises a review of the coded data extracts within in each theme in order to find clear patterns. If clear patterns are identified then the researcher can progress to level two. However, if there is a question regarding fit then the theme may need to be revised. This may involve creating a new theme, moving extracts to an existing theme or discarding extracts from the analysis. Once satisfied that candidate themes adequately capture the coded data, the researcher can move to level two which involves reviewing and refining the whole data set to check that the themes work and code data that may have been missed during the earlier stages of coding. Braun and Clarke (2006) suggest that further review and refinement could potentially result in the identification of additional themes but caution against continued refinement of codes if this doesn't add value. They assert that phase four concludes once a thematic map of the analysis is established and the researcher has a sound understanding of the different themes and what they represent.

Phase five focuses on defining and naming themes. Themes undergo further refinement and the specific aspects of the data the theme captures, as well as the essence of what the theme represents are established. Here, collated data extracts for each theme are revisited and organised to give a clear account of what is interesting about the data and why. Thus, the researcher is able to complete a detailed analysis that not only gives a clear account of each theme but considers how the themes fit into the overall story presented by the data (Braun and Clarke, 2006). When refining themes it is important to consider whether themes contain sub-themes, which give structure to large or complex themes (Braun and Clarke, 2006). Braun and Clark (2006) assert that by the end of phase five the researcher should be clear about the names that will be given to research themes in the final analysis and should be able to describe these succinctly. If this is not possible further refinement is required.

Phase six is the final phase of analysis. It begins once themes have been established and focuses on producing a report that provides the reader with the assurance that data analysis is valid and holds merit (Braun and Clarke, 2006). Braun et al (2019) assert that this phase is not only about producing a report but is also a final test of how well the themes work. Braun and Clarke (2006) highlight the importance of using rich examples to illustrate the story and the point being made. Furthermore, they suggest that the report needs to go beyond description so that it not only provides the reader with a narrative account of data within and across themes but makes a compelling argument in relation to the research question. In order to achieve this, Braun and Clarke (2006) assert that in the final phases of analysis the researcher needs to consider a number of questions to guide the analysis including:

> "*What does the theme mean? What are the assumptions underpinning it? What are the implications of the theme? What conditions are likely to have given rise to it? Why do people talk about this thing in a particular way (as opposed to other ways)? What is the overall story the different themes reveal about the topic?" (Braun and Clarke, 2006, p 94)*

When undertaking thematic analysis, Braun and Clarke (2006) stress the importance of being clear about epistemological assumptions, as this will guide what is said about the data, determine how meanings are theorised and provide clarity about the method applied to data analysis. They make a distinction between researchers providing a rich description of the overall data set versus providing a detailed account of a specific element. The former provides the reader with a sense of the prevalent themes and is useful when researching subjects where views on a topic are unknown. The latter provides a more detailed account of a particular theme or group of themes relating to a specific question or point of interest within the data. Furthermore, Braun and Clarke (2006) make a distinction between inductive and theoretical thematic analysis. Inductive analysis is data driven and focuses on coding the data without fitting it to a pre-existing coding frame or the pre-conceived ideas of the researcher. Conversely, theoretical analysis is driven by the researcher's theoretical interest in the topic and has a focus on providing a much more detailed analysis on specific aspects of the data. Finally, Braun and Clarke (2006) make a distinction between themes identified as semantic themes and those identified as latent themes. Semantic themes are identified by examining the surface meanings of the data whilst latent themes look beyond this and examine underlying thoughts, concepts and ideas.

Braun and Clarke (2006) acknowledge that some of the phases in thematic analysis are similar to those in other qualitative methods, as described by Ryan and Bernard (2000). They also recognise the differing views with regards the point at which researchers should engage with the literature in order to complete their analysis, such as Tuckett (2005) who suggests that early reading can either limit the researcher's focus or improve analysis by drawing attention to more subtle features within the data. Consequently, Braun and Clarke (2006) are not prescriptive in how to approach reading for thematic analysis. However, they suggest that inductive approaches are enhanced by not engaging in early reading for analysis whilst a theoretical approach requires engagement with the literature before commencing analysis.

In summary, Braun and Clarke (2006) contend thematic analysis is a relatively straight forward method that offers a flexible and more accessible form of analysis, particularly for those in the early stages of their research career. They highlight that the method is well suited to exploring the differing perspectives of research participants and that the analysis not only generates unexpected insights but can be used to inform policy development, which resonates well with what I set out to achieve. However, they also warn that limited literature on thematic analysis, in comparison to other methods such as grounded theory, may cause novice researchers to feel uncertain about using the method. Furthermore, Holloway and Todres (2003) suggest that the flexibility of the method may also be a disadvantage that results in inconsistency and lack of coherence when developing themes. Braun and Clarke (2006) warn that thematic analysis has limited interpretative power when its use is not applied within an existing theoretical framework, as this could potentially impact on the credibility of the research. Thus, they emphasise the importance of rigorously applying theory and method when undertaking thematic analysis; which involves being clear about theoretical assumptions, using examples from the data to illustrate points and analysing patterns across data sets to identify themes. To this end, Braun and Clarke (2006) provide a checklist of criteria for generating a good thematic analysis (Table 3).

Table 3: A 15-point checklist of criteria for good thematic analysis

Process	No:	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail and the transcripts have been checked against tapes for accuracy.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for each theme have been collated.
	5	Themes have been checked against each other with reference back to the original data set.
	6	Themes are internally coherent, consistent and distinctive.
Analysis	7	Data have been analysed and interpreted rather than just paraphrased or described.
	8	Analysis and data match each other, and extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well organised story about the data and topic.
	10	A good balance between analytic, narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to adequately complete all phases of the analysis.
Written report	12	The assumptions and specific approach to thematic analysis are clearly explained.
	13	There is a good fit between what you claim you do and what you show you have done, i.e. the described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process – themes do not just emerge.

(Braun and Clarke, 2006, p96)

3.5.2 Analysis of data

Interview analysis commenced with a focus on familiarising myself with the data, as set out in phase one. Digitally recorded interviews were transcribed verbatim. Due to time constraints, I transcribed the first interview then employed the services of a data transcription company to transcribe the remaining interviews. I commenced analysis of interview data by listening back to recorded interviews whilst reading and re-reading interview transcripts to check accuracy and make some initial notes about what was interesting. Once I had familiarised myself with the data, I proceeded to phase two of the analysis, where I focused on line-by-line coding of each transcript. Line-by-line coding comprised reading through transcripts in detail, then underlining and highlighting key words and terms in order to identify initial codes. Sticky notes, colour coded for each interview transcript, were also used to highlight interesting features of the data that could possibly form patterns or themes across the data set. Codes were recorded in the left-hand margin of transcripts whilst the right hand margin was used to note any comments and emerging thoughts. Codes were then matched with data extracts that illustrated that code. Table 4 provides an example of how initial codes were identified. The example draws on data extracts from interview transcripts relating to participants' understanding of the term clinical leadership. This process was applied across the entire data set.

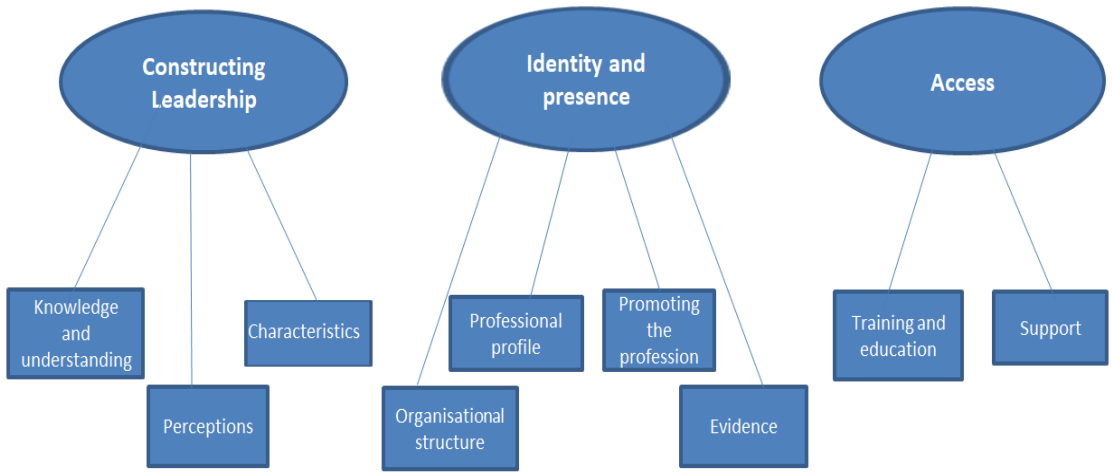
Table 4: Examples of extracts from the data with codes applied

Data extract	Code	Comments
Extract 1 I think clinical leadership means to have leadership from within your own professional group. Where you can get clear day to day guidance on issues that you're facing with an immediate patient but also have an overarching support from your professional organisation in terms of how you should be delivering the service.	Leadership within own profession Day to day guidance Support from professional body	Importance of profession specific leadership Role of the RCOT
Extract 2 I think it means, having some expert knowledge in a particular field, an ability to supervise and develop new people coming into that field, to advise on clinical interventions and approaches, development of skills, recognition of training needs, and that's by no means an exhaustive list. I suppose it's also about advocating for your profession, so it's not just the support you're giving to the people that work with you, or in your team, but also ensuring that senior managers are aware of what this particular service can offer or what this profession can offer, so that it's on everybody's radar.	Having expert knowledge Supervising people Developing skills Giving clinical advice Identifying training needs Advocating for the profession Ensuring senior managers are aware	Clinical expertise Leading, supporting and developing people Promoting the profession
Extract 3 It's really as the title says it, that it's people who have a clinical background leading a clinical service, I think.	People with a clinical background leading a clinical service	Clinical background important
Extract 4 For me it's about clinicians having a leadership position, and again about service improvement really, looking at what's best for patients and using the skills that they have, their leadership and clinical skills to improve the quality of services that patients receive. So within occupational therapy I suppose it's to improve the quality of occupational therapy that patients receive.	Clinicians in leadership positions Service improvement Quality in patient care Clinical and leadership skills	Leadership, quality and service improvement in occupational therapy

Phase three involved organising codes into potential themes and collating data extracts within these themes. Braun and Clark (2006) offer a number a number of suggestions for this phase of the analysis including the use of mind maps, tables and lists. I began by drawing a mind map so that I had a visual representation of codes and potential themes. However, this was an organic process and I found that writing individual code names onto sticky notes that I then moved around to consider patterns, connections and relationships, facilitated the process of organising codes into potential themes. As I progressed through the analysis, phase four focused on reviewing and refining the developing themes. This involved referring back to data extracts, interview transcripts and the entire data set; checking that the relationship between themes worked well, that all codes were accounted for and that data extracts used were both appropriate and relevant. By the end of this phase, I had a clear idea of the different themes and what they represented. Phase five of the analysis focused on further refining and defining the essence of each theme, and finalising theme names.

Throughout the process of analysis and development of themes, I continually reflected on my role as researcher, referring back to memos, field notes and reflective notes to ensure that the generation of themes were reflective of the analysis and that themes addressed the research objectives. As a result of the final analysis, a total of nine themes were identified and these were clustered into three overarching themes. Figure 3 provides an illustration of the thematic map of the overarching themes and sub-themes generated from the final analysis. A write-up of findings from the analysis, which constitutes phase six, is reported in Chapter 5. The report sets out to provide a narrative account of the data, using data extracts to illustrate themes.

Figure 3: Thematic map illustrating final themes generated from the analysis



3.6 Reflexivity

Our thoughts, beliefs and behaviours are an important consideration in research. Reflexivity describes how researchers critically reflect on the knowledge they produce from the research process and the role they play in producing that knowledge (Braun and Clarke, 2013). It is concerned with the way that the position of the researcher may have influenced data collection and analysis and requires:

> *"An awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject while conducting research." (Willig, 2008, p10)*

Reflexivity aids credibility and trustworthiness since it enables the reader to understand the researcher's position and how this affects their relationship with participants. It focuses on how our values, beliefs, interests and experiences shape our research and the implications of this on research findings. Findley (1998) argued that that reflexivity provided the means whereby subjectivity in research turned into an opportunity by facilitating deeper understanding of the subject. In a similar vein,

Braun and Clarke (2013) assert that qualitative researchers can use their individuality and subjectivity as a research tool.

There are two types of reflexivity; personal reflexivity and methodological reflexivity. The former is concerned with how our values, beliefs, interests and experiences shape our research whilst the latter is concerned with how we reflect on the assumptions we make throughout the research process and the implications this has on research findings (Willig, 2008). Reflexivity was an important consideration for me throughout the research process and I will now describe how both personal and methodological reflexivity were present in my research. Whilst my personal interest in clinical leadership determined the focus and aims of the study, I was cognisant of the fact that the research needed to provide the opportunity to ascertain the perceptions and experiences of other occupational therapists in order to address the research objectives. Thus, as an occupational therapist with my own thoughts and ideas about clinical leadership in the profession, it was important that I considered my position as researcher through a critical lens but also consider how leadership theories and previous research shaped my initial thoughts and ideas for developing the research. I came to the study with my own preconceived ideas about clinical leadership in occupational therapy but it was important to examine previous research in terms of context, method and outcomes in order to ascertain how this would inform my research with regards method, analysis and development of themes. I shared some common ground with research participants, in that that all participants had a professional occupational therapy qualification, had professional registration with a regulatory body and had clinical experience in the field, albeit in different practice settings and at different levels. However, I was conscious that my influence as researcher could potentially steer participants to pathways of thinking that were not in keeping with the thoughts and experiences that were both important to them and that they were willing to share. It was also important to consider that shared values and a shared culture within the profession may have meant that some things may have been taken for granted and therefore not stated explicitly. This could have been limiting to

the potential and scope of the study and may well have put the credibility of research findings into question. Thus, consideration of these issues was an important factor in the study design. For the quantitative phase of the study, it was important that in my communication to participants, I made it clear to them that the survey sought their views and experience of clinical leadership in occupational therapy. It was also important to act on feedback from the pilot survey to ensure questions were clear, relevant and unambiguous. Finally, survey questions offering 'other' in the list of options and a final question that invited comments on any aspect of the questionnaire provided participants with the opportunity to note any thoughts and ideas they wished to share. Selection of the 'other box' indicates that responses came directly from participants and that my role as researcher was not an influencing factor. Similarly, completion of the final comments text box at the end of the survey was entirely participant choice. These comments enabled me to have a richer understanding of the key issues to take forward for further exploration in the qualitative interviews.

Throughout the research process my aim was to ensure that, as far as possible, my position as researcher did not adversely impact on participant engagement. As stated, I was aware of the potential influence and impact my presence and role as investigator might have on participants, particularly during qualitative interviews. I was cognisant of the notion that participants could potentially view the interviewer/interviewee relationship as a power relationship. However, my aim was that interviews were based on a mutual relationship where participants were seen as equal partners. I also hoped that the fact that I too was an occupational therapist, with an 'insider perspective' of current practice, may have given participants a level of confidence and affinity that put them at ease. It was important that I maintained a conscious awareness of this insider perspective, as losing sight of this could easily alter the dynamics of the interviewer/interviewee relationship.

During interviews, I was conscious that whilst I had an interview guide I wanted to treat interviews as a conversation. It was important that I was guided by the flow of

the conversation, picking up on points requiring clarification or further exploration before returning to unanswered questions from the guide. I was also conscious that participants had their stories to tell, some of which resonated with me. However, it was also important that I didn't make assumptions based on my own experience. In these instances it was important that I didn't interrupt and compromise my role as interviewer but instead accentuated my role as listener, giving interviewees the time and space to share their experiences; acknowledging that silences were an important part of their stories.

Critical reflection and methodological reflexivity were important considerations during qualitative data collection, analysis and write up. I had to consider my own thoughts, feelings and biases and their potential impact on participant engagement. It was important to acknowledge to myself that my thoughts and feelings were 'real' but that the onus was on establishing the thoughts and perceptions of participants. Thus, the use of a reflective diary and memos enabled me to record any particular points of interest and any observations whilst at the same time noting my own thoughts and feeling about the process. From a methodological perspective, I maintained reflexivity by continually referring back to the aims and objectives of the research to maintain focus and direction. Furthermore, qualitative analysis was driven by thematic analysis as set out by Braun and Clarkes (2006). Thus, the process of coding rather my own ideas and beliefs resulted in the generation of themes.

As an occupational therapist, engagement with service users is core to professional practice. Verbal and non-verbal communication, active listening, observation, analytical skills and documentation are key components of the assessment process. The aim is that an objective picture of the service user's key issues and concerns are presented and that our own biases do not negatively impact on the people we serve. These skills, that have been developed and refined over a number of years, influenced the way I approached interviews, engaged with the data, analysed the data and wrote up findings. Over the years I have learnt the importance of active listening. I have

learnt that a script is there as a guide and that there is flexibility in the ordering of questions. I have learnt that giving people time and space and being comfortable with silence empowers them to share their stories. I have also learnt to check that I have understood what has been said so that what is documented accurately reflects experience. This transferable learning helped shape the way I approached data collection and analysis.

In summary, undertaking this study has taken me on a journey of critical reflection that has not only heightened my awareness of my position as researcher but has also reinforced that acknowledging one's own thoughts, feelings and biases is an important part of the research process that should not be underestimated.

CHAPTER 4: SURVEY RESULTS

Recruitment to the survey was gained via two access points; the West Midlands Occupational Therapy Network and the Occupational Therapy (OT) Show. Three hundred questionnaires were sent to occupational therapists in the West Midlands and 82 (27.3%) were returned. A further 820 questionnaires were distributed at the Occupational Therapy Show, a free two day event attended by 3,200 delegates. Four hundred questionnaires were placed as a seat drop in the main auditorium and further 420 questionnaires were handed to conference delegates who expressed a willingness to participate in the survey. A total of 83 questionnaires were returned but the exact response rate is difficult to compute, as the number of questionnaires taken from seats in the main auditorium is unknown. Thus, based on the total allocation of questionnaires the most conservative response rate is 10.1%.

Table 5: Research objectives

No.	Objective
1	To map the current roles, education, training and leadership experience of occupational therapists practising in the UK.
2	To explore the key attributes of an effective clinical leader from the perspective of occupational therapists.
3	To examine the impact of training and development on clinical leadership positions held by occupational therapists.
4	To develop an understanding of the perceived barriers and facilitators influencing occupational therapists' leadership development.
5	To use findings to generate recommendations for leadership training, development and practice.

The survey primarily addressed 'objective 1' and collected baseline data in relation to 'objectives two, three and four (Table 5) and posed questions to enable:

- Profiling of current employment/position of participants
- Mapping participants experience of leadership training and development
- Mapping the career paths of participants
- Ranking perceived factors of importance for effective occupational therapy clinical leadership
- Mapping perceived barriers and facilitators to leadership development

Survey data were entered into SPSS version 22 and analysed using descriptive statistics, as the aim was to summarise key features of the data in order to inform development of phase two of the study. Written comments in response to the final survey question were analysed using content analysis (Bowling 1997) and categorised into themes.

4.1 Profile of participants

Participants in the survey (n=165) qualified between 1973 and 2014 (Table 6), with the majority (n=158) completing their training within the United Kingdom (Table 7). Table 6 illustrates that 44.2% of those surveyed qualified pre 2000, whilst more than half (55.8%) qualified post 2000. A point of note is that 39.4% (n=65) of participants qualified between the year 2000 and 2009.

Table 6: Qualification period

Qualification period	Number	Percentage
1973 – 1979	9	5.4
1980 – 1989	21	12.7
1990 – 1999	43	26.1
2000 – 2009	65	39.4
2010 – 2014	27	16.4
Total	**165**	**100.0**

Table 7 shows that participants completed their training in a range of locations across the United Kingdom (UK) and abroad. More than half the respondents (52.7) completed their training in the West Midlands (Coventry, Derby and Wolverhampton), 42.5% completed their training in other UK regions including London and Bristol and 4.8% completed their training overseas in India, New Zealand, South Africa, Sweden and Australia. It should be noted that whilst participants may have gained their occupational therapy qualification outside the UK, all survey participants were HCPC registered and practising as occupational therapists in the UK.

Table 7: Place of training

Training Location	Number	Percentage
Not stated	3	1.8
Brighton	1	.6
Brunel	5	3.0
Canterbury	1	.6
Cardiff	2	1.2
Coventry	62	37.6
Derby	22	13.3
East Anglia	1	.6
Essex	1	.6
Exeter	7	4.2
India	4	2.4
Lancaster	1	.6
Liverpool	2	1.2
London South Bank	5	3.0
New Zealand	1	.6
Newcastle	1	.6
Northampton	7	4.2
Oxford	5	3.0
Salford	3	1.8
Sheffield	5	3.0
South Africa	1	.6
Southampton	3	1.8
Sweden	1	.6
Sydney Australia	1	.6
West London Institute	9	5.5
Wolverhampton	3	1.8
York	8	4.8
Total	**165**	**100.0**

Information was sought on participants' professional occupational therapy qualification. Table 8 shows that the majority (72.7%) graduated with a degree and just 3% (n=5) qualified with a postgraduate qualification.

Table 8: Professional occupational therapy qualification

Qualification	Number	Percentage
Diploma	40	24.2
Degree	120	72.7
Postgraduate qualification	5	3.0
Total	165	100.0

Information was also sought on participant's post qualification education, with results indicating that 28% (n=46) of respondents held a postgraduate qualification (Table 9). Furthermore, Table 10 shows that over half of those with a postgraduate qualification (56.5%) were educated to Master's degree level and a further 2.2% (n=1) had attained a Doctorate/PhD. Postgraduate education covered a range of subject areas including specialist clinical practice, professional development, service innovation, research methods, leadership and management.

Table 9: Postgraduate qualification

Postgraduate Qualification	Number	Percentage
Yes	46	28.0
No	119	72.0
Total	165	100

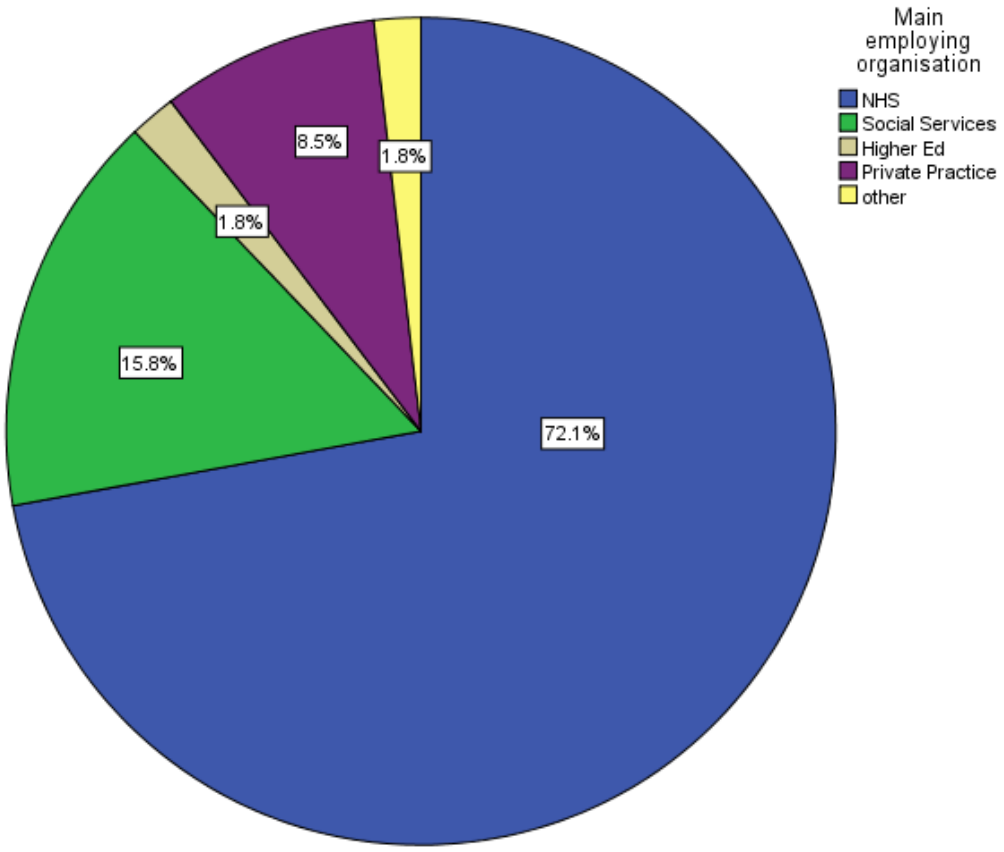
Table 10: Highest postgraduate qualification

Qualification attained	Number	Percentage
Postgraduate Certificate	11	23.9
Postgraduate Diploma	8	17.4
MSc	26	56.5
Doctorate/PhD	1	2.2
Total	46	100.0

Participants were asked to select their main employing organisation from a list of options which included NHS, Social Services, Higher Education, Private Practice and other. Figure 4 reveals that almost three quarters (72.1%) of survey respondents were employed by the NHS. The remainder described their employing organisation as Social Services (15.8), Private Practice (8.5%), Higher Education (1.8%) and other (1.8%). In

each instance where the category other was selected, the Ministry of Defence was named as the main employing organisation.

Figure 4: Participants Main Employing Organisation



The questionnaire required participants to state their job title and grade. Rather than offering a list of options, these were open questions requiring a free text response from participants. Table 11 revealed a diversity of roles across employing organisations with the majority (n=119) associated with NHS employment. The title OT (occupational therapist) featured in over half of the roles listed e.g. highly specialist OT, renal OT and consultant OT. Conversely, other roles indicated level of seniority e.g. principle OT, head OT and director. Table 12 describes participant grades and shows a prevalence of survey participants at NHS Band 6 (n=51) and Band 7 (n=34).

Grades within Social Services were much more evenly distributed within the grading structure whilst in the other organisations a number of participants did not specify a grade (n-2) or indicated that that grade was not applicable to their role (n=9).

Participants were asked the profession of their immediate line manager. Figure 5 represents a breakdown of line management by profession and reveals that 46.1% of those surveyed were line managed within their own professional group, i.e. occupational therapy. However, when combined a greater percentage (48.3%), predominantly those employed within the NHS, received their line management via other professional groups including physiotherapy, other allied health professions (dietetics, podiatry, speech and language therapy) nursing, social work, teaching and psychiatry.

Table 11: Participant Roles

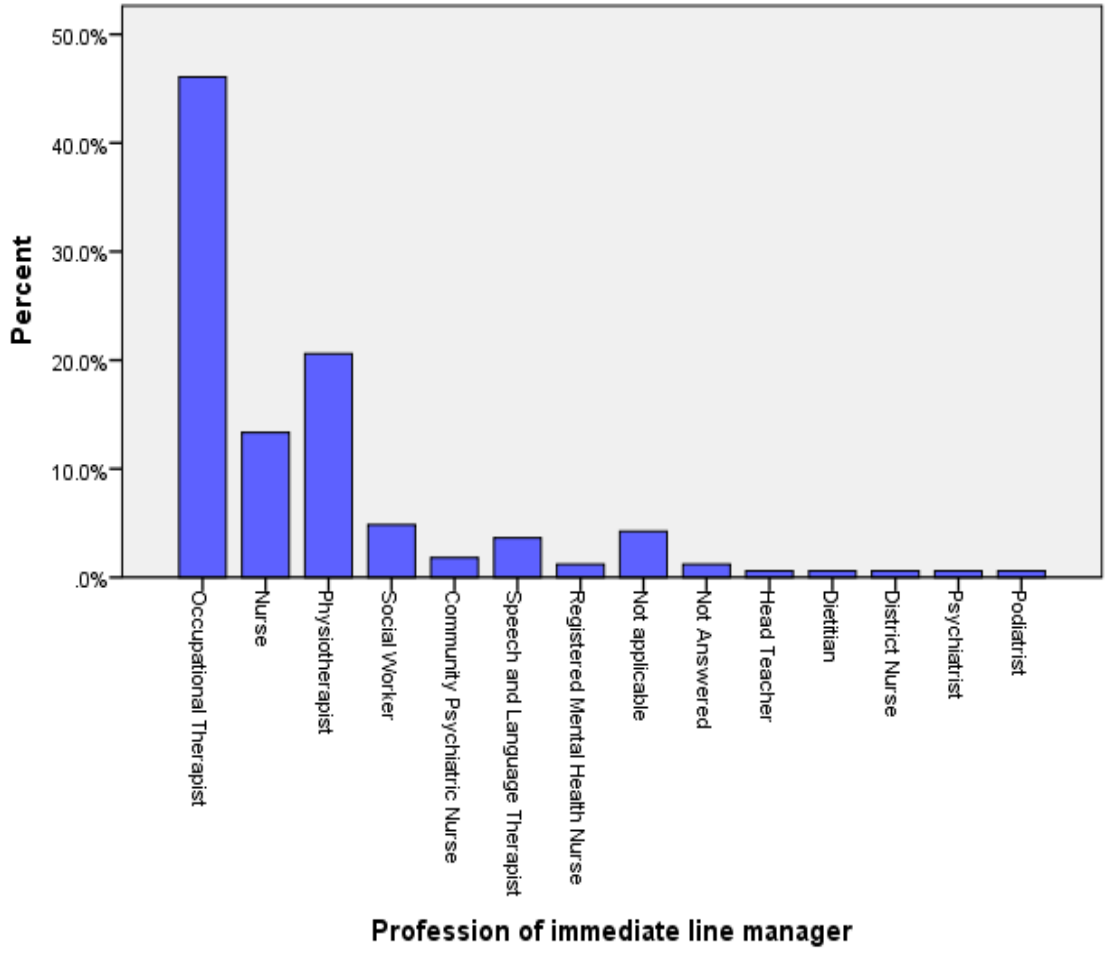
	Main Employing Organisation			
Job Title	NHS	Social Services	Other	Total
Advanced OT	2	0	0	2
AHP Lead	1	0	0	1
Case Manager	5	1	4	10
Children's OT	1	0	0	1
Clinical Lead	6	0	0	6
Clinical Specialist	10	0	0	10
Community Falls Prevention Lead	1	0	0	1
Community OT	2	0	0	2
Consultant	0	0	2	2
Consultant OT	1	0	0	1
Director	0	0	2	2
Head of Adult Care	0	1	0	1
Head OT	2	1	0	3
Highly Specialist OT	2	0	0	2
Independent OT	0	0	1	1
Lead OT	2	0	0	2
Lead Research OT	1	0	0	1
Locum OT	0	1	0	1
Manager	2	1	0	3
Older Adult Mental Health OT	1	0	0	1
OT	46	10	6	62
OT Palliative Care	1	0	0	1
OT Practitioner Level 1	0	1	0	1
Practice Supervisor OT	0	1	0	1
Principle OT	1	0	0	1
Professional Development Lead	1	0	0	1
Quality Lead	1	0	0	1
Reablement OT	1	1	0	2
Rehab OT	1	0	0	1
Renal OT	1	0	0	1
Senior Lecturer	0	0	2	2
Senior OT	18	1	1	20
Senior Practitioner	0	4	0	4
Specialist OT	1	0	2	3
Team Lead	7	2	0	9
Team Manager	1	1	0	2
Total	**119**	**26**	**20**	**165**

Table 12: Participant Grades

	Main Employing Organisation			
Grade	NHS	Social Services	Other	Total
Band 5	14	0	0	14
Band 5 equivalent	0	0	1	1
Band 6	51	1	2	54
Band 7	34	0	2	36
Band 7 & Band 8b *	1	0	0	1
Band 8a	13	0	0	13
Band 8b	3	0	0	3
Basic	0	2	0	2
Chief Officer Grade	0	1	0	1
Clinical Specialist	2	0	0	2
Expert Practitioner	0	0	1	1
GR6	0	1	0	1
Grade 5	0	2	0	2
Grade 6	0	1	1	2
H9	0	3	0	3
KR8	0	1	0	1
12	0	1	0	1
Level 3	0	1	0	1
Locum OT	0	1	0	1
M3	0	1	0	1
N/A	1	1	9	11
Not Stated	0	3	2	5
PO3	0	1	0	1
S8	0	1	0	1
Senior Lecturer	0	0	2	2
Senior Practitioner	0	1	0	1
Senior	0	1	0	1
Senior 1	0	1	0	1
Team Manager	0	1	0	1
Total	**119**	**26**	**20**	**165**

* Occupational therapist in a split role

Figure 5: Profession of Immediate Line Manager

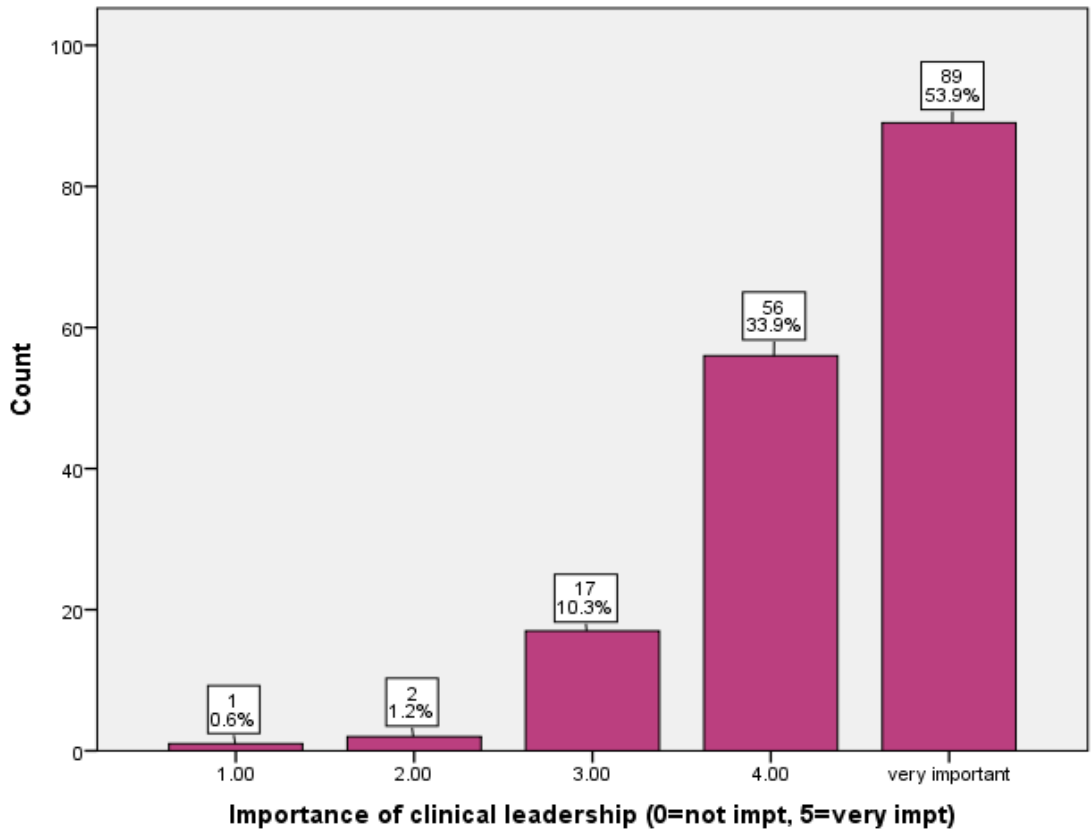


4.2 Key Attributes of an Effective Clinical Leader

One of the objectives of the research was to explore the key attributes of an effective clinical leader. In order to begin to understand participants' thoughts about clinical leadership they were asked to rate the importance of clinical leadership. Therefore, using a numeric rating scale, with 0=not important and 5=very important, respondents rated the importance of clinical leadership to them in their career. Figure 6 demonstrates that 87.8% of respondents rated clinical leadership as very important (53.9%) or important (33.9%). Towards the opposite end of the scale participants ranked the importance of clinical leadership as 1 (0.6%) and 2 (1.2%) whilst 10.3% rated the importance of clinical leadership to their career in the mid-range (3). This

suggests that clinical leadership was not as important to them in their career. Notably none of the participants ranked clinical leadership as not important (0).

Figure 6: Importance of Clinical Leadership to Career



Based on their experience and from a menu of responses, participants were asked to indicate the qualities, behaviours and skills that characterise an effective clinical leader. With regard to the qualities of a leader Table 13 illustrates that respondents considered honesty to be the quality that is most characteristic of an effective clinical leader. However, self-awareness, vision, being innovative, flexibility and accountability were also viewed as important by at least 80% of respondents. Notably 37% of respondents identified additional qualities that characterise an effective clinical leader including being inspiring, integrity, being genuine and fairness.

In a follow-up question, participants were asked to identify the leadership quality that was most important to them. Figure 7 illustrates that honesty was the most important quality (22.4%), followed by being innovative (18.2%). Figure 6 also highlights instances where participants identified more than one quality as being most important, for example honesty and integrity.

Table 13: Qualities that Characterise an Effective Clinical Leader

Quality	Number of positive responses	Percentage
Honesty	151	91.5
Innovative	148	89.7
Self-awareness	140	84.8
Flexibility	139	84.2
Vision	132	80.0
Accountability	132	80.0
Other	61	37.0

Participants were asked to indicate behaviours that characterise an effective clinical leader. Table 14 illustrates that the majority of respondents (97.6%) considered that being motivating was characteristic of an effective clinical leader, followed by being supportive (90.3%) then empowering (89.7%). Participants were then asked to identify the most important leadership behaviour to them and Figure 8 shows that 34.5% of participants identified empowering as the most important leadership behaviour.

In Table 15 participant views on skills that characterise an effective clinical leader highlighted that clinical expertise (90.3) effective communication (89.7) and people management (88.5) were rated highly. However, Figure 9 illustrates that by far the most important leadership skill was effective communication (42.2%).

Figure 7: Most Important Leadership Quality

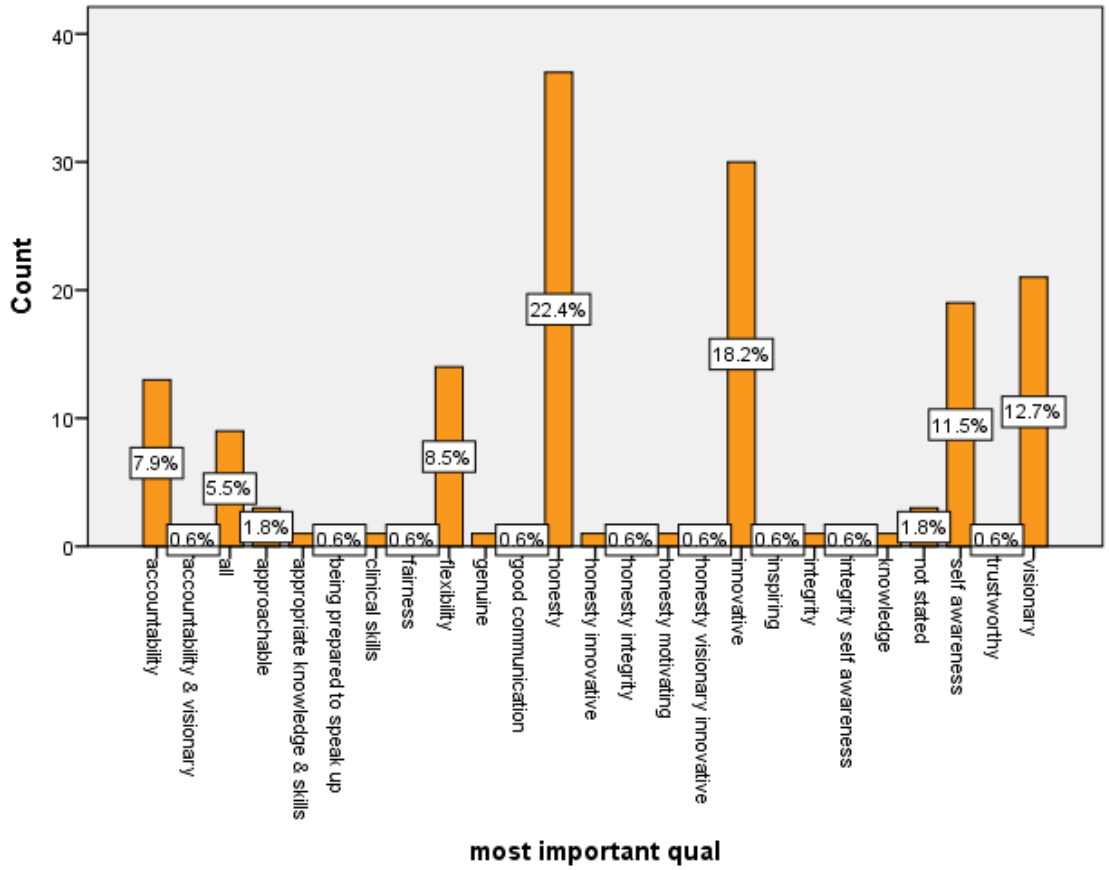


Table 14: Behaviours that Characterise an Effective Clinical Leader

Behaviours	Number of positive responses	Percentage
Motivating	161	97.6
Supportive	149	90.3
Empowering	148	89.7
Influencing	118	71.5
Challenging	96	58.2
Directive	75	45.5
Other	24	14.5

Figure 8: Most important Leadership Behaviour

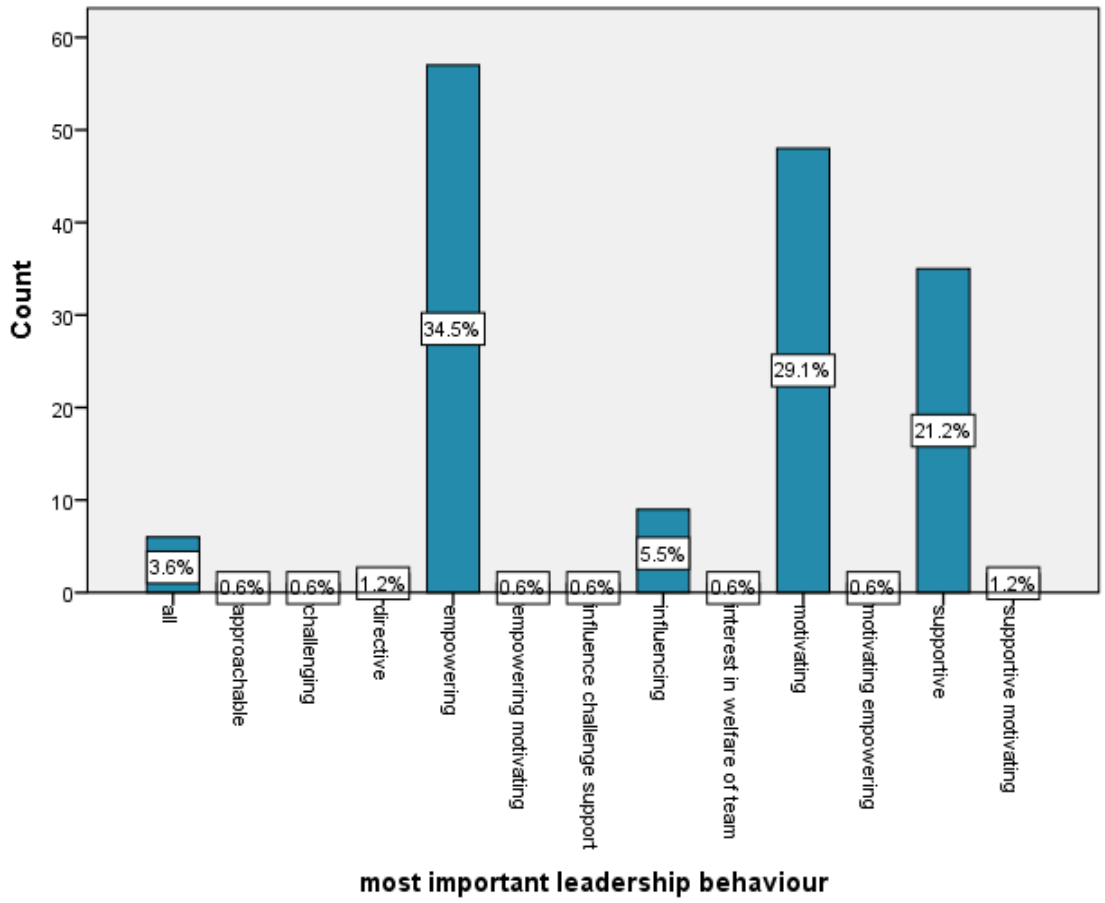
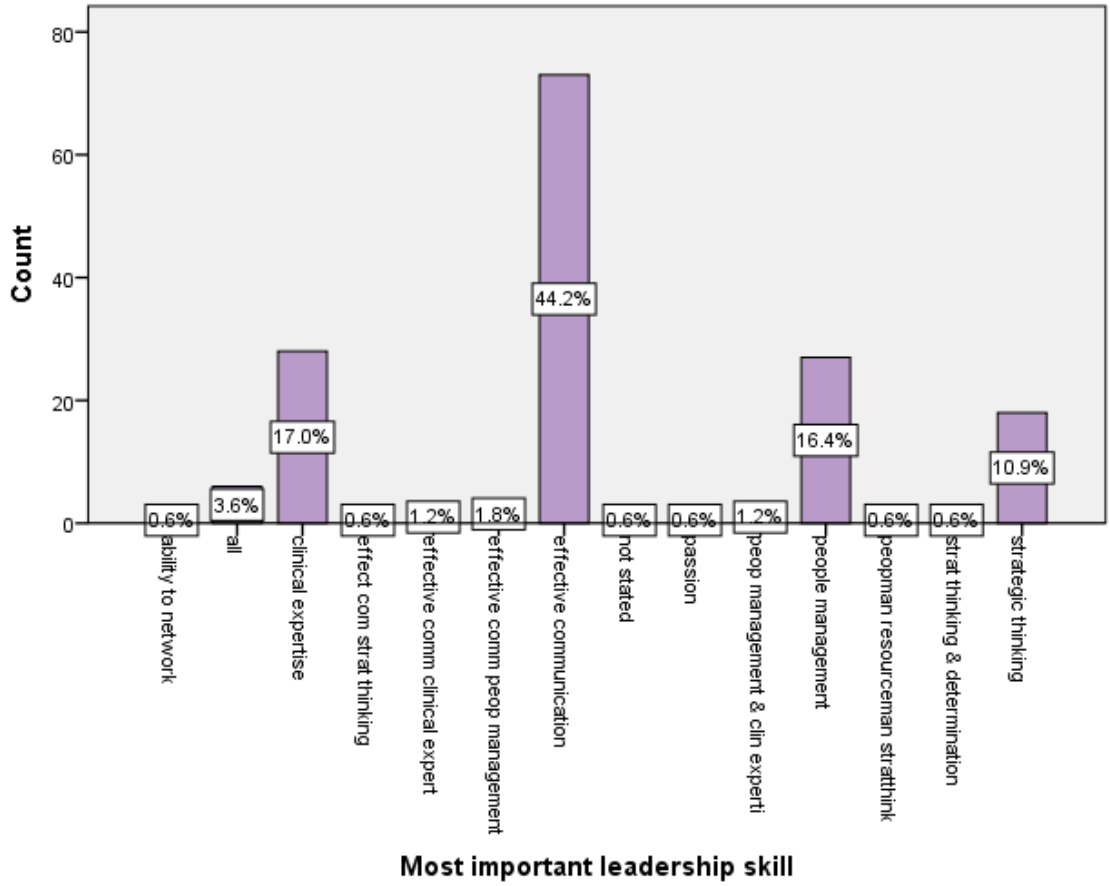


Table 15: Skills that Characterise an Effective Clinical Leader

Skill	Number of positive responses	Percentage
Effective Communication	158	89.7
Clinical Expertise	149	90.3
People Management	146	88.5
Strategic Thinking	127	77.0
Resource Management	100	60.6
Ability to Network	95	57.6
Other	18	10.9

Figure 9: Most Important Leadership Skill



4.3 Leadership Development

To gain an understanding of the importance assigned to leadership development, participants were asked to complete a numeric rating scale to indicate the importance of 'on the job training', mentorship and formal leadership training to their own clinical leadership development. Figure 10 demonstrates that the majority (82.3%) considered on the job training to be very important (43.9%) or important (38.4%). Figure 11 illustrates that almost three quarters of respondents considered mentorship to be very important (38.4%) or important (34.8%), with less than three percent rating mentorship as not important. Moreover, Figure 12 illustrates that three quarters (75.6%) of the respondents considered formal leadership training to be very important (36%) or important (39.6%).

Figure 10: Importance of on the Job Training to Clinical Leader Development

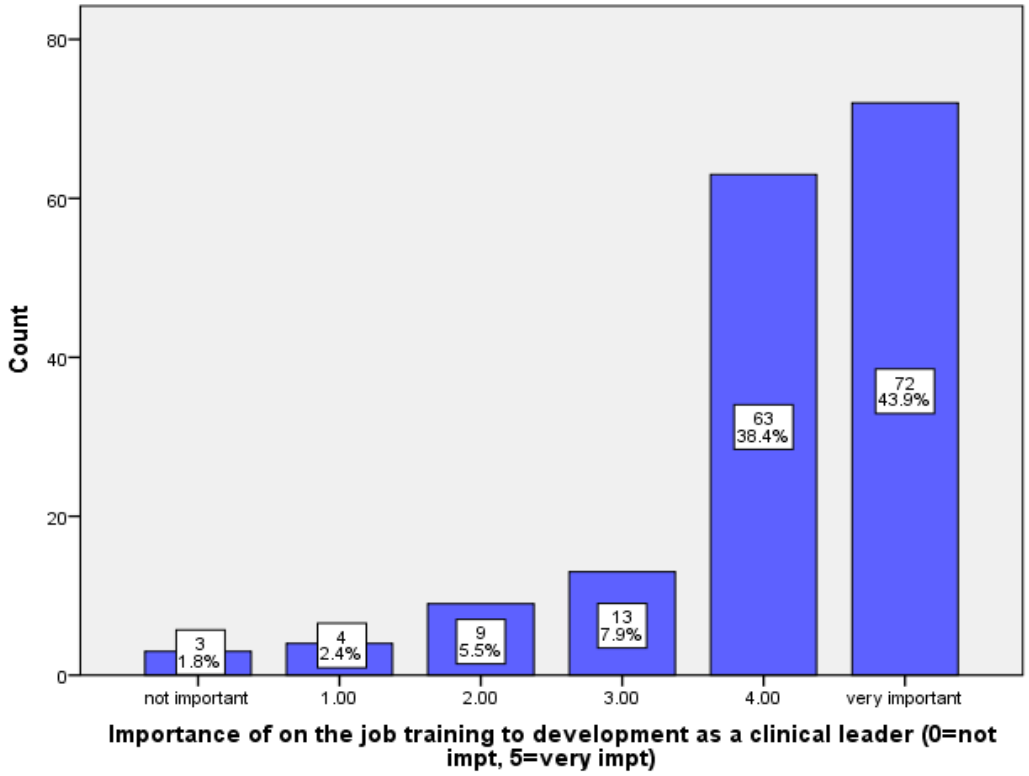


Figure 11: Importance of Mentorship to Clinical Leader Development

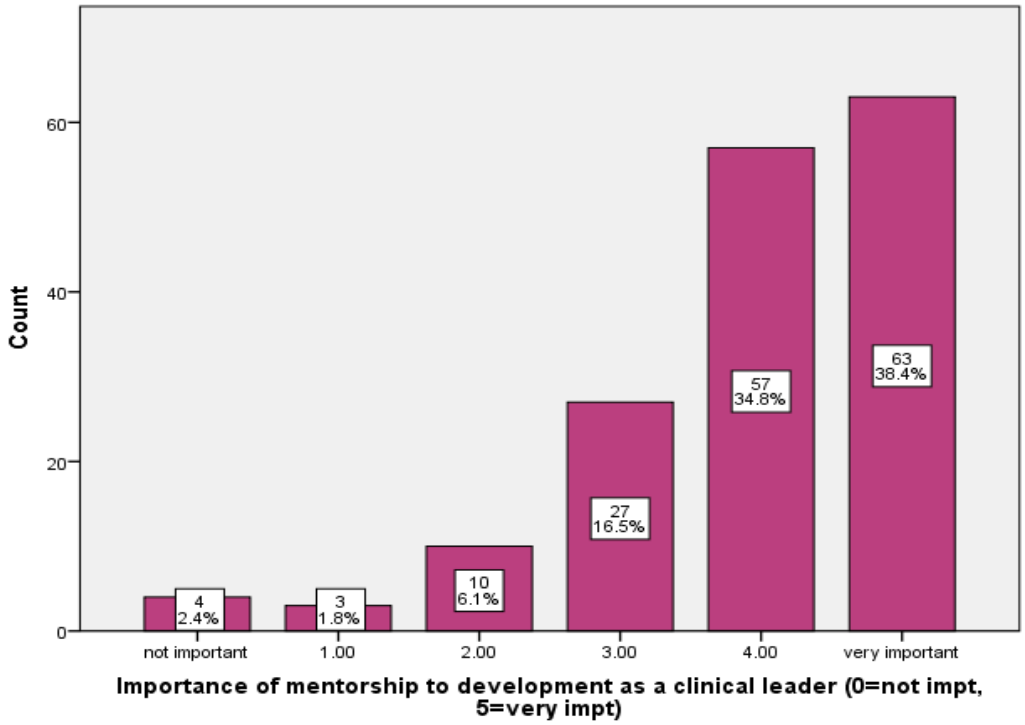
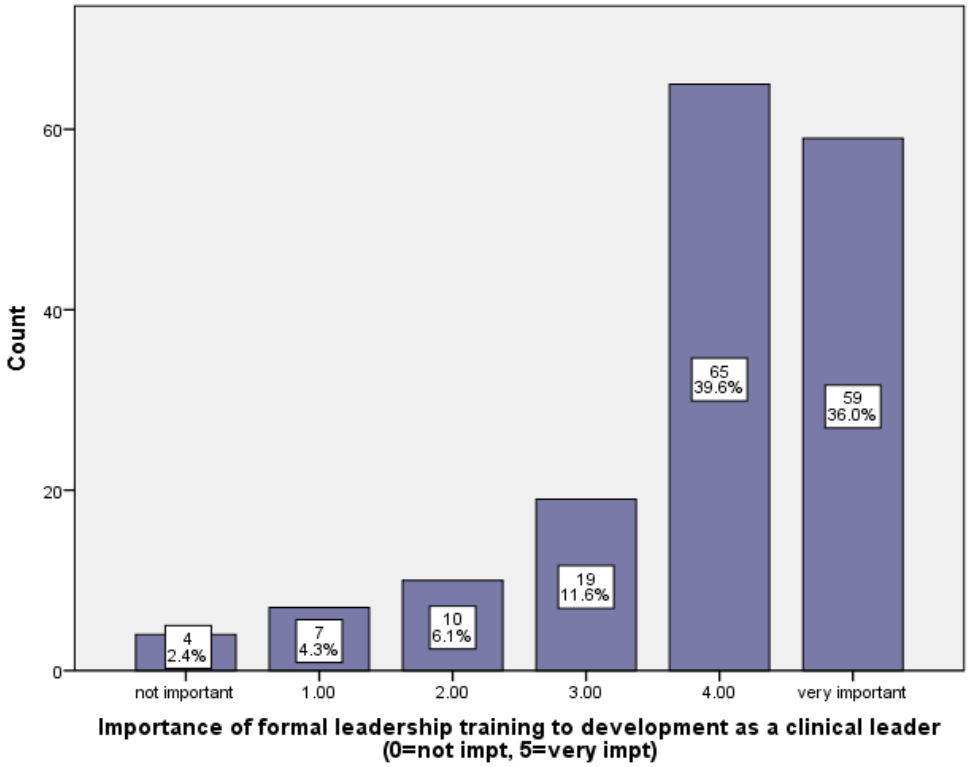


Figure 12: Importance of Formal Leadership Training to Clinical Leader Development



4.4 Barriers and Facilitators to Clinical Leadership Development

Participants were asked to indicate whether they had experienced any barriers to their development as a clinical leader. The response was almost evenly split with just over half of the respondents (50.3%) reporting that they had encountered barriers to their development as clinical leaders, indicating that almost as many hadn't encountered barriers. Table 16 provides participant feedback on the barriers encountered, highlighting that limited opportunities for shared learning (61.2%) was perceived the primary barrier to clinical leadership development, closely followed by career structure (55.2). Limited opportunities for training and limited opportunities to gain experience were also considered to be barriers but to a lesser degree 33.9% and 18.2% respectively). In addition, 16.4% of participants sited other barriers to the development of clinical leaders including limited development opportunities available and staff resources and funding.

Table 16: Barriers to the Development of Clinical Leaders

Barriers	Number	Percentage
Limited opportunities for training	56	33.9
Limited opportunities to gain experience	30	18.2
Career structure	91	55.2
Limited opportunities for shared learning	101	61.2
Other	27	16.4

Participants were asked for their views on what facilitates the development of clinical leaders. Table 17 clearly illustrates that training (79.4%) and experience (73.9%) were the predominant factors supporting the development of clinical leaders. Opportunity for shared learning and (61.2%) and career structure (55.2) also featured relatively highly. Moreover, 16.4% cited other facilitators to the development of clinical leaders including resources to support development and direction from the Royal College of Occupational Therapists.

Table 17: Facilitators to the Development of Clinical Leaders

Facilitators	Number	Percentage
Training	131	79.4
Experience	121	73.9
Career structure	91	55.2
Opportunity for shared learning	101	61.2
Other	27	16.4

To end the survey participants were invited to make any final comments about clinical leadership that hadn't been captured elsewhere in the survey. Twenty-four respondents provided free text comments. Responses included:

> *"I am very keen to develop clinical leadership skills. I am currently about to apply for an MSc Advancing Practice, specifically because I wish to develop my career options in clinical leadership. However, there may be little or no funding available for me to do this. I am concerned that I may be investing time, money and effort into a professional qualification specifically to pursue a career path that may not actually be available to me as an occupational therapist." (Senior occupational therapist – Band 6)*

> *"In our Trust about eight occupational therapists are now team leaders. The Trust encourages training and offers good opportunities. I ensure my team have training opportunities and plenty of built in time for reflection and thinking time." (Team Manager – Band 7)*

> *"Occupational therapists need to stand up and be counted. We need a strong identity and key people to push the leadership agenda. Without strong leadership occupational therapy will fall into the shadows of other professions e.g. nursing and physiotherapy." (Senior occupational therapist)*

All comments were analysed using content analysis (Bowling, 1997). Content analysis enables the researcher to systematically analyse text from transcripts, documents and field notes so that qualitative data can be summarised in a quantitative way. This is achieved by looking for recurring instances and frequencies of key words and phrases within the data, then looking at the relationships between these words and phrases so that they can be categorised. In content analysis data may be coded to fit pre-determined categories or the categories may be developed from the data. The former is described as 'coding down' whilst the latter and the approach adopted for this research is described as 'coding up'. I began the process of theme development by typing each free text comment into a word document so that individual comments could be printed. I then looked at the significant features of each comment, highlighting key words and phrases. Once I had highlighted the key words and phrases from all 24 comments, I scrutinised the data for recurring words and phrases, counting and recording the frequency of each occurrence. I then reviewed the data, looking for patterns and relationships that were then grouped together and organised into themes. The emergent themes were:

- Identity: concerned with the profile and presence of occupational therapy as a profession
- Role: concerned with relevance, suitability and access to clinical leadership roles
- Training: focused on opportunities for leadership training and development
- Structure: highlighted organisational challenges that preclude progression
- Support: identified the importance of encouragement and support to facilitate the development of clinical leaders.
- Development: focussed on opportunities for clinical and professional development
- Experience: highlighted the importance of experiential learning

Table 18 shows the themes identified following content analysis of the final survey question. The prevalence of each theme is highlighted and examples of written comments that contributed to theme development are included.

Table 18: Themes developed following content analysis of comments in response to the final survey question

Theme	Occurrence	Quote
Identity	3	The profession has lost (or lacks) identity, which has impacted on the professions position as leaders. We need to seize the opportunity to raise our profile and showcase the special qualities occupational therapists have in developing services and contributing to the local and national agenda. Occupational therapists are in a perfect position to influence the future provision of health and social care but are in danger of missing the boat. **Team Leader – B8a**
Role	21	Prior to training as an occupational therapist I worked in telecommunications for 15 years where, generally, those who managed were the people most suitable for the role with good leadership skills. My experience in health and social care has been different. In order to progress it is expected that you will supervise and carry out formal leadership regardless of whether you are the most competent person to perform that role. I feel we are all responsible for non-formal leadership as we should lead by example. However, I feel that leaders are born not made therefore greater efforts should be made to give this important role to those best suited to it! **Occupational Therapist (Intermediate Care) – B6** How can a person with a different line of profession manage an Occupational Therapist effectively? It's not clear to me whether they fully understand the role of an Occupational Therapist and the clinical reasoning behind our practice. **Occupational Therapist – Band 5** Limited Band 7 roles for people to progress to. Mine is a secondment role to cover services. I will go back to Band 6 as there are no other Band 7 OT clinical leadership roles in this Trust. **Clinical Specialist OT Older Adults/Inpatient Services – Band 7**
Training	11	I found training and experience were equally important in developing my leadership skills. As a Band 6 I had the opportunity to undertake a leadership course. Then working alongside this my then manager supported me in turning theory into practice by increasingly taking on projects. Therefore when a Band 7 post became available I felt I had the skills and competencies to deliver. **Lead Occupational Therapist – B7**

Theme	Occurrence	Quote
		Need more training in specific clinical areas, where occupational therapists are not traditionally placed or well known for. **Occupational Therapist – B6**
Structure	6	Currently career structures are limited. Band 6 job descriptions are being reviewed to look at incorporating leadership roles. This is what would previously be considered a Band 7 post. **Community Occupational Therapist – B6** The highest band OT leads have been moved from the acute setting to develop community services. There are no 8s in the acute setting. Physiotherapists' leadership is very prevalent within the Trust – 10 Band 8s. Occupational Therapy roles have been scrutinised, criticised and the way we have worked, paperwork, structure is being eliminated gradually. OTs need OT clinical Leads to develop, encourage, motivate, empower and support our roles. **Senior Occupational Therapist – Band 6**
Support	9	Although the Trust offers an extensive management course it feels as though it is to tick a box to indicate they are developing staff. There is no mentoring or support to accompany the theoretical sessions. I moved into management with a clinical case load and team of three, three support workers. My role has changed due to Trust redevelopment with no discussion of the impact on my clinical role. Given the opportunity I would step down to clinical. **Occupational Therapy Team Lead – B7** I have found clinical leadership development to be best learned on the job with the support of a manager, supervisor, mentor or coach. **Professional Development Lead – Band 8a**
Experience	7	I observe some AHP colleagues complaining of being marginalised and about financial constrictions of their work. However, I have always found that engaging directly in higher risk clinical areas and in the unpalatable financial issues driving change, means that I get opportunities to lead and learn a lot from experience. I attended a COT Leadership course and it was not useful to me. **Home Treatment Service Manager – B8a**

Theme	Occurrence	Quote
		People who go into leadership roles will either have the challenge of balancing clinical caseload with management or are put into management roles without relevant experience or support. **Senior OT – Band 7**
Development	6	Limited development further up career ladder. **Senior Occupational Therapist – B6** I left the NHS as I was not able to develop clinically or professionally in the area of specialism I had gained experience in. By moving into private practice my clinical and professional skills have been increased. I can influence Government agendas and COT now I am not constrained by the NHS. I believe there are a significant increased number of OTs who are not using a traditional clinical leadership role to influence and promote their profession. **Independent OT – Practitioner, Expert/Specialist**

4.5 SUMMARY AND BRIEF DISCUSSION

Survey findings highlight the importance of clinical leadership to occupational therapists in their career. The survey found that honesty, empowering others and effective communication were the most important attributes of an effective clinical leader. These findings are consistent with that of Dillon's research (2001) on effective leadership, which attributed leadership success to enabling others, focusing on the greater good, collaborative visioning and leadership through caring. This suggests that occupational therapists both value and are empowered by opportunities to actively engage in open and honest dialogue about matters that affect their professional practice and career development. This is noteworthy, since the literature places great importance on clinical leadership to ensure clinicians' views are fully represented at all levels in order to bring about continuous quality improvement, innovation and change (Department of Health, 2008, Stanley, 2012). Moreover, occupational therapy professional bodies both in the UK and abroad assert that occupational therapy needs leaders so that the profession will continue to grow, develop and realise it's potential (Reimer, 2000, Duncan and Bannigan, 2009 and the College of Occupational Therapists, 2013). Essentially, what seems to be important is that leadership requires that a vision is clearly communicated. Further, through the use of influencing skills the leader is able to motivate and empower individuals to follow the vision, implement new ideas and embrace change in order to achieve the desired outcome.

The survey highlighted the importance of education, training and mentorship to facilitate leadership development. Whilst the majority of respondents rated the value of on the job training, mentorship and formal leadership programmes as important, there was acknowledgement that for many opportunities for development did not exist. Just over half the respondents reported barriers to their development as clinical leaders, with limited educational and training opportunities and career structure identified as the main barriers to leadership development. Conversely, on the job training, mentorship and formal leadership programmes were deemed important for

leadership development. This supports the findings of Burtner, Crowe and Lopez (2009) and Schemm and Bross (1995) whose studies highlighted the importance of inspirational leadership, role modelling and mentorship for the development of clinical leaders. It also supports the need for profession specific postgraduate educational programmes, such as the doctorate in occupational therapy described by Copolillo et al (2010).

The Leadership Academy (2011) asserts that effective leadership requires individuals to draw on their values, strengths and abilities to deliver high standards of service (NHS Leadership Academy, 2011). This position is echoed by the College of Occupational Therapists who state that strong professional leadership is important for occupational therapists through all stages of their career, in order to maximise potential and deliver high quality services (College of Occupational Therapists, 2013). Whilst previous research supports the contention that powerful leadership is required to influence change and reform (Fleming-Castaldy and Patro 2012, Schemm and Bross, 1995), Bannigan (2005) warns that occupational therapists should not rely on others to take the lead but instead consider their potential to become leaders themselves.

Leadership skills can be developed through formal educational programmes or through informal activities including work-based learning, coaching and mentoring. A combination of both approaches has been found to be the most effective to equip people with the skills appropriate to the practice setting (Cook and Leathard, 2004, Dierckx de Casterlé, Willemse, Verschueren and Milisen, 2008, Hartley and Hinksman, 2003). Certainly survey findings would support this contention, as evidenced by occupational therapists undertaking postgraduate education and accessing coaching and mentorship where there is resource to support this. However, respondents also suggested that support and direction from the Royal College of Occupational Therapists is required to promote the future development of occupational therapists as clinical leaders. This correlates with the findings of Bondoc, Kroll and Herz (2008) and Kroll, Bondoc, and Herz (2008) whose study concluded that further support is

required to prepare occupational therapists as leaders, managers and administrators but suggests that the role of the Royal College of Occupational Therapists in providing this support and direction requires further exploration.

Finally, the survey indicated a need to focus on raising the profile of occupational therapy as a profession, with key people to push the leadership agenda. This correlates with the findings of the study by Lloyd-Smith (1997) and Fleming-Castaldy and Patro (2012) who in their respective studies highlighted the need to justify and market the role of occupational therapy, particularly in a time of change and reform and highlighted the need for powerful leadership to influence development and change. In addition, findings suggest that without strong leadership occupational therapy will fall into the shadows of other professions and points to the role of the Royal College of Occupational Therapists in marketing and promoting the profession.

4.6 Limitations of the survey

This was a small scale survey of qualified occupational therapists that were employed in the UK across a range of employing organisations and across a range of practice settings. Thus, whilst findings offer a view of occupational therapists perceptions and experiences of clinical leadership in professional practice, the results cannot be seen as representative of the wider population of occupational therapists. The survey elicited a low return despite the use of follow-up measures that have been shown to increase return potential (Cook, Dickinson and Eccles, 2009). Postal reminders, follow-up telephone calls and email reminders were utilised as measures to increase the return rate. Whilst follow-up measures did result in additional responses, the return rate remained low thus survey results are not generalisable. It could be argued that an electronic version of the survey or a combined approach using email surveys followed by postal surveys (Kroth et al, 2009) may have yielded a higher response rate. However, the decision to proceed with the sole use of postal surveys was based on research findings (Sheehan, 2001, James, 2007, and Shih and Fan, 2009) indicating that

postal surveys elicit a higher response rate. Given the limited impact of follow-up measures, the use of email or web-based surveys should be a future consideration.

The survey did not profile participants' demographic details such as age, sex and ethnicity. In hindsight, it may have been useful to ascertain whether these factors had influenced participants' experiences. However, with a population that is predominantly white and female (Hendricks and Troth-Cohen, 2018 and Burke and DePoy, 1991), I didn't want to include questions that may have enabled participants from minority groups to be identified. Furthermore, a point of note is that free text comments did not provide any indication that these characteristics were factors that influenced participants' thoughts on clinical leadership.

The survey sought information on education and qualifications, including year of qualification and place of training. However this brought with it a level of hesitancy from respondents. During a follow-up telephone call aimed at increasing survey returns, it was highlighted that there may be a reluctance to complete the survey due to concerns that anonymity could be compromised. The feedback suggested that questions pertaining to professional education could potentially identify individuals. Despite assurance that confidentiality and anonymity would be maintained, survey analysis identified that a question asking respondents to state where they completed their training was not answered by three respondents. Whilst it is acknowledged that questionnaires were returned in the example cited, the feedback suggests that if participants felt that they might be identified then they may not have completed the survey.

A further limitation of the survey was that participants were not asked if they considered themselves to be clinical leaders or if they wanted to be clinical leaders. However, they were asked if clinical leadership was important to them in their career. In addition, they were asked to indicate the qualities, skills and behaviours of an effective clinical leader. The analysis of responses to these questions provided a baseline on which to develop the study. However, the inclusion of a question that

specifically asked participants if they considered themselves to be clinical leaders would have illuminated findings. This was an oversight and a question that required exploration. Thus, this question was included in phase two of the study, comprising qualitative interviews that enabled an in-depth exploration of the topic.

4.7 Conclusion

The survey provided an outline of occupational therapists' thoughts and experiences of clinical leadership in professional practice; highlighting that honesty, effective communication and empowering others were key attributes of effective clinical leaders. The survey provided baseline data on participants' perceptions of the barriers and facilitators to their development as clinical leaders. In addition, the survey highlighted that training and mentorship as well as support and direction were issues of importance for clinical leadership development. Finally, the survey identified that that the profile of the profession was as issue of concern. Thus, for phase two of the study it was important to consider the issues raised in the survey, outlined in Figure 13, in greater depth in order to make recommendations for future clinical leadership training, development and practice.

Figure 13: Key issues from survey requiring further exploration in interviews

Knowledge and understanding of clinical leadership	*Characteristics of effective clinical leaders*	*Experiences that shaped development*
Participants perceptions of themselves as clinical leaders	*Opportunities that facilitate leadership development*	*Barriers to clinical leadership development*
Occupational therapy's profile as clinical leaders	*The need for support and direction*	*Recommendations for the development of clinical leaders*

The key issues arising from the survey informed development of the interview guide (Appendix 6). Each key issue is considered in turn.

Knowledge and understanding of clinical leadership mapped to questions three and seven of the interview guide. Question three sought to establish what the term clinical leadership meant to participants and question seven sought to establish whether participants perceived there to be a difference between leadership and management.

Characteristics of effective clinical leaders mapped to objective two of the study, which sought to explore the key attributes of an effective clinical leader from the perspective of occupational therapists. This was addressed by question five of the interview guide, which asked participants what makes a person a leader.

Experiences that shaped development mapped to objectives three and four of the study, which examined the impact of training and development on clinical leadership positions held by occupational therapists, and the barriers and facilitators influencing clinical leadership development. Questions eight and nine of the interview guide were designed to explore these key issues. Question eight sought to explore what had influenced participants' views on clinical leadership development and question nine explored the key factors influencing the development of clinical leaders in occupational therapy.

Participants' perceptions of themselves as clinical leaders mapped to question six of the interview and sought to explore whether participants considered themselves to be clinical leaders but also consider how others saw them.

Opportunities that facilitate leadership development mapped to objective four and were addressed by questions eight, nine and ten of the interview guide. Question eight sought to explore how participants' experiences had influenced their clinical leadership development whilst questions nine and ten focused on potential opportunities to facilitate clinical leadership development.

Like opportunities, barriers to clinical leadership development mapped to objective four of the study, with question eight providing the opportunity to explore this key issue.

Occupational therapy's profile as clinical leaders linked to question four of the interview guide, which sought to explore participants' thoughts on why relatively little had been written about clinical leadership in occupational therapy and the potential reasons behind this.

The need for support and direction mapped to objective four. Questions eight to eleven were designed to enable participants to comment on what would be beneficial to them in terms of their leadership development.

Recommendations for the development of clinical leaders mapped to objective five, which set out to use findings of the research to generate recommendations for leadership training, development and practice. Questions nine, ten and eleven of the interview guide were designed to give participants the opportunity to share their views on what would facilitate the development of future leaders based on their knowledge and experience.

Chapter 5 presents the findings from qualitative interviews undertaken with a cohort of occupational therapists who had participated in the survey. Preceding chapter five is a brief introduction to each of the interview participants, which seeks to guide the reader to view the data in the context of the participants' working lives.

INTRODUCTION TO INTERVIEW PARTICIPANTS

Interview participants were employed across a range of practice settings including health social care and higher education.

Note: All participants were given pseudonyms

Interviewee 1

Margaret was a Network Quality Improvement Manager within an NHS regional network and senate. At the point of being interviewed, she had been in post for three years. She described her responsibilities as leading on service improvement projects within different specialities across the region.

Interviewee 2

Katherine was a team lead for an intermediate care service. She had been in post for two years and her responsibilities included leading a home based intermediate care service and processing referrals into bed based intermediate care.

Interviewee 3

Sarah was a senior occupational therapist who had been in post for 18 months. Her role involved working as part of a project team that assesses and treats patients requiring intensive therapy in the community.

Interviewee 4

Jess was employed as a Professional Lead for Allied Health Professionals. She had been in post for three years and had responsibility for providing professional leadership to occupational therapists, physiotherapists, speech and language therapists, dietitians, podiatrists and a Trust employed paramedic.

Interviewee 5

Kerry was a Disability Support Case Manager who described her role as using the core skills of occupational therapy to help clients achieve what they want to achieve with their lifestyle. At the time of the interview Kerry had been in post for 14 years.

Interviewee 6

Kirsty described her role as a clinical team lead. She had been in post for eight years and described her responsibilities as leading a locality multidisciplinary team and services delivering multiple pathways.

Interviewee 7

Lauryn was a senior lecturer in occupational therapy. She had been in post for three years and described her responsibilities as head of year for first year students and visiting placement tutor.

Interviewee 8

Rebecca was a Band 6 occupational therapist who had worked within a community rehabilitation service for ten years. Her responsibilities included assessing and treating patients within the stroke pathway, supervising a therapy assistant practitioner, providing training and supervising students.

Interviewee 9

Claire was a Band 6 occupational therapist who had responsibility for managing a clinical caseload for patients with neurological conditions. She was also student coordinator for occupational therapy students. At the time of the interviewee, Claire had been in the post for one year.

Interviewee 10

Dawn was an occupational therapy manager in social care. She had worked as team manager for ten years and had been in her current post for two years. Dawn had responsibility for managing two teams of occupational therapists. The first focused on access and prevention with responsibility for duty, recommending equipment, adaptions and specialist equipment. The second team focused on assessment and independence, with Dawn taking management responsibility for the moving and handling team and acting as OT consultant to the team on any aspects of occupational therapy.

Interviewee 11

Gemma was a consultant occupational therapist in secure care, within a mental health trust. She had been in post for six years and described her responsibilities as providing professional leadership and developing occupational therapy services by looking at new models of working. Gemma explained that whilst her substantive role was consultant occupational therapist she had also taken on the role of Trust lead occupational therapist. Gemma explained that the previous post holder had retired and that there was some concern that the post was vulnerable. Thus, when half-time cover was suggested on an interim basis, Gemma agreed.

Interviewee 12

Andrew was a Consultant occupational therapist/Acting Trust lead for occupational therapists within a mental health trust. He had been in post for eight years and described his responsibilities as providing professional development, supporting clinical development, providing professional support and training to occupational therapists. Andrew was the only male to participate in the qualitative interviews.

Interviewee 13

Angela was one of the clinical heads of service within a mental health trust. She described her role as largely management, having a large portfolio with hundreds of staff and millions of pounds worth of budget. Angela had responsibility for the management of two combined service lines; child and adolescent mental health and mental health assessment. She is also responsible for managing one sector of a national deaf service for children with mental health problems (where the child or their family may be affected). In spite of the size of the services she managed, Angela felt that she was not too far removed from the patient and clinical area.

CHAPTER 5: INTERVIEW FINDINGS

This chapter reports on the findings of interviews conducted with thirteen occupational therapists who had participated in an earlier survey about clinical leadership in occupational therapy. Analysis of interviews identified nine themes that were clustered into three overarching themes, illustrated in Table 19 below. Each overarching theme is considered in turn. Data is presented within each of the themes/sub themes and direct quotations from participants are used to illuminate the findings.

Table 19: Interview themes

Overarching themes	Sub themes
Constructing Leadership	Knowledge and understanding Characteristics Perceptions
Identity and presence	Professional profile Promoting the profession Organisational structure Evidence base
Access	Training and education Support

5.1 CONSTRUCTING LEADERSHIP

Constructing leadership captured participants understanding of clinical leadership in occupational therapy, focusing on their understanding of clinical leadership and how this manifests in practice. This overarching theme comprised three subthemes:

i) Knowledge and understanding

ii) Characteristics

iii) Perceptions

5.1.2 Knowledge and understanding

Participants were asked to explain what they understood by the term clinical leadership. This question elicited a range of responses, captured in the visual representation of the key elements of clinical leadership (Figure 14) and participants' narratives.

Figure 14: Key elements of clinical leadership



Participants were in agreement that clinical leadership involved clinicians leading people and leading clinical services, focusing on the clinical priorities within a service. However, one participant, employed within adult social care commented that 'clinical' was a health term but acknowledged its relevance to her practice setting, stating:

> *"I think clinical sounds like a treatment, a health term. But I think the overall philosophy of leadership is very relevant." (Dawn – Interviewee 10)*

In spite of these comments there was a consensus amongst participants that clinical expertise, staff development, promoting the profession and advocating for the profession were all important features of clinical leadership. One participant summarised clinical leadership as:

> *"Having some expert knowledge in a particular field, an ability to supervise and develop new people coming into that field, to advise on clinical interventions and approaches, development of skills, recognition of training needs; and that's by no means an exhaustive list. I think it's much more than that. I think anyone in a leadership role has more than just the clinical bit. I suppose I am providing clinical leadership to some individuals, but my role is professional lead, so it is about supervising and supporting people along their own clinical career pathways as well. I suppose it's also about advocating for your profession, so it's not just the support you're giving to the people that work with you, or in your team, but also ensuring that senior managers are aware of what this particular service can offer or what this profession can offer, so that it's on everybody's radar." (Jess – Interviewee 4)*

Another stated:

> *"Well, I think it's come to mean different things, really. When occupational therapists managed their own service, I think clinical leadership was fairly obvious, because it was about having influence over the whole health economy.... There was the operational side of it, but then there was the whole professional development side of it, and I think that probably is what it means now, the development of the profession within a context of the wider agenda, and I think it's about making sure that standards of practice are high, and then seeing how the profession can develop and go into different areas and be key voices in the whole health economy, at a trust level, regionally and nationally as well." (Andrew – Interviewee 12)*

A third stated that clinical leadership should involve harnessing individual skills and abilities to improve services; and alluded to the importance of leadership at all levels within an organisation:

> *"So everybody has an ability to be a leader, regardless of what level they are, so whether they're a band five, a band six or a band seven and we should be utilising their skills in order to develop services." (Rebecca – Interviewee 8)*

A number of participants pointed to the importance of maintaining a clinical caseload for clinical leadership, although it was acknowledged that this often became a challenge with increased levels of seniority. Referring to consultant occupational therapists, one participant (Gemma) argued that maintaining a clinical caseload and continuing to have clinical expertise were vitally important and something that should be protected. She stated:

> *"Professional leadership or management roles and half clinical caseload are enormously hard to balance. They're very, very demanding but I do think that it's important for our professional credibility to try and continue with that sort of clinical input. I mean, if you look at medics, they tend to continue with their clinical role and their managerial and leadership roles, until they're medical directors really. So I think it's important that we do that. (Gemma – Interviewee 11)*

Another stressing the importance of maintaining a clinical caseload, stated:

> *"So, to me part of the reason we…I'm still called a clinical leader is because we still retain some clinical…a clinical caseload or some clinical activity. I think that's important from a clinical point of view because I think for me I'm much more comfortable with leadership when I'm still doing the do, as they say. I think it enables me to earn the trust/respect from the people I work with. (Kirsty – Interviewee 6)*

Finally, some participants believed clinical leadership extended beyond clinical expertise, advice and support. They pointed to a focus on strategic thinking, as evidenced by having a wider understanding of the organisation they worked in and the national drivers affecting the delivery of services but also have overarching support from your professional organisation in terms of how you should be delivering the service. Kirsty explained:

> *"So, clinical leadership, I think, is at a level where you've still got that…you still walk the walk as well, you still see patients, you can offer that senior advice, problem solving, guidance, supervision, support, but at the same time you do more of that strategic thinking, that horizon scanning with regards to what do we need to…how do we need to develop the services to meet our…the demands of either our local demographics or population or future demand and what the future of the NHS is going to look like." (Kirsty – Interviewee 6)*

5.1.3 Characteristics

The sub theme 'Characteristics' refers to participants' views on what they considered to be the key attributes constituting effective leadership. The key attributes were based on what participants valued as essential leadership qualities, skills behaviours. These were identified as: visionary, authentic, effective communication, professional, belief, drive, proactive, approachable, self-awareness, encouraging, strategic thinking and resilience.

Participants agreed that having a vision was essential for effective leadership, describing this as having clarity about the direction of travel and articulating this. Participants believed that being visionary involved having knowledge of the key drivers affecting services and being aware of the impact of this on service demands. One participant summarised being visionary thus:

> *"Someone who's clear about the direction of travel, so if they're leading, so if you're reconfiguring the service in the organisation, have they got a clear idea*

of how, where they want it to get to. They may not know all the steps to get there but to give you a bit of a vision I suppose about where you want to be aiming for and then I do believe it's someone who's proactive in supporting people, to move them on in that journey. So they're able to stand up and make their opinion heard, not in a bolshie way but to be able to stand up and articulate what their opinion is with other peers." (Katherine – Interviewee 2)

Authenticity referred to leaders who were genuine, open and honest and true to themselves. One participant stated:

"I think one of the most important qualities is to be true to yourself, which isn't something you always read about, is it? We think about communications skills and transformation over transaction and all that, if you think of styles and theories, but I think you have to be true to yourself." (Jess – Interviewee 4)

Effective communication involved being articulate, using active listening skills and appropriate questioning to ensure that messages are clear. Participants emphasised the importance of leaders using effective communication in order to bring people with them. Margaret summed this up as:

"Being able to speak to a range of people and use a range of communication techniques to transmit the message so that people understand clearly what's occurring and where the vision's going to take you." (Margaret – Interviewee 1)

Margaret went on to give an example of an individual she considered to be a good leader, explaining that effective communication had been key:

"So one of the leaders that I was working with communicated clearly and consistently what the vision was, and also what the end point was, and also engaged me into what we're actually doing as a team, so you felt part of the movement to actually achieve the end goal. And they listened to your feedback, and that was very important. So within my example I'd go out and I'd find information from different areas and feed that back into the leader, and then

the leader would reflect back and possibly change things to make sure that the end goal was actually achieved." (Margaret – Interviewee 1)

Another participant spoke of the importance of inclusivity and listening to everybody's voice rather than forging ahead with your own agenda, although he acknowledged that this may not always be possible. He stated:

"I can think of one person in particular who was absolutely brilliant at including people and generating conversation, but it could be that in that particular situation, the individual didn't have the avenues to take that forward. I've seen people listen in difficult situations and take things forward, but perhaps I've also felt that maybe there was an element of bowing down to the system in the end, and not following through." (Andrew –Interviewee 12)

Professional referred to leaders being competent, credible and accountable. Here participants spoke about leaders demonstrating their clinical expertise, providing professional advice and ensuring adherence to professional standards of practice.

Belief centred on leaders displaying positivity, courage and conviction in leading services and teams. This was considered an important attribute to Angela who stated:

"I couldn't possibly lead something if I didn't believe in it. You know, if somebody put me in a service that, well, I don't know, I just didn't think it was kind of ethical or the right thing to do, I couldn't convince people this is the right thing to do. So I think it is about having the absolute kind of belief that this is the right place to be going, and this is why. And being able to present that and saying, well, come on folks, we're off over here and I'd quite like you to come with me. I understand if you can't and why, but actually let's kind of go, and I'm taking you with me, but in a safe way for what I consider to be the right reasons. (Angela – Interviewee 13)

Proactive denoted leaders who were passionate about promoting and advocating for the profession. These individuals were described as being confident, assertive and a

voice of influence. One participant shared her experience of working with someone whom she saw as being both a role model and advocate for occupational therapy:

> *"In my organisation we used to have a professional lead for occupational therapy but she retired about seven years ago. When that person was in post, she did a lot of proactive work, a lot of pilot development. So, I came into the organisation based on a pilot that she championed. So she was for me quite visionary. She had time for staff and she was quite interested in developing their CPD. I think looking back at that time, you don't realise what you've got until it's gone... For me personally she was very much a role model. And again it wasn't until she retired and you were trying to maintain something that you'd find she actually fought quite hard to get it there. She was innovative about how to get more OTs into the service and proactive in terms of supporting CPD. (Katherine – Interviewee 2)*

Being approachable referred to leaders who were warm, friendly, accessible, responsive and inclusive. Participants believed that individuals with these attributes valued staff and engaged with their team. Drawing on previous experience Claire summarised being approachable thus:

> *"So, for me, for a good leader I would want them to be approachable. I would hate them...like, my last manager at my last team, vile woman, if she was in a bad mood you would know about it, you wouldn't go near her. And that is not appropriate, you can't have that. So, I would be approachable, be friendly, and just be calm, that's what you want, rational, pragmatic. So you want someone that's not going to freak out when you take them a problem, and be really rational about something and just be supportive. But, also not...I don't know, not take things away from you, but support you in doing those things appropriately, probably. (Claire – Interviewee 9)*

Self-awareness was seen as having insight and understanding of your own abilities, strengths and gaps but also understanding how others perceive you. Jess gave an

example of this, explaining that she was visionary and liked to generate ideas rather than lead a project from start to finish. This awareness of her strengths and recognising where she needed support meant she could motivate people and help them complete a project.

Encouraging symbolised leaders who were supportive of staff development. Participants saw this as someone who might assume a coaching or mentoring role but also harness an individual's skills and abilities by utilising a range of learning opportunities. Katherine described how one individual had been instrumental in her journey to becoming an occupational therapist; providing support and encouragement even when it seemed that she would not be able to complete the programme. She explained that whilst working as a care assistant she was encouraged by colleagues to apply for a place on an occupational therapy training programme that was being offered as a sponsored programme by her employer. Katherine explained that her colleagues directed her to an occupational therapy service manager who provided further information about the sponsorship programme. She applied for the programme and was called for interview. Katherine attended the interview and recalls receiving feedback from a panel member who happened to be the occupational therapy manager she had previously met. She stated:

> *"I didn't quite have the grades to be fair but they called me back after the interview and she spoke to me and said you're not quite there but I can see something, I think you might make a good OT. I'm going offer you a place. And that was quite important to me, to have someone actually see something in me." (Katherine – Interviewee 2)*

Katherine went on to explain that she commenced the programme. However, at the end of the first year, she failed one of her exams twice. She described her own disappointment and a sense of letting down the person that had shown interest and recognised her potential. Katherine recalls being keen to continue with the programme and being encouraged by a telephone call whereby the same occupational

therapist that had given her the initial encouragement and support, urged her to make contact if she re-sat the exam and was successful. Katherine explained that she re-sat the exam and passed. She returned to university, made contact with the occupational therapy manager as suggested and was subsequently accepted back onto the sponsorship programme.

Strategic thinking involved taking a broad view of the influence and impact of national priorities, policy and research on practice. Katherine summed this up as:

> *"Having insight into the bigger picture about how as a profession we fit in, to the wider impact of the NHS or wherever it is you're working; and to just be able to articulate from an OT perspective, articulate our place in that market and how we can have a positive impact on that." (Katherine – Interviewee 2)*

Finally, resilience denoted individuals who were able to handle challenge and adapt to change. Gemma stated:

> *"I think you need to be hugely resilient. I think you need to, whilst having a vision, try and be flexible, because there's so many changes in terms of what happens outside of our profession, but also politically and in the wider scheme of things. So you need to try and be adaptable. (Gemma – Interviewee 11)*

5.1.4 Perceptions

An important consideration in the study was to ascertain whether participants' deemed themselves to be clinical leaders, whether they were perceived as clinical leaders by others and whether anyone could be a leader. Some participants were clear in their view that they were clinical leaders, seeing this as leading whilst maintaining a close connection to the clinical workforce and keeping up to date with clinical developments. Others were specific around use of the word clinical, with one

participant describing herself as a leader with a clinical background rather than a clinical leader, stating:

> *"I think I am a leader with a clinical background, and I say that just because I don't clinically practice at the moment but I do use my clinical skills. I suppose the term clinical leader for me would be someone that's still clinically practicing as their profession, and doing leadership activities." (Margaret – Interviewee 1)*

Similarly, Andrew did not consider himself to be a clinical leader with regards to expert clinical practice. He believed his role had a greater emphasis on strategic leadership and spoke of the tension and frustration of a dual role:

> *"I think what they're expecting us to do is to be more…leading strategically, I think that's the way it falls. I don't think you can be both, that's my opinion, so I think I'm going to be bad at one and my role is split, but I have specifically asked to decrease the amount of direct clinical work I do so I can get more into sort of broader programme development and clinical development, because I think that's what we need." (Andrew – Interviewee 12)*

Notably, two participants commenced their interviews stating they were not clinical leaders but changed their position as interviews progressed. Jess began her interview by stating that she did not consider herself to be a clinical leader, instead seeing herself as a professional lead because she was not just leading occupational therapists but had professional responsibility for physiotherapists, speech and language therapists, podiatrists, dietitians and a paramedic. However, later in the interview Jess stated:

> *"Yes, and I suppose on reflection, I am a clinician, and when I think about my counterparts who are not clinicians, there's a part of my role that I have got to think like a clinician ... I need to think about what does that mean for the clinician, so I am involved in that sort of thing to give the point of view of the clinician, and I think I said before, if I'm doing one to one supervision with an*

OT, then I am providing clinical supervision, which is part of that clinical lead role. I do advocate for OT in amongst the other Allied Health Professions, so I think that is part of clinical leadership, isn't it, really? I've talked myself around, yes, I am a clinical leader." (Jess – Interviewee 4)

Similarly, Claire was very clear that she was not a clinical leader, although she believed that leadership occurred at all levels. She stated that her role as a band six occupational therapist was where she had always wanted to be and that she had no desire to progress to a more senior position. However, as the interview progressed Claire explained that she was keen to support the development of others and saw this as an important part of her role. Upon further exploration she stated that to some extent she was a clinical leader, specifically referring to therapy assistant practitioners whom she delegated treatment plans to and students. However, she saw this as being quite different to senior or executive level leadership.

Others had experienced changing views of their perceptions of themselves as clinical leaders. One participant (Kirsty) explained that she had experienced self-doubt about being a clinical leader but gained validation through leadership training and completion of her Master's degree. Another (Lauryn) stated that she found it was difficult to describe herself as a clinical leader in her role as a lecturer but did so in a previous clinical role. A third (Sarah) felt that in her previous work environment she had not considered herself to be a clinical leader but that there had been a complete turnaround in her current role. She stated:

"I do actually (think I am a clinical leader), in this role I do. If this had been the previous role I'd have said no, because I felt that my voice was never listened to, I was never heard, and so you just think, can't be bothered, and that's how I felt, and it's probably not the way to be, but that's just me. If someone's not there to give me that encouragement or give me that support, then it does dampen me. But in this role where I have got support and I have got people motivating me, encouraging me, then yeah, definitely." (Sarah – Interviewee 3)

Participants' perceptions on whether others considered them to be clinical leaders garnered mixed responses. Several reported that they were viewed by others as clinical leaders, pointing to 360 degree feedback as positive affirmation. Others fed back that they were considered clinical leaders by some but not all whilst a small number stated that they hoped that they were seen as clinical leaders. Reflecting on her own experience, Lauryn stated that others saw her as a clinical leader more than she saw this in herself, explaining:

> *"I present as more confident than I feel. I'm quite assertive. I can be seen as quite brusque and forthright; and I tend to find answers for things. And I've certainly learned over the years about that difference between how I'm seen and how I feel. And it helps with teaching students before they go on placement, about putting on that professional persona." (Lauryn – Interviewee 7)*

Conversely, Andrew stated that whilst there were people that viewed him as a leader, he had previously experienced feedback to the contrary. In what he described as a period where he felt his ability to effect change was severely diminished, he received feedback from an occupational therapist who said, *"There are a group of us who don't think you do enough for us."* Andrew described feeling "incredibly hurt" by the feedback, which he described as "really personal and hard to take."

The question of whether anyone can be a leader yielded mixed responses. A number of participants held the view that everyone has the potential to lead, and that this may be influenced by a natural aptitude for leadership or one's ability to learn leadership skills. Many felt that capacity to lead was often determined by opportunity or circumstance but also pointed to the importance of having a network of support and encouragement to motivate leaders. Margaret stated:

> *"I think everyone has the potential to be a leader. I think sometimes the environment and the system doesn't allow or foster people to be leaders, or support them to be leaders. So you might have a very junior member of staff*

that has leadership qualities, but actually because they're a junior member of staff their thoughts, their opinions might not be promoted or encouraged because of their position, and sometimes that's a difficult hurdle to get over. So a junior member of staff trying to lead something that needs high level consultant buy in, sometimes the hierarchies that occur and the environment that they're working in can often become a barrier to that individual actually being the leader that they could be." (Margaret – Interviewee 1)

Others emphasised the importance of followership, highlighting that effective leaders are the ones that bring people along with them and help them to grow. Katherine stated:

"Yes anyone can be a leader but I think there is a difference between effectiveness and bringing people. So people can lead by instruction, like you have to do this. But you don't always get the best results from people, I don't think. So, the ones I think of as effective leaders are the ones that have encouraged and brought you along with them so you're sharing the journey as opposed to being right this is what I want you to do and you've got to do it and don't ask me questions about it! So you know; you're just doing as you're told as opposed to understanding the reasons why. (Katherine – Interviewee 2).

Some participants believed that whilst everyone had the potential to be a leader, not everyone had the desire or capacity to lead. Gemma captured this viewpoint, stating;

"Some people will have a natural aptitude towards the sorts of skills, so the sort of flexibility, the ability to see a different way to do things. And I suppose it's that age-old question, isn't it, you know, I think people can learn, they can learn leadership skills. But some people don't have the drive or the interest. Some people are content to broadly do their job in the same way." (Gemma – Interviewee 11)

Others firmly rejected the notion that anyone can be a leader. One participant stated:

"No, I don't (think anyone can be a leader). I think there's quite a skill to being a good leader, and I think it's that getting other people on board with what you want to achieve that a lot of people find difficult, sort of, promoting where you're going, really, and why you're doing something. I think that can be very hard for them to do, and it's very hard for people to understand, sometimes, where they're going with it. So no, not everyone can be a good leader. (Kerry – Interviewee 5)

Another described two instances where individuals took on leadership roles. She explained that both were excellent senior clinicians but struggled with leadership and got to the point where they had to stop, recognising that leadership wasn't for them. A third explained that she knew people in leadership roles that were very good managers but not good leaders, which fuelled the debate whether a leader can be a manager and vice versa.

Some participants believed that a leader could be a manager and that a manager could be a leader. Others believed that it was possible to manage without being a good leader and equally possible for a leader to work within a management framework. There was consensus amongst participants that there was a difference between leadership and management. Some saw the difference as quite subtle whilst others saw stark differences but all agreed that it was important to understand the difference. Leadership was seen as engaging, inspiring and influencing people to go on a journey to bring about change and development. Management was seen as being much more task focused and process driven, working to a set plan and within structural processes.

5.2 IDENTITY AND PRESENCE

The theme 'Identity and presence' focused on participants' perceptions of how occupational therapists presented and positioned themselves, and the impact this had on their leadership capability. This overarching theme comprised four interrelated sub themes:

i) Professional profile

ii) Promoting the profession

iii) Organisational structure

iv) Evidence base

5.2.1 Professional profile

A number of participants voiced concern regarding the profile of occupational therapists, fearing a loss of identity, professional standing and professional pride. Participants described instances where occupational therapy was not recognised for its unique skills and the valuable contribution the profession brings to patient care.

Reflecting on the climate within her organisation, Gemma commented that she was not alone in thinking that occupational therapy had "lost its mojo." She described how historically occupational therapy was a prominent service that was held in high regard. However, this changed when the lead occupational therapist in the organisation was given generic responsibilities in addition to her professional leadership role. She explained:

> *"So there was an example when the lead OT was asked to do like a generic operational role alongside her occupational therapy leadership role. And I think that just made it very, very difficult to maintain the profile of the profession. And, you know, maybe other leaders around at the time made it difficult; weren't as supportive or as receptive to the contribution that OT can make." (Gemma – Interviewee 11)*

Integrated working together with leadership of individuals and teams by different professions was seen by some as being less favourable with regards enhancing the profile of occupational therapists. Kerry described her experience of leadership both from within the profession and by other professional groups. She described a previous experience of being line managed by an occupational therapist that had a passion for developing services and put occupational therapy on the map. She also described

more recent experiences where she had worked with a variety of clinical leaders, commenting:

> *"I think, if you've got a different profession leading you, there is always a concern that the emphasis is going to be with their profession. So yeah, that does give you, then, concerns about your own profession. I suppose the ideal is to have everybody on an equal footing, and each profession going forward together where they interrelate. I don't think that's necessarily what will happen and does happen." (Kerry – Interviewee 5)*

Similarly, Katherine explained how integrated working, with more focus on generic mobility assessments and less focus on activities of daily living, had resulted in occupational therapists informally raising concerns with her because they didn't feel confident to raise their concerns with their line managers. She stated:

> *"It was easier for people to find alternative work than to try and fight a system that they felt they weren't going to be recognised in or even potentially penalised for raising concerns." (Katherine – Interviewee 2)*

Loss of identity was a concern for a number of participants. Some felt this was attributed to the integration of services described earlier but others felt that appearance, perceptions and presentation were a major influence. One participant remarked that uniform meant a lot to her and that the traditional green and white occupational therapy uniform was an outward representation of her achievement. She explained that when a decision was made to change the uniform she registered her concerns, highlighting that her uniform identified who she was and what she did. However, the response received stressed that it was the person rather than a uniform that identifies you.

One participant (Rebecca) questioned whether issues of identity, value and recognition were institutional, potentially stemming from university. She shared her experience of her first day at university, describing how one of the lecturers (an occupational

therapist) welcomed students, saying *"Welcome to all the failed physiotherapists."* She described how this made her feel stating:

> *"So you're instantly in that mind-set that you…it's not what you really wanted to do, what you really want to do is physio, because what's OT kind of thing." (Rebecca – Interviewee 8)*

Rebecca felt this did not instil confidence in someone who wanted to be an occupational therapist and that it was not conducive to developing good team relations between the two professions.

A number of participants spoke of nursing and physiotherapy dominance with respect to leading clinical developments and leadership of teams and leadership within senior organisational structures. Claire stated that occupational therapy is perceived well when there is an occupational therapist or therapist at a very senior level within the organisation. She emphasised the importance of occupational therapists progressing through the ranks and being represented at high levels but explained that her experience was one of nursing dominated leadership.

In describing her current role, Margaret explained that she was the only occupational therapist within her division and that there were only one or two occupational therapists in higher positions of influence. Consequently, when decisions needed to be made they often took the perspectives of physiotherapists, nurses or doctors who were well represented. Similarly, Sarah reflected on her experience of working in physiotherapy led services. She explained that working in an environment where all of the senior leads were physiotherapists had not been an encouraging experience for her. Conversely, Kirsty described a very different experience where all of the clinical team leaders within her service were occupational therapists. She believed occupational therapists made good clinical leaders because of the skill set derived from their training and a focus on supporting and developing people, based on their core values.

The importance of developing and maintaining a professional profile was summarised by Jess who stated:

> *"I do think there's some work to be done about supporting therapists to have as high a profile as other leaders." (Jess – Interviewee 4)*

5.2.2 Promoting the profession

A number of participants expressed concern that occupational therapists were not doing enough to promote the value, scope and potential of profession; a point captured by Claire who stated:

> *"We know what we do well and we know that we all do a good job, but I just don't think we promote it enough and I don't know why we don't do that." (Claire – Interviewee 9)*

Claire went on to describe how she had worked in Trusts where occupational therapy was promoted during Occupational Therapy Week and other events but had not experienced this in her current organisation. Claire questioned whether staff morale was an influencing factor and pointed to the pressures of trying to maintain a clinical caseload impacting on capacity to engage in promotional activity. She stressed the need to keep pushing forward otherwise she feared occupational therapy would be forgotten.

Participants felt that individually and collectively occupational therapists had a professional responsibility to promote the profession and increase the presence, impact and leadership capacity of occupational therapy across health and care services. Dawn, who had a long history of working within social care, emphasised the importance of promoting occupational therapy to senior management so that they understand the value that occupational therapists bring. She explained that historically managers leading the profession within her local authority had not promoted occupational therapy, downplaying their skills and labelling occupational

therapists as issuers of equipment. Dawn described how this had resulted in non-qualified staff being appointed to positions to the detriment of qualified occupational therapists, which she felt was damaging and a disservice to the profession. In a similar vein, Katherine stated that an emphasis on integrated working meant that clinical leadership was not promoted in her organisation. She explained that she found it extremely difficult to promote clinical leadership in occupational therapy and felt that any attempts to do so were viewed negatively. Notably, Jess cautioned against the potential challenges of profession specific clinical leadership, stating:

> *"We have to be careful, don't we, about pigeon-holing ourselves. Is clinical leadership in OT any different to clinical leadership in any other profession?" (Jess – Interviewee 4)*

Participants spoke of the need to promote and advocate for the profession on a wider scale. Margaret highlighted the need for occupational therapists to raise their heads above the parapet but suggested that more support was required from the Royal College of Occupational Therapists (RCOT). She stated:

> *"I think occupational therapists as a whole need to understand the bigger picture and how occupational therapy fits in with the world that we now live in, and we need to promote our profession, not just the silo of what we used to do, but I do think that we need to be more vocal about the things that we do and the things that we can do. So stop restricting ourselves to this is what an occupational therapist does and will always do for the next however many years. I think we need to broaden our scope and horizons otherwise I think we won't exist. (Margaret – Interviewee 1)*

Others believed that occupational therapists and the RCOT were proactive in promoting the profession, pointing to professional publications, media campaigns including a series of articles in the Guardian promoting the value of occupational therapy and the work of specialist occupational therapy sections. Claire stated:

"I think the college do quite a few things, don't they, and I think there are always articles, in OT news and whatever about how to change practice or being aware of the changes that are happening, how to be flexible and encouraging us to think more flexibly." (Claire – Interviewee 9)

Lauryn agreed, adding that it was difficult to see what else RCOT could do and that it was individual choice with regards how much people engaged with promoting the profession.

5.2.3 Organisational structure

Some participants held the view that the structure of organisations was a major influence on occupational therapists' position as clinical leaders and that this became more apparent with increased levels of seniority. Participants predominantly spoke of nursing dominance at senior levels within organisations, an issue relating back to presence and professional profile. Andrew described the issue thus:

"It's structure, its systemic problems, that's the way I view it. I feel…and let's look at it this way, let's look at it in a very tangible way, so if there's an OT starts out as an OT, and they start out, whatever, band five, and they go up band six, and if they're lucky, they might get band seven, is that person ever, ever going to be a ward manager? Now let's look at the nurses, so the conduit for nursing is, you come in and you think, what would I like to do? Well, they can slip into multiple management positions. If you look at the structure of our Trust and you look at the people who are in key positions, nurses, everywhere. Nurse leader, it's a nurse in training, it's a nurse in head of clinical development, it's a nurse in organisational development, director nurses, nurses everywhere, and why do they get into those positions? Because they get the opportunities lower down." (Andrew – Interviewee 12)

Andrew went on to explain that he believed occupational therapists' aspirations had been curtailed and that he was not alone in thinking this. He described a recent

conversation with two head occupational therapists where they discussed that with their experience, drive and aspirations they could all be directors at this point in their careers but they were not. They reasoned that this was because they were occupational therapists. Andrew concluded by expressing his anger and frustration, stating:

> *"The profession has limited us, which is…I mean, it's a hard thing to say, but the profession has limited us. Not us, not our desire, but the profession and the structure and the whole system has limited us, and I think that's a bitter pill to swallow, it's really bitter to sit there and think, I could have been in that position, I know I could do that." (Andrew – Interviewee 12)*

Similarly, Jess described her experience of working in an organisation where her counterpart for psychology was Banded 8d whilst she was Band 8a. She queried why one person was deemed more important than another and emphasised the need for parity within organisational structures. Angela reported a very different experience. She explained that in her organisation she was the sole occupational therapist in senior management but knew of occupational therapists in other trusts that had gone into senior management roles. She suggested that perhaps the issue wasn't that occupational therapists were not acquiring senior leadership positions but that this was not being promoted and celebrated.

In spite of individual experiences, participants agreed that it was important for occupational therapists to be in a position that was sufficiently senior for them to be a voice of influence. Reflecting on her own experience of being a senior leader within her organisation, Gemma stated:

> *"One good thing for this particular service, and I think it's probably one of the key things in terms of leadership for occupational therapy is you need people in at a senior enough level to have an equal conversation. So this band…the consultant OT role in this service is banded an 8b you know, that's not hugely senior, but it's sufficiently senior to be equivalent to the clinical nurse managers*

and to have sort of a voice in the meetings, where a lot of the decisions are made, where you can represent the profession and work with others to do that." Gemma – Interviewee 11)

5.2.4 Evidence base

An important element of the research was to ascertain participants' thoughts on the assertion that little had been written about clinical leadership in occupational therapy. I was cognisant of the fact that participants should not feel compelled to agree with this assertion therefore when stating that little had been written, I qualified this with the caveat that participants may wish to disagree. Notably, there was no disagreement. However, some participants commented that it was something that they hadn't really thought about whilst others expressed surprise that little had been written and wondered whether this was because occupational therapists are naturally leaders. Although some believed occupational therapists were naturally leaders, Kirsty was keen to point out that this didn't mean it was easy. She referred to the start of her own leadership journey as a steep learning curve and stated:

"To have information and literature written by other OTs, you know, maybe about leadership through an OT lens, could have been really useful at that time... so your work's going to be really useful." (Kirsty –Interviewee 6)

Many participants believed that occupational therapy did not command the recognition and leadership profile afforded to other professions because occupational therapists were "doers" primarily focused on patient care. Angela summed this up stating:

"*I think we don't foster that leadership bit too well. We look very much on clinical delivery and what we're doing clinically, and how skilled we've become in delivering whatever specialty we may well be working in. And I think people write a lot about that. I think we don't maybe consider the leadership bit*

enough or where we've arrived at in terms of leadership." (Angela – Interviewee 13)

Similarly Lauryn pointed to the professions' focus on providing the evidence base for clinical practice rather than thinking about leadership, and cautioned:

"I guess the profession is never going to progress if we don't have people looking into that." (Lauryn – Interviewee 7)

Several participants believed that an emphasis on "doing" had placed occupational therapy in the shadows of other professions, particularly nursing and physiotherapy who had a long history of engagement in audit and research. Referring to a previous role, Sarah described how occupational therapists were criticised for not having enough evidence to support the work they were doing. She explained that physiotherapists were proactive in their use of outcome measures whilst occupational therapists were unable to evidence patient outcomes. Sarah went on to explain that in her current role occupational therapists were evidencing outcomes and emphasised the importance of clinical leaders playing a role in influencing this change.

Some participants expressed a lack of confidence in occupational therapists' research ability. They emphasised the need for occupational therapists to be research active thereby providing the evidence base to enhance the professions profile and impact. Claire stated:

"I just don't think we are probably, like, very good at research as a profession. Even though, when you think about things like supervision and reflection, they are all, sort of, core OT values, aren't they. So, really, we have, sort of, developed it a lot, haven't we, and always as an OT, I always had, sort of, regular supervision and clinical leadership has always been, sort of, very important, wherever I have worked. So, I don't know why we don't research it, or why we don't write about it. I think we are probably, just, maybe, a bit

rubbish as a profession, that sounds really bad, doesn't it. (Claire – Interviewee 9)

Similarly, Andrew stated that *"the profession has never been really good at getting into research"* but hoped the situation was changing.

Like other participants, Gemma acknowledged the importance of occupational therapists evidencing the value, scope and potential of profession but emphasised the need to ensure this relates to current policy. She stated:

"I think evidence is good... but I think for me, it's how do we then tie that to things like the five-year forward view? …. I think it needs to be like a stronger sort of argument about, you know, these are the challenges facing this country, this is what the brightest minds in like healthcare say we need to do, the prevention, all of the sort of empowerment and the networking and community engagement, and all those, sort of, things. We are the profession that will help you do that. Therefore, you need us in those positions to make those things change. And I don't know quite where we do that or how we do that. So I think that would be the next issue. (Gemma – Interviewee 11)

5.3 ACCESS

The theme access related to occupational therapists' exposure to and experience of opportunities available to facilitate their own clinical leadership development, as well as the leadership development of others. This overarching theme comprised two subthemes:

i) Training and education
ii) Support

5.3.1 Training and education

Participants reported mixed experiences regarding opportunities available to access training and education to facilitate their development as clinical leaders. Some reported very little support and encouragement to access training or education to support their development whilst others were actively encouraged to access formal and informal training. The level of support provided was often determined by funding and resources available to facilitate learning. One participant stated:

> *"I think we have all had barriers in the sense of time constraints, increased caseloads, reduced resources, that sort of stuff. Opportunities for training aren't really there, because of things like time, we haven't got the time, and we have got increased caseloads, so you can't really take the time off." (Claire – Interviewee 9)*

Katherine reported that she was initially supported by her line manager to undertake postgraduate study to facilitate her leadership development. However, organisational changes 18 months into the programme resulted in a withdrawal of management support, study leave and course funding. Katherine explained that she successfully completed her Masters but had to self-fund and use annual leave in order to do this. She explained that the use of annual leave was challenged and that she accessed her union for advice and guidance, which created unease with colleagues. Similarly, Dawn reported that she had very few opportunities to develop as a manager or leader. She explained that she had been offered training in NVQ 4 management 15 years ago but no other training had been offered. Dawn described her leadership development as "learn as you go" and explained that she adapted her leadership style dependent on the situation and how well people responded. Dawn did not believe that limited opportunities to leadership development had hindered her career progression but wondered whether it would have an impact if she where to seek employment elsewhere.

Kirsty reported a very different experience symbolised by encouragement and support to develop as a clinical leader. She explained that her first experience of leadership development training was the Leaders for Change programme delivered through the Health Foundation. Kirsty explained that she attended the programme out of desperation because she had just become a team leader and felt that she needed to do something because she felt she was struggling. She subsequently completed additional programmes to facilitate her development including a Masters in leadership but felt that early exposure to leadership awareness would have been helpful. She stated:

> *"I think what I would have found useful before I became a leader was to at least have an awareness of leadership, a basic level of leadership, and in my training even, and just highlighting how transferable some of our skills are from a day to day sort of clinical practice to leadership, because it took me a while to work that out really. Whereas, you know, if I'd have started that understanding a little bit earlier it might have helped." (Kirsty – Interviewee 6)*

This was a point echoed by a number of participants who felt that leadership should be an essential component of occupational therapy undergraduate education. Many stated that this had not been their experience but acknowledged that occupational therapy programmes were continually evolving and that students demonstrated greater awareness of leadership.

In addition to formal training and education, participants also pointed to the importance of on the job learning for clinical leadership development, with many pointing to the importance of learning from role models. Participants reported that their experiences, whether good or bad, had shaped the way they approached leadership. They described how they took cues from positive role models and endeavoured not to repeat the behaviours displayed by those they deemed as obstructive and unsupportive.

Notably, participants believed that greater support and guidance was needed to prepare occupational therapists to be clinical leaders, with some pointing to the role of RCOT within this. Participants acknowledged that RCOT offered information and support but there was a sense that information and support available was not always obvious. Katherine who described the challenges she encountered when undertaking her Masters remarked that it never occurred to her seek support from occupational therapy support networks. She stated:

> *"It never crossed my mind! I mean, I attended stuff all the time but I never thought to go to get some support or just sound it out with them. And now, now it's all over I look back and think so why didn't I do that. And I think that's one of the issues with us OTs is that we're quite autonomous so we don't necessarily seek support from each other. But then maybe that as a professional body maybe that should be promoted more so that people are aware that it's out there. I know the College of OT with the website and stuff, it's almost like you've got to go to rather than, no disrespect to them or anything but rather them being in your face a bit more." (Katherine – Interviewee 2)*

Similarly, Jess stated:

> *"I think anecdotally I hear a lot of OTs will say the college is rubbish, they don't do anything, but they probably do offer a lot but you've got to physically go onto the website and have a look at what they're offering. I don't ever hear of any courses offered to support clinical leadership from the COT. It doesn't mean they don't do them, but I haven't heard about them, so when I'm busy at work every day, and all our OTs are busy at work every day, they are not going to go out of their way to look at what's on offer, so I think the college needs to be a bit more proactive in what they offer and where they offer it." (Jess – Interviewee 4)*

5.3.2 Support

Participants acknowledged the role that practical guidance and support played in shaping the development of clinical leaders; pointing to the importance of supervision, coaching and mentorship. Some participants had experienced supportive supervisors whilst others had experienced supervisors who did not support growth and development. Participants considered regular supervision as being essential for the development of clinical leaders, suggesting that a good supervisor would encourage discussion of clinical cases and practice issues. Claire advocated the importance and value of supervision, commenting:

> *"As an OT, I always had regular supervision and clinical leadership has always been, very important, wherever I have worked." (Claire – Interviewee 9)*

The importance of mentorship was highlighted from the perspective of both the mentor and mentee, with a number of participants reporting that they mentored staff in junior roles and students. A number of participants had themselves been mentored and on the whole reported positive experiences, appreciating the opportunity to, as Jess described; *"Check-in with someone who asks the probing questions and allows you to arrive at the answers by yourself."* Not all experiences were positive, a point highlighted by Margaret who reflected on both positive and negative experiences. She stated:

> *"The positive one was…and it was about the individual. So the positive one, they were leading a project and when we had mentoring sessions it was dedicated time. I know this individual was very busy, but they dedicated time, a venue and space for us to have our sessions. They weren't interrupted, and there was an end goal. I felt like I'd moved from one position… So I'd sorted through something that I wanted to achieve and I'd actually got to that position at the end of the mentoring sessions. Conversely, the negative one was that the sessions were interrupted. It was kind of just fitted in. So there wasn't an*

allocated space. It was quite ad hoc at times. I'd get a phone call, can you make it tomorrow at whatever time, and if I said no there'd be another long period before there was another session booked. The person would take calls as well. So it was just as though my time wasn't valued." (Margaret – Interviewee 1)

Finally, some participants acknowledged the value of coaching for the development of clinical leaders. Rebecca described how a coaching course heightened her awareness of how she communicates with people. She explained that she tries to involve people as much as possible in establishing their learning needs and utilises coaching techniques to support them to achieve their goals. Similarly, Kirsty stated that she enjoyed coaching staff and supporting them to develop and realise their aspirations. She also commented that the philosophy of supporting staff development was akin to the core values of occupational therapy, a point echoed by many of those interviewed.

CHAPTER 6: SYNTHESIS AND DISCUSSION OF FINDINGS

6.1 Introduction

This chapter begins by considering interview findings in light of the survey results presented earlier. The chapter then goes on to present a model of clinical leadership in occupational therapy that offers a structure and framework to address the key issues raised by participants. Next, the resonance of the key findings in relation to the wider literature is examined and limitations of the study are considered. There then follows a discussion of the main contributions and implications of the research to the body of knowledge, occupational therapy practice and policy. Finally, reflections on the research process, limitations of the study and personal reflections are presented.

6.2 SYNTHESIS OF FINDINGS

6.2.1 Defining clinical leadership

Interview participants agreed that clinical leadership in occupational therapy involved clinicians leading people and leading clinical services, focusing on the clinical priorities within a service. Some emphasised the importance of a clinical background whilst others emphasised the importance of maintaining a clinical caseload. There was a consensus that clinical leadership required expert knowledge in a chosen area of practice, an ability and willingness to support and develop people, and a passion for promoting and advocating for the profession. This aligned to feedback from survey respondents which ranked clinical expertise, people management and strategic thinking as key elements of clinical leadership.

Whilst the survey didn't ask whether participants considered themselves to be clinical leaders, almost all interviewees considered themselves to be clinical leaders regardless of role or grade. Furthermore, there was a consensus amongst interview participants that leadership occurs at all levels.

6.2.2 Importance of clinical leadership

The majority of survey respondents considered clinical leadership to be important or very important to them in their career, with interviewees emphasising the importance of leadership from within their own professional group. The survey revealed that 46.1% of those surveyed were line managed within their own professional group. However, when combined 48.3% received their line management via other professional groups including nursing, other health care professionals, social workers and the teaching profession. This point is noteworthy since content analysis of the final survey question indicated that participants questioned the effectiveness of management of occupational therapists by someone from a different professional group. Moreover, interviewees highlighted a concern that when a different profession is leading a team, the emphasis will be on the profession represented by the clinical leader. Moreover, a move to integrated working was seen by some to have weakened the profile, potential and scope of occupational therapists as clinical leaders thereby limiting opportunities available to them.

6.2.3 Clinical leadership effectiveness

Interview participants described effective clinical leaders as individuals who had self-belief and were: visionary, driven, authentic, effective communicators, self-aware, professional, approachable, encouraging, proactive, strategic thinkers and resilient. Again these findings support the results of the survey, which associated these attributes with the qualities, skills and behaviours of an effective clinical leader. Interview participants described authentic as being genuine, open and honest. This correlates with survey results which identified that honesty was considered to be the quality that is most characteristic of an effective clinical leader.

The survey illustrated that effective communication was the most important leadership skill, followed by clinical expertise, people management and strategic thinking. Interviewees highlighted the importance of effective communication with

regards clearly articulating the vision. They also highlighted the importance of actively listening and responding to queries and concerns thereby instilling confidence in order to bring people with them on the journey to realising the vision. Survey respondents placed clinical expertise as an important leadership skill, second only to effective communication. Interviewees also advocated the importance of clinical expertise, which came under the umbrella 'professional.' Professional signified leaders who were competent, credible and accountable. Here participants spoke about leaders demonstrating their clinical expertise, providing professional advice and ensuring adherence to professional standards of practice.

The survey showed that the majority of respondents considered that being motivating, supportive and empowering were characteristic behaviours of an effective clinical leader. In a similar vein, interviewees deemed encouragement as behaviour that symbolised effective leaders. These individuals were seen as being supportive of staff development, with one participant describing how the support and encouragement of one individual had been instrumental in her journey to becoming an occupational therapist.

6.2.4 Developing clinical leaders

The majority of survey participants considered 'on the job learning' important or very important for the development of clinical leaders. Similarly, three quarters of survey respondents acknowledged the importance of mentorship and formal leadership training for the development of clinical leaders. Content analysis of the final survey question revealed that opportunities for training, experiential learning and support were important for clinical leadership development. There was a consensus that occupational therapists need occupational therapy clinical leaders to encourage, motivate, empower and support the development of clinical leaders. This is consistent with interview findings, which highlighted that learning through experience, supervision and mentorship together with formal education and training, were important for the development of clinical leaders.

The survey identified that 28% of respondents held a postgraduate qualification and that half of this number were educated to Master's degree. The focus of postgraduate education included specialist clinical practice, professional development, service innovation, research methods, leadership and management. A number of interview participants had achieved Masters level qualifications whilst others expressed a desire to develop their careers through advancing education and clinical skills development. However, there was a concern amongst some participants that opportunities may be limited and that support and guidance is needed to prepare occupational therapists to be leaders.

The survey considered whether occupational therapists had encountered any barriers to their development as clinical leaders. The numbers reporting that they had encountered barriers was almost equal to those that hadn't encountered barriers. Where barriers were encountered, this related to opportunities for learning and development but also barriers to career progression. Structure was an emergent theme from the content analysis of final comments from the service, with participants commenting that structure was gradually being eliminated. Again this was consistent with interview findings, as some interviewees reported a very supportive culture where opportunities for learning and development were given full support whilst others reported that they were constrained by limited opportunities, reduced funding and the need to fulfil clinical priorities.

6.2.5 The profile of occupational therapists as clinical leaders

The survey highlighted that occupational therapists were predominantly employed within the NHS. There was a diversity of roles across the grade spectrum, with level of seniority indicated by grade, for example Band 5 through to Band 8 (NHS). Post titles also indicated level of responsibility for example lead occupational therapist, highly specialist occupational therapist and consultant occupational therapist. As previously mentioned the survey highlighted that almost half of survey respondents were line managed by other professions and interviews highlighted a concern that this

influenced how occupational therapists were represented and perceived. A survey respondent commented on the need for occupational therapists to have a strong identity with key people to push the leadership agenda, and warned that without this occupational therapy "would fall into the shadows of other professions e.g. nursing and physiotherapy." Similarly, interviewees acknowledged that level of seniority within an organisation increased a leader's sphere of influence and highlighted that whilst some occupational therapists had attained senior leadership positions there remained a culture of nursing dominated leadership at very senior levels. Finally, there was agreement amongst survey respondents and interview participants that occupational therapy has lost (or lacks) identity, which has impacted on the professions position as leaders. Both survey respondents and interview participants spoke of the need to seize the opportunity to raise the profile of the profession in order to influence the agenda with regards the future provision of health and social care. The consensus position was that more work needs to be done to support occupational therapists to have as high a profile as other leaders or risk "missing the boat."

The above synthesis demonstrates that the findings of the qualitative interviews support and illuminate the survey results. Occupational therapists are concerned about their professional profile, status and influence as clinical leaders. Moreover, findings indicate the need for a step change in the way that the profession positions, develops and markets occupational therapists as clinical leaders but also how the profession positions itself. This will be considered in the following section.

6.3 A MODEL OF CLINICAL LEADERSHIP IN OCCUPATIONAL THERAPY

This study indicates that occupational therapists are concerned about their position as clinical leaders both operationally and strategically. Participants spoke of the need for training, education and support for the development of clinical leaders. Equally,

participants emphasised the importance of the role occupational therapists and the professional body in enhancing the profile and position of the profession. However, what appears to be lacking is a formalised process to support and guide occupational therapists. Therefore, I propose a model of clinical leadership in occupational therapy that offers a structure and framework to enhance clinical leadership capability and address the key issues raised by participants (Figure 14).

Figure 14: A model of clinical leadership in occupational therapy



The model comprises six interconnecting elements that have been developed based on participants' feedback on what was important to them with regards to clinical leadership in occupational therapy. Each element will be considered in turn.

- Professional profile focuses on enhancing the profile and presence of occupational therapy and stems from a concern that the profession lacked identity and was overshadowed by other professions. Promoting the professions unique selling points and advocating the potential and scope of occupational therapy to key

stakeholders, through media campaigns for example, and advocating for the profession is a component of this element. Participants emphasised the importance of the role of the Royal College of Occupational Therapist (RCOT) in raising the profile of the profession but also recognised that occupational therapists have an individual responsibility to raise the profile of the profession.

- Clinical expertise places emphasis on enabling occupational therapists to develop expert knowledge in their chosen field and use that knowledge to support the development of clinicians, enhance clinical practice and contribute to the ongoing development of services. Developing clinical expertise not only requires clinicians to embark on training but also places emphasis on experiential learning and 'on the job training' to facilitate the development of clinical leaders.
- Research evidence is closely aligned to clinical expertise and has a focus on promoting research. Interview participants described occupational therapists as 'doers' and expressed a lack of confidence in occupational therapists' research ability. Thus, a key element of the model is that occupational therapists are encouraged and supported to be research active thereby providing the evidence base to advance clinical practice and enhance the professions profile and impact.
- Formal leadership training has a focus on scoping opportunities and providing support to occupational therapists to access leadership training and development. This is important as some participants cited access to training and education as a barrier to their development as clinical leaders.
- Professional development and support emphasises the need for occupational therapists to be supported and guided on their leadership journey. Supervision, coaching, mentorship and experiential learning are key to the on-going development of clinicians, current leaders and future leaders. There is also recognition that leadership occurs at all levels therefore packages of support need to be tailored to individual needs.
- Strategic positioning is closely aligned to professional profile and focuses on how occupational therapy positions itself as a profession that has a key role in

advancing the delivery of health and care provision. Strategic positioning centres on actively seeking out opportunities to promote the value, scope and potential of occupational therapy, using research evidence to demonstrate the contribution the profession can make within the health and care sector. Operationally, strategic positioning may be beneficial in helping to navigate some of the structural barriers that occupational therapists report have limited their career progression. Looking more widely, strategic positioning enables the profession to situate occupational therapists as key players in delivering on key national priorities. As with professional profile, strategic positioning requires occupational therapists to take an individual and collective responsibility for promoting their status and standing but it also requires input, support, guidance and direction from the RCOT.

In summary, the model of clinical leadership in occupational therapy comprises a framework of interconnecting elements that work in unison to facilitate clinical leadership development. The model offers flexibility in its use and permits the application of individual elements of the model to facilitate clinical leadership development dependent on an individual's specific learning needs. This flexibility means that the model can be applied at any stage in an individual's leadership journey to support and enhance their clinical leadership development.

6.4 DISCUSSION

This study highlights that clinical leadership is an important topic for occupational therapists and that occupational therapists' have the potential to be clinical leaders regardless of role or grade. However, findings also identified a number of issues and concerns that have challenged occupational therapists' position and influence as clinical leaders. These included:

- The low profile of occupational therapists; with a fear of loss of identity, professional standing and professional pride
- Leadership from a different profession may be to the detriment of occupational therapists
- Integrated working has diluted the potential and scope of occupational therapy
- Some occupational therapists have attained leadership positions but it is still nursing dominated
- Opportunities for development were not readily available
- Support and guidance is needed to prepare occupational therapists to be clinical leaders

The research aimed to gather and summarise occupational therapists' perceptions and experiences of clinical leadership, and to investigate the influence and impact of education, situational factors and social influences upon these perceptions and experiences, in order to provide recommendations for future training, development and practice. The discussion will consider the key issues arising from the synthesis of findings, as they relate to the research objectives and their importance in relation to the wider literature. The research objectives are listed below:

- To map the current roles, education, training and leadership experience of occupational therapists practising in the UK.
- To explore the key attributes of an effective clinical leader from the perspective of occupational therapists.
- To examine the impact of training and development on clinical leadership positions held by occupational therapists.
- To develop an understanding of the perceived barriers and facilitators influencing occupational therapists' leadership development.
- To use findings to generate recommendations for leadership training, development and practice.

6.4.1 The key attributes of an effective clinical leader

Survey and interview participants were consistent in their perceptions of what constituted an effective clinical leader. Key attributes included honesty, authenticity, motivation, effective communication, vision, self-awareness, being proactive, resilience and strategic thinking; as outlined in the synthesis of findings. These findings are consistent with those of Bondoc, Kroll and Herz (2008) and Kroll, Bondoc, and Herz (2008) who highlighted that interpersonal communication, organisational skills, time management and problem solving skills are essential management and leadership competencies.

There was a consensus amongst interviewees that occupational therapists were natural leaders and that this propensity to lead stemmed from the professions core values and the skill set derived from their training; focusing on motivating, supporting and developing people. The earlier brief summary and discussion of survey findings confirmed that this is consistent with Dillon's research (2001), which attributed an effective, authentic and accomplished leader's success to enabling others, focusing on the greater good, collaborative visioning and leadership through caring. George (2003) describes these attributes as the essence of authentic leadership; highlighting that a passion, purpose and commitment to values will result in meaningful and lasting relationships that gets results. Similarly, George, Sims, McLean and Mayer, et al (2007) assert that authentic leaders recognise that leadership is not about their own success but rather empowering leadership at all levels. Thus, authentic leaders not only inspire those around them but empower those individuals to step up and lead. The NHS Long Term Plan (NHS England, 2019) and the Interim People Plan (NHS Improvement, 2019a) acknowledge that AHPs can significantly support the demands the NHS faces and emphasise the importance of creating a leadership culture that is compassionate and inclusion. West and Bailey (2019) also point to the importance of leaders in healthcare systems being compassionate and inclusive to ensure that the

voices of all staff are heard and that there is a shared understanding of the challenges health and care staff face.

6.4.2 Occupational therapists' attainment of leadership positions

The survey identified that 46.1% of respondents were managed by occupational therapists. However, a greater number (48.3%) were managed by other professional groups; predominantly physiotherapy and nursing. Additionally, when looking at senior leadership, interviewees commented that there was a dominance of nursing at senior levels in comparison to occupational therapists or indeed other AHPs. One interviewee described nurses as being everywhere, occupying all the key positions. This dominance was attributed to the way organisations were structured and opportunities this presented, opportunities which were not available to occupational therapists. These findings are consistent with a review of the evidence by West, et al (2015) which highlighted that greater attention has been given to medical and nursing professions than to other clinical and non-clinical leadership roles in health care. Findings are also in keeping with the findings of a report by NHS Improvement (2018) which highlighted that board-level accountability for AHP issues is ultimately via the chief Nurse but issues may not be adequately represented due to the scale of the nursing agenda. Whilst the report is not specifically focused on occupational therapy leadership it encompasses all AHPs as a collective group and has been a trend with much of the work form NHS Improvement, for example the guide for trust boards and clinicians focusing on developing allied health professional leaders (NHS Improvement, 2019d).

This collective approach has brought AHP issues to the fore and has undoubtedly resulted in success with regards AHP leadership, as evidenced by the emergence of chief AHP roles (NHS Improvement, 2019c). However, it does lead one to question whether this has been at a cost for occupational therapists and whether it has

impacted on occupational therapists status and position as clinical leaders. Notably, one interviewee questioned whether clinical leadership in occupational therapy was any different to clinical leadership in any other profession, suggesting that occupational therapists need to be careful that they don't 'pigeon-hole' themselves. However, another stated that occupational therapy was perceived well when there was an occupational therapist or therapist at a very senior level within the organisation. This point was substantiated by a consultant occupational therapist who spoke of the need to have people at a senior enough level to have an equal conversation. She described her band 8b role as being not hugely senior, but sufficiently senior to represent the profession and be a voice of influence in decision making meetings.

It is clear from interview findings that occupational therapists believe that generic roles and integrated working have impacted their progression to senior leadership positions. Furthermore, participants believed that integrated working had made it very difficult to maintain the profile of the profession and market the potential contributions that occupational therapy can make. However, it is also of vital importance that occupational therapists seize potential opportunities. Brindle (2015) commented on the role that occupational therapists have in the meeting the challenges of future health and social care provision, noting that whilst no single group of professionals holds complete responsibility, occupational therapists may have more influence than most. This gives occupational therapists a clear platform to promote the potential and scope of the profession but requires a professional responsibility and strong leadership to ensure these messages are communicated and received. This position is reinforced by Fleming-Castaldy and Patro's study (2012) which concluded that strong leadership capabilities are influential in times of change and reform. It also echoes Rodger (2012) who encouraged occupational therapists to identify themselves as leaders wherever they are positioned within organisations, urging them to embrace leadership opportunities so that leadership is recognised and celebrated as being very much a part of the profession's territory. The model I propose addresses these issues

and advocates that occupational therapists promote their unique selling points at every available opportunity; and that the RCOT market the potential and scope of occupational therapy to key stakeholders, through media campaigns and at key national forums.

6.4.3 Supporting the development of clinical leaders

The research identified that a combination of learning through experience, supervision, mentorship, training and formal education were important for the development of clinical leaders. This aligns with NHS Improvement's Developing Allied Health Professional Leaders Guide (NHS Improvement, 2019d), which highlights the importance of combining formal learning with mentorship and guidance. The model of clinical leadership in occupational therapy that I propose, draws on these key insights and provides a framework to guide and support clinical leadership development.

With specific reference to mentorship, the findings are consistent with those of Schemm and Bross (1995) who recommended that plans to initiate mentorship programmes should include activities that promote powerful leaders beyond the status and position of their mentors. The findings also correlate with those of Burtner, Crowe and Lopez (2009) and Lapointe, Baptiste, von Zweck, and Craik (2013) who emphasised the importance of effective and inspirational leadership, effective role modelling and the use of mentorship strategies to increase leadership capacity and ensure the continued growth of occupational therapy as a profession.

Participants reported mixed experiences with regards the opportunities for learning that were available to them but all agreed that more support and guidance were needed to develop clinical leaders. This builds on the findings of Bondoc, Kroll and Herz (2008) and Kroll, Bondoc, and Herz (2008) whose study of the knowledge, skills, competencies and personal attributes required to succeed in management roles concluded that further support is required to prepare occupational therapists as leaders, managers and administrators. A number of participants felt that leadership

should be an essential component of occupational therapy undergraduate education. They reported that final year students now complete a leadership or management module as part of their training and education but that this was not their experience. They highlighted the importance of embedding leadership concepts into the occupational therapy curriculum from the outset, ensuring that this is a continuous thread throughout the whole programme, that it is developed whilst out on placement and that it continues post qualification. In so doing, students will be better equipped to link the theory to practice and make more informed decisions about their development needs as they embark on their career path.

Participants emphasised the importance of mentorship to support the development of leaders but also pointed to the need for emerging leaders to take responsibility to demonstrate their leadership potential. These findings align with those of Heard (2014) who highlighted the importance of embedding leadership concepts into the occupational therapy curriculum and ensuring this continues post qualification. They also support the findings of Lachter and Ruland (2018) who advocated peer-mentoring for the development of essential professional skills and leadership development from an early stage. Participants also highlighted the importance of experiential learning and pointed to the significant impact of positive role models and negative experiences on their development and their approach to leading people and services. This aligns with Ziviani (2017) who emphasised the importance of leaders valuing, respecting and nurturing staff in order to achieve successful outcomes.

A number of participants suggested that the Royal College of Occupational Therapists (RCOT) needed to do more to prepare occupational therapists for clinical leadership, suggesting a need for information, courses and resources that are easily accessible. The RCOT Career Development Framework (RCOT, 2017) and RCOT Strategic Intentions 2018-2023 (RCOT, 2018) offer support and guidance for professional practice, professional development, research development and leadership. These resources are intended for staff practicing at all levels within the profession. However, there was a

perception amongst some participants that RCOT resources needed to be more prominent and that the RCOT needs to be more proactive in terms of what it offers. However, others believed that information was readily available and that people needed to put in the effort to find it and take responsibility for their part in shaping their development. This is consistent with the findings of the study by Heard (2014), which highlighted the need for emerging leaders to take responsibility to demonstrate their leadership potential.

6.4.4 Professional profile

Study participants voiced concerns regarding the profile of occupational therapists; fearing a loss of identity, professional standing and professional pride. Participants described instances where occupational therapy was not recognised for its unique skills and the valuable contribution the profession brings to patient care. For the most part, this was in relation to how other professions viewed occupational therapy. However, this was not always the case. In fact, one participant recalled being welcomed onto an undergraduate occupational therapy programme and being described as a failed physiotherapist. The interview participant questioned whether issues of identity, value and recognition were institutional, potentially stemming from university. However, the fact that the comment came from an occupational therapist implies potentially deep rooted issues around professional identity and pride. It is important that curriculum development promotes occupational therapy in a positive light that inspires future leaders and supports the continual growth of the profession (Burtner et al, 2009) but there is also a need for the profession to enhance its profile as outlined in the model of clinical leadership in occupational therapy that I propose. It is hoped that an enhanced profile will restore the professional pride that is missing for some

Several participants believed that an emphasis on “doing” had placed occupational therapy in the shadows of other professions, particularly nursing and physiotherapy which were viewed as having a long history of engagement in audit and research,

leading clinical developments, leading teams and attaining leadership positions within senior organisational structures. Participants felt that as a profession, occupational therapists were not good at research and needed to do much more to evidence and showcase the value, potential and scope of occupational therapy in leading change and transforming patient care. These findings are consistent with Heard (2014) whose study highlighted that nursing journals had placed specific emphasis on leadership as a professional obligation and an area for continued research, whilst other health professions including occupational therapy had a limited volume of leadership studies. There was also a call to ensure that evidencing the value, scope and potential of profession relates to current policy. This is particularly important given that the NHS Long term Plan (NHS England, 2019) and the Interim NHS People Plan (NHS Improvement, 2019a) acknowledges that AHPs can significantly support NHS demands. Meeting the health care needs of the 21 century will require a diversity of skills and innovation, and occupational therapists' skill set make them ideally placed to support the delivery of health and care provision.

6.4.5 The Role of the Royal College of Occupational Therapists

The study identified that occupational therapists have divergent views with regards the role of the RCOT in promoting and supporting clinical leadership development. Some thought that the RCOT did a good job whilst others felt that as a professional body, RCOT needed to do much more to raise the profile of the occupational therapy in order to strategically position itself as a key player in healthcare delivery. Participants emphasised a need for the occupational therapy profession to be proactive in increasing its status and profile, with more promotional activities and key people to push the leadership agenda. The synthesis of findings highlight that participant's saw the nursing profession and physiotherapy as being proactive in 'getting a seat at the table' and being a part of national conversations that influence healthcare provision, change and reform. Participants believed that the RCOT did not hold the same profile and status as the nursing and physiotherapy professional bodies,

which they saw as limiting. Notably, these perceptions reflect participants own experiences of their position and status as clinical leaders and reinforces the need for strong professional leadership (Jones, 2019) and innovative leaders who are able to collaborate with policy makers (Hunter (2013).

Participants felt that individually and collectively occupational therapists had a professional responsibility to promote the profession and increase the presence, impact and leadership capacity of occupational therapy across health and care services. Some pointed to the importance of the role of the RCOT within this, suggesting that more information, direction and support was required. However, the presence of a number of publications and practice resources (COT, 2016, RCOT, 2018 and RCOT, 2019) would suggest that the RCOT is already working to raise the profile of the profession. In spite of this, some participants still felt that much more information and support was needed with regards promoting the profession, which may suggest that the information does not have the reach or impact. However, others believed that sufficient information was available and that it was individual choice with regards how much people engaged with promoting the profession.

Participants spoke of the need for the RCOT to do more to prepare occupational therapists for clinical leadership, suggesting a need for information, courses and resources that are easily accessible. As previously stated, the RCOT Career Development Framework (RCOT, 2017) and RCOT Strategic Intentions 2018-2023 (RCOT, 2018) offer support and guidance for professional practice, professional development, research development and leadership. However, a lack of knowledge and awareness of these resources would again suggest that the information is not having the intended reach and impact. This would suggest that a different approach needs to be considered but it is also an opportunity to adopt the model I have proposed, as the key elements will support occupational therapists to navigate the support, information and resources they need to facilitate their clinical leadership

development. The model may also be a resource for students embarking on their journey, enabling them to access information to support their learning. This early exposure may be one way of increasing the reach and impact of information coming from the RCOT.

6.5 Limitations of the study

The limitations of the study have been highlighted by chapter but will be given further consideration and consolidation here. Phase one of the study comprised a small scale survey of qualified occupational therapists that were employed in the UK across a range of employing organisations and across a range of practice settings. The survey elicited a low return rate despite the application of follow-up measures aimed at increasing return potential (Cook, Dickinson and Eccles, 2009). Thus, whilst survey results offer a view of occupational therapists perceptions and experiences of clinical leadership in professional practice, the results cannot be seen as representative of the wider population of occupational therapists. The use of an electronic or web-based survey may have yielded a higher return rate, although there is evidence that highlights that postal surveys elicit a higher response rate than those sent electronically (Sheehan, 2001, James, 2007, and Shih and Fan, 2009). However, Kroth et al (2009) found that a combined approach using email surveys followed by postal surveys yielded a higher return. The use of surveys delivered by electronic means, whether that be web-based or email should be a future consideration, particularly as digital technology is more accessible and has a greater reach.

The survey did not profile participants' demographic details such as age, sex and ethnicity, which may have been useful in establishing whether these factors had influenced participants' experiences. However, a follow-up telephone call aimed at increasing survey returns, highlighted that there may have been a reluctance to complete the survey due to concerns that anonymity could be compromised. Given this apprehension, I didn't want to include questions that may have enabled

participants from minority groups to be identified. A further limitation of the survey was that participants were not asked if they considered themselves to be clinical leaders or if they wanted to be clinical leaders. However, they were asked if clinical leadership was important to them in their career. The inclusion of a question that specifically asked participants if they considered themselves to be clinical leaders would have illuminated findings. This was an oversight and a question that was included in phase two of the study, which enabled an in-depth exploration of the question.

The qualitative phase of the study comprised in-depth interviews with 13 occupational therapists that had taken part in the survey and expressed an interest to take part in the interviews. Purposive sampling of participants using maximum variation led to the selection of participants. This approach was adopted because it provided a small sample that was representative of the wider occupational therapy population that participated in the survey. A potential limitation of using this approach was selection bias which could potentially have resulted in the sample not being representative of the population. However, when selecting participants for interview I was conscious that I considered their work setting, their level of experience, their specialism and their grade to enable a select that was representative of occupational therapists that participated in the survey.

Whilst some participants were satisfied with the work of RCOT, interview findings highlighted that the RCOT needs to take a more proactive stance in raising the profile of occupational therapy and in promoting the potential and scope of the profession, nationally. Findings also point to the need for RCOT to provide more resources and guidance to support the leadership development of occupational therapists. Whilst the interview sample comprised a cohort that was representative of the survey sample, it did not include members the RCOT, as they were not represented in the survey sample. Given that the interviews point to a need for the RCOT be more

proactive in raising the profile of occupational therapy and providing greater support and direction for the development of clinical leaders, in hindsight it would have been beneficial to interview representatives from the RCOT to gain their perspective on clinical leadership.

Finally, the analysis of interviews involved rigorously checking interview transcripts against audio recordings to ensure that transcripts were an accurate reflection of what was said. In hindsight, member checking would have been a useful mechanism to confirm that interviewees were happy with content and that there was nothing further they wished to add. However, interview findings validate and build on the survey results, thus providing assurance on the findings of the study as a whole.

6.6 Summary

The discussion examined research findings in the context of the wider literature and the confirmed the results of previous research, particularly with regards supporting the development of clinical leaders. However, findings also suggest that concerns regarding occupational therapists' position and influence as clinical leaders was worthy of investigation, as the study identified that occupational therapists need a structure and framework on which to build and develop clinical leadership capacity. These issues will be considered in the following sections which highlight the main contributions of this study to the body of knowledge, practice and policy.

6.7 Contribution of the research to the body of knowledge

Embarking on this research journey highlighted that there is a paucity of research regarding clinical leadership in occupational therapy. The available research has been described as being limited in volume and disparate in focus (Heard 2014), thus justifying the need to explore this phenomenon.

The study has confirmed that clinical leadership is an important topic for the profession and offers an insight into occupational therapists perceptions and experiences of clinical leadership in professional practice. The study has highlighted the key attributes of effective clinical leaders and identified the support required to facilitate clinical leadership development. Findings confirm those of previous studies, which highlight the importance of effective and inspirational leadership, effective role modelling and the use of mentorship strategies to increase leadership capacity and ensure the continued growth of occupational therapy as a profession. Findings also support previous studies that highlight the need to ensure that leadership is an integral component of undergraduate education and that opportunities for clinical leadership development are made available along the career trajectory.

This study has highlighted that the identity, profile and status of occupational therapy is a concern for the profession and that organisational structures have limited occupational therapists potential to progress to senior positions of leadership and influence. Whilst it was acknowledged that some occupational therapists had attained leadership positions, participants spoke of nursing dominated leadership and highlighted a concern that occupational therapy would fall into the shadows of other professions without a sustained effort to raise the profile, scope and potential of the profession.

Participants highlighted the valuable contribution that occupational therapists make to the provision of health and care but stated this needed to be marketed and promoted. Whilst some acknowledged the efforts of the RCOT and pointed to an individual responsibility to promote the profession, others believed that the professional body needed to do much more to promote and raise the profile of occupational therapy.

It has already been stated that there is a paucity of research regarding clinical leadership in occupational therapy. Previous studies have focused on particular

specialisms or practice settings. Thus, this research adds to the body of knowledge by contributing a perspective of clinical leadership in occupational therapy from clinicians employed across a range of practice settings and across the grade spectrum.

Participants in this study expressed concern regarding occupational therapists' research ability. There was a consensus that occupational therapists focus on clinical delivery and that research undertaken has tended to follow that path. Thus, participants called for occupational therapists to be research active, not only in relation to clinical practice but also clinical leadership. My proposed model of clinical leadership in occupational therapy acknowledges these concerns and advocates that research evidence and developing clinical expertise are key element in clinical leadership development for occupational therapists.

In summary, this study confirms and illuminates findings of previous studies but importantly it also brings a UK perspective that has been lacking, as previous studies were undertaken outside the UK, including USA, Canada, Australia and South Africa. To date there is no defined model of clinical leadership in occupational therapy for practising occupational therapists. Moreover, the study highlights the importance of evidencing the value, scope and potential of the profession whilst ensuring this relates to current policy. Therefore, as a result of undertaking this research, I propose a model of clinical leadership in occupational therapy that provides a framework and structure to enhance clinical leadership capacity and address the key issues raised in this study.

6.8 Implications of the research for policy

The literature, as outlined in Chapter 2, highlights that clinical leadership is high on the healthcare agenda and is seen as the method to provide high quality, responsive and sustainable services (Department of Health, 2008). The study highlighted that participants believed that occupational therapists have the potential to be clinical

leaders regardless of role or grade, stating that occupational therapists were natural leaders. Despite these findings participants also identified that organisational structures, access to training and education and the professions profile had challenged occupational therapists' position and influence as clinical leaders. The literature (Brindle, 2015 and Jackson, 2016) highlights that occupational therapists have a powerful role to play in meeting the challenges of 21st century health and social care, and interviews highlighted an awareness amongst some that the RCOT had engaged in a media campaign to promote the value of occupational therapy. However, not all study participants were aware of the breadth of work undertaken by the RCOT. Furthermore, there was a consensus that the opportunities for occupational therapists to lead on clinical developments, research and transformational change was not being realised. These concerns are worthy of further exploration and it is recommended that RCOT consults with its members to understand the issues in order to ensure that in the midst of any developments the occupational therapy voice is not lost and that the profession maintains its identity, professional standing and professional pride.

The literature also highlights the work undertaken on clinical leadership from an AHP perspective, as evidenced by the push for chief AHP roles and greater board level representation from AHPs. AHPs are the third largest clinical workforce after doctors and nurses (Chief Allied Health Professions Officer's Team (2017) and occupational therapists are the third largest profession within AHP group (HCPC, 2019). West et al (2014) advocate collective leadership which requires each member of an organisation to not just focus on their area of work but to take responsibility for the organisation's success as a whole. This works wells when considering AHPs as a collective group but should not be to the detriment of individual professions. Given that the research highlighted that occupational therapists were concerned about the professions profile and impact, it is suggested that the RCOT work with NHS England/Improvement and other national bodies to ensure that the value, scope and potential of occupational

therapy is firmly on everyone's agenda and considered in policy development, improvement initiatives and transformational programmes .

6.9 Implications of the research for practice and future leadership

This study has highlighted that the occupational therapists have the knowledge skills and ability to undertake clinical leadership roles. There was a consensus that occupational therapists believed that a focus on clinical delivery and development of expert clinical skills positioned them well for clinical leadership. However, there was a concern that this focus, together with organisational limitations had also hindered occupational therapists' progression to senior leadership roles. Occupational therapists in the study highlighted that the profession needed to be proactive in promoting the value, scope and potential of the profession in order to ensure that occupational therapy is on everyone's agenda. This was considered to be both an individual and collective responsibility without which the current status will remain unchanged.

This study began with an introduction to the profession of occupational therapy, which described how occupational therapists support people whose health prevents them doing the activities that are meaningful and important to them, with the aim being to maximise independence in these activities. It went on to explain that occupational therapists may work within the NHS, social care services and other sectors; with a focus on building self-reliance rather than dependency on services (Scott, 2017). The Long Term Plan NHS (NHS England, 2019) and the Interim NHS People Plan (NHS Improvement, 2019a) are very clear that the future delivery of health care will require diverse skills and transformative change in order to meet the needs of 21st century health and care. There is also an acknowledgement that AHPs will be instrumental to delivering the plan. Thus it is imperative that occupational therapists position

themselves clinically and strategically to not only participate in care delivery but to lead on improvement and transformation programmes.

The work of occupational therapists in meeting the challenges of delayed hospital discharges has been described by Jackson (2016) as a quiet revolution that was pushing occupational therapists to the forefront of healthcare. However, this study suggests that occupational therapists' quiet persona has been to the detriment of the profession. Therefore, occupational therapists need to:

- Proactively seek opportunities to demonstrate how they can contribute to delivering health and care in challenging times
- Advocate for the profession
- Promote the diverse areas of practice and highlight scope of practice
- Use evidence and research to promote and profile the profession
- Work with RCOT and use available RCOT resources

Equally RCOT need to engage with members to ensure that concerns are heard and that appropriate support is provided to ensure occupational therapists are the clinical leaders on this very important agenda. Thus, the proposed model emphasises the importance of strategic positioning to enable the profession to position occupational therapists as key players in delivering on key national priorities.

Finally, this research has culminated in the development of a model of a model of clinical leadership in occupational therapy that offers a structure and framework to enhance clinical leadership capability and address the key issues raised by study participants. The model, comprising interconnecting elements offers flexibility in its use and permits the application of individual elements of the model to facilitate clinical leadership development dependent on an individual's specific learning needs. Thus, model can be applied at any stage of an individual's development journey to support and enhance their clinical leadership development.

REFLECTIONS

My reflections on this research journey will be considered in two parts. Part one provides my reflections of the research process and considers the limitations of methods employed to complete the research. Part two provides a personal reflection of my research journey.

Reflections on the research process

Undertaking this research has been journey of self-discovery, as well as a journey in learning more about research. The taught components of the programme provided a firm foundation on which to increase my understanding of the theoretical underpinnings of research and research methods. By choosing to undertake mixed methods research it was important that I had a sound understanding of both qualitative and quantitative research methods. Based on my previous studies I felt relatively comfortable with approaching qualitative research but less comfortable with quantitative research, particularly statistics. However, taught components, statistics drop-in clinics, use of online resources and YouTube videos were instrumental to facilitating my understanding, navigation and application of SPSS.

Reflecting on the quantitative phase of the study, an identified limitation was that I didn't include a question asking whether respondents considered themselves to be clinical leaders. Given the research was aimed to explore occupational therapists' views on clinical leadership this was an important question to ask, and was included in the qualitative interviews. With regards to distribution and return of questionnaires, I was conscious that I had been sent questionnaires in the past, which I hadn't completed. This was not due to a lack of interest but because of time restraints and competing priorities. I hoped that occupational therapists would take an interest in my survey and was encouraged when responses arrived in the post. In an ideal world I would have liked to have received many more responses but felt confident that I had done all that I could to maximise return potential.

Reflecting on the qualitative phase of the study, I would have ideally liked to have transcribed all interviews. However, time constraints and the competing demands of work and family commitments did not allow for this. Whilst I was unable to transcribe all interviews I do not believe this impacted on the quality of my data analysis as I read and re-read transcripts as I listened to digitally recorded interviews to check accuracy. In addition I wrote interview summaries and took field notes, which were all used to facilitate data analysis.

A Personal reflection

As an occupational therapist, I have encountered many different styles of leadership that have influenced my views on what constitutes effective leadership. In fact, recognising the qualities that I value in a leader was something I was acutely aware of even before I gained my qualification as an occupational therapist. As a student I recall my most memorable placements were the ones where my practice educators were supportive, provided time and space to listen to concerns, created learning opportunities and gave constructive feedback.

Post qualification, I became more aware of the different styles of leadership adopted by my line managers and supervisors and the impact this had on me and my clinical practice. I learned that I was more receptive to supervisors who were supportive and inclusive as opposed to those who were much more authoritative in their approach to leading individuals and teams. As I gained experience and progressed to a senior clinical role with responsibility for junior staff, I consciously strived to be supportive and inclusive as these were the role model behaviours that framed my positive experiences. However, I soon learnt that leadership requires an element of flexibility as situations often arise where a more directive or authoritative approach is required to 'get the best' from individuals and teams. This was a steep learning curve which

helped shape how I approached my future leadership of individuals, teams and services.

Reflecting on my own leadership journey, the influence of roles models, experiential learning and line manager support to access training and education have been instrumental to my leadership development. Not all experiences have been positive but each experience has contributed to my professional growth and development. Speaking to colleagues I realised that my experience was not unique and that anecdotal feedback highlighted a frustration amongst some occupational therapist that the true value, potential and scope of occupational therapy was not being recognised. Hearing these concerns and discovering there was limited written information about clinical leadership in occupational therapy ignited my interest and motivation to undertake this research.

CONCLUSION

This study sought to explore occupational therapists perceptions and experiences of clinical leadership in professional practice. The rationale for the study was that relatively little had been written about clinical leadership in occupational therapy from a national or indeed international perspective. Mixed methods were employed to undertake the research. Findings of a qualitative interview supported and illuminated the results of an earlier survey. The study identified the key attributes of an effective clinical leader and highlighted that occupational therapists were considered to have these qualities. The study also highlighted that whilst occupational therapists were considered to have clinical leadership skills and attributes, they were limited in terms of access to clinical leadership development opportunities and opportunities for progression. Key findings from the study were that:

- Honesty, empowering others and effective communication are key to effective clinical leadership

- A combination of learning through experience, supervision, mentorship, training and formal education are important for the development of clinical leaders
- Occupational therapists need to take responsibility for the role they play in their clinical leadership development
- Direction from Royal College of Occupational Therapists is important for clinical leadership

This study is significant because it provides an account of occupational therapists views on a subject that has received very little attention in the occupational therapy literature. The study gave occupational therapists a voice which allowed them to discuss issues which concerned them but also provided the opportunity for them to make recommendations for improvement, culminating in the development of a proposed model of clinical leadership for occupational therapists. Notably participants expressed an appreciation for the research, which is summed up by one participant who reflected on her leadership journey thus:

> *"To have information and literature written by other OTs, you know, maybe about leadership through an OT lens, could have been really useful at that time... so your work's going to be really useful."*

It is hoped that this study will be a reference for occupational therapists embarking on their leadership journey and that this view from an occupational therapy lens will be a source of support and guidance.

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APPENDICES

APPENDIX 1: NARRATIVE OVERVIEW OF RESEARCH

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
A Case Study of Occupational Therapy Managers in NSW: Roles, responsibilities and work satisfaction. **Gamble J. E, Lincoln, M. and Adamson, B. (2009) Australian Journal of Occupational Therapy 56: pp.122-131**	To explore the roles and responsibilities of occupational therapy managers who are clinician managers or manager-administrators, and sources of their work satisfaction, in order to provide a deeper understanding of the work of occupational therapy managers in NSW.	**Qualitative** - Case study. - Purposive sample of 16 occupational therapy managers, holding a broad range of positions and contexts (six manager-administrators and 10 clinician-managers) - Semi-structured telephone interview	1. What are the management responsibilities occupational therapy managers assume? 2. Are their differences between the two categories of occupational therapy managers in terms of their characteristics, and if so what are they? 3. What do occupational therapy managers perceive as the main sources of satisfaction and dissatisfaction in their work and are their differences between the two groups?	Six emergent themes but no clear differences between the two types of manager: - Manager administrator category is dependent on the number of people being managed. - Taking a clinical case load is at the discretion of the manager. - Managers engage in a broad range of typical management roles and responsibilities for both categories. - Balancing priorities and the work as a clinician and manager - Managing people - a source of joy and a source of frustration. - Mediating between staff and senior management and the autonomy to make management decisions.	Seeking opportunities to develop skills in people management and organisational politics can enhance effectiveness and work satisfaction. Further research on the work of occupational therapy managers is required to build on the findings of this exploratory study.	Focus on clinical leadership
Leadership, Administration, Management, and Professionalism (LAMP) in Physical Therapy: A Delphi Study **Lopopolo, R. B, Scafer D.S. and Nosse, L. J. (2004) Physical Therapy 84 (2):pp.137-150**	To define the range of LAMP components relevant to physical therapy clinical management and to explore the LAMP knowledge and skills required of physical therapists upon entry into the profession.	**Quantitative** - Delphi survey. - Survey conducted in three rounds via the internet. 81 clinical managers agreed to participate in the study. 44 completed rounds one and two and 34 completed all three rounds.	1. Is the list of (expanded) LAMP components complete in that it encompasses all the LAMP content used by physical therapists who work as clinicians? 2. What are the most important LAMP components for physical therapy management?	- Respondents agreed that 178 items should be on the LAMP component list - Almost all components important in the management of clinical practice - Some components may not need to be a feature of professional education but minimal to moderate knowledge and skill required in the majority of LAMP categories.	The study provides a basis for the use of LAMP in entry level physical therapist curricula and which should be learned after graduation but further research is needed to take into account the views of a broader and more representative sample.	Need to establish what leadership skills are important for: a) graduates, b) clinicians, c) managers.

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
			3. What levels of knowledge and skill in each LAMP component are needed by new graduates?			
A Study of the Skills and Roles of Senior-Level Health Care Managers **Guo, K. L. (2003) Health Care Manager 22 (2): pp.152-158**	Identify and analyse the skills and roles of senior-level managers appropriate for the current healthcare environment.	**Qualitative** Semi-structured interview with ten senior-level health care managers with at least five years' experience in health care and educated to degree level as a minimum.	Question not explicitly stated but participants were interviewed to determine the most vital skills and roles needed to perform their tasks from a descriptive of skills and roles of managers.	From a list of 24 roles drawn from 4 models, six essential managerial roles were identified: leader, liaison, monitor, resource allocator, disturbance handler and strategist. Each role requires associated skills including human relations, technical and conceptual. A graduate degree alone is inadequate preparation for senior level management positions	A combination of education and experience would be the preferred method for gaining skills. Further, even those in senior-level management must continually advance knowledge to stay ahead of the competition.	Need to consider the influence/impact of knowledge, skills and experience on leadership.

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
Three Perspectives on Physical Therapist Managerial Work **Scafer, D. S. (2002) Physical Therapy 82 (3):pp.228-236**	To ascertain the perceived importance of managerial role and skill categories among three groups of physical therapists, in order to better understand the work priorities of physical therapist managers.	**Quantitative** Three groups simultaneously surveyed using the same instrument. **Sample** - one faculty member from each US physical therapy accredited education programmes (n=61/155), 161/300 randomly selected physical therapists holding management positions in US hospitals, 121/375 randomly selected physical therapy private practitioners.	Faculty members were asked to rate how important they thought each activity (from 11 work roles) was to physical therapist managers. Both clinical manager groups were asked to rate the importance of each activity as part of their job.	All groups identified communication, financial control, entrepreneur, resource allocator and leader as the 5 most important categories, suggesting these are universal across study populations. Technical expert and figurehead were rated least important. **But** differences between faculty members and private managers in 15 work categories, hospital managers and private managers in nine categories, and faculty members and hospital managers in eight categories. Work setting appears to have an impact on the level of importance placed on managerial work categories.	Study contributes to the process of identifying a universal description of physical therapist managerial work but obtaining evidence from practicing managers on what they actually do rather than their perceptions will help to facilitate development of measures of managerial competence.	Do occupational therapists have unique leadership skills/ qualities?

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
Variables that Contribute to Leadership Among Female Occupational Therapists **Scott, W. E. (1985) The American Journal of Occupational Therapy 39 (6):379-385**	To investigate factors contributing to leadership among female occupational therapists, by comparing leaders with those who have not occupied leadership positions.	**Quantitative** Questionnaire containing 118 items - several drawn from existing instruments including those focusing on traditional division of labour, power structures, political status of women. **Sample** – Leaders of the profession (n=103) divided into four categories – AOTA Executive Board members, Directors of OT curricular throughout the US, College Deans who are female OTs, Recipients of Eleanor Clarke Slagle lecture Non-leaders (n=600) randomly selected and stratified into three groups of 200 each.	1. Which characteristics differentiate leaders from non-leaders? 2. Which support systems differentiate leaders from non-leaders? 3. Which characteristics and support systems contribute most heavily to women's rise to leadership roles?	Demographically no difference found between leaders and non-leaders. Leaders saw themselves as leaders and desired leadership. Variables that distinguish leaders from non-leaders are socialisation, work history, leadership role, sex role, and role in the marriage and family.	Study highlights the importance of experiences that develop managerial, competitive and leadership skills.	Consider the influence of personal experiences on leadership.
Mentorship Experiences in a Group of Occupational Therapy Leaders **Schemm, R. L. and Bross, T. (1995) American Journal of Occupational Therapy**	To describe the mentorship experiences of occupational therapy leaders.	**Quantitative** 30 item questionnaire distributed at the annual state association meeting. **Sample** – Attendees at the Annual Meeting of State Association Presidents (CSAP).	1. Questions about age, economic background, marital status and mentor/ mentee experiences. 2. Questions about mentor, such as age and profession. 3. Participants asked to list the characteristics they	Respondents were exposed to role models, were assisted by sponsors, or were mentored or acted as mentors. Little evidence that respondents were mentored by high powered individuals that helped launch their careers.	Plans to initiate mentorship programmes should include activities that promote powerful leaders beyond the status and position of their mentors.	Consider impact of models of professional development on leadership.

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
49 (1): 32-7		Number of attendees not specified but 53 CSAP officers completed the questionnaire.	would look for in a mentor. 4. Participants asked whether a state association mechanism to foster networking existed.	Relatively few surpassed the status and position of their mentors.		
Authenticity in Occupational Therapy Leadership: A Case Study of a Servant Leader **Dillon, T. H. (2001) American Journal of Occupational Therapy 55 (4):441-8**	To gain an understanding of the leadership of an occupational therapy educator – Genevieve Cummings.	**Qualitative** Ethnography Modified life story approach, using semi-structured interviews **Sample** – Snowball Faculty, staff, administrators and friends who the educator well. 29 interviews – 1 hour Plus, review of departmental and personal files; and telephone/ email communication with people that had worked with the subject of the study.	1. Questions about the subject's approach to work as a teacher, administrator, mentor and leader. 2. Questions about the subject's values, priorities, assets, areas for improvement, accomplishments and examples of leadership.	The subject of the study was an effective, authentic and accomplished leader whose success was attributed to; - enabling others - focusing on the greater good - collaborative visioning and - leadership through caring Service	The leadership style presented serves as a model for occupational therapists that have multiple challenges, pressures and roles.	Whilst self-perceptions of leadership are important it is useful to gain the perspective of others.
An Emerging View of Mastery, Excellence and Leadership in Occupational Therapy Practice. **Burke, J. P and DePoy, E. (1991) American Journal of Occupational Therapy 45 (11): 1027-32**	To determine the characteristics of occupational therapists' mastery and excellence in practice and explore the degree to which they engaged in leadership behaviour.	**Qualitative** Semi-structured interview and observations in practice setting. **Sample** – 10 occupational therapists who met the research team's (eight experienced practitioners in an advanced master's class) perceptions of	1. What are the common and distinguishing elements of mastery in occupational therapy? 2. What are the common and distinguishing elements of excellence in occupational therapy? 3. What are the common and distinguishing	Mastery, excellence and leadership are independent of one another but some characteristics are common to each of these phenomena. Excellence is surpassing external standards and mastery is achievement of the standard on an individual level.	Important for occupational therapists to understand the developmental steps involved in mastery, excellence and leadership. Informs curriculum development.	Need to consider what is important in leadership – power, influence, expertise.

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
		mastery, excellence and leadership. Interviews (n=10) – seven in person, three telephone Observations (n=7)	elements of leadership in occupational therapy? 4. What are the relationships among mastery, excellence and leadership in occupational therapy?	Link between excellence and leadership lies in public recognition. Leaders have power and influence Leader and excellent practitioner need each other to promote change.		
Faculty Perceptions of Occupational Therapy Programme Directors' Leadership Styles and Outcomes of Leadership **Snodgrass, J. and Shachar, M. (2008) Journal of Allied Health. 37 (4): 225-35**	To investigate the relationship between faculty perceptions of occupational therapy programme directors' leaders and outcomes of leadership and the effects of moderating demographic and institutional characteristics.	**Quantitative** Multifactor Leadership Questionnaire Form 5X and self-designed Demographic and Institution Questionnaire. **Sample** – 184 graduate occupational therapy faculty members from 95 (65%) of all accredited academic occupational therapy programmes in the US for the 2005/6 academic year.	Questions/statements to measure leadership based on seven factors related to transformational leadership.	Overall transformational leadership had a significant positive predictive relationship with the leadership outcomes whilst transactional leadership had a significant negative predictive relationship. However transactional leadership was found to be a positive predictor of leadership outcomes. Thus most effective leaders in academia combine transformational and transactional leadership styles. Demographic and institutional characteristics did not significantly influence on leadership styles and outcomes.	Both transformational and transactional styles are important for effective leadership.	Consideration needs to be given to self-perceptions of leadership.

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
Leadership Qualities of Occupational Therapy Department Programme Directors and the Organisational Health of their Departments **Dudek-Shriber, L. (1997) American journal of Occupational Therapy. 51 (5):369-77**	To investigate the leadership of occupational therapy programme directors, the organisational health of their departments, and the relationships between them.	**Quantitative** Organisational Health Assessment - survey to determine how directors of accredited occupational therapy programmes and faculty members perceive their departments' organisational health. Also, faculty members surveyed for their perception of their programme directors' leadership, using the leadership behavior questionnaire. **Sample** – 65 directors of accredited occupational therapy programmes and 185 faculty members.	1. Questions to establish the personal and departmental background of programme directors 2. Leadership behavior questionnaire used by faculty members to describe the leadership behaviors of their programme directors 3. Conways organisational health questionnaire	Faculty and respondents rated their departments high in organisational health. Faculty respondents rated the overall leadership of directors as average. Strong relationship between leadership and organisational health.	Informs practice in accredited occupational therapy programmes.	Research focused on professional clinical practice is required.
Innovations in Coaching and Mentoring: Implications for nurse leadership and development. **Fielden, S. L. et al (2009) Health Service Management Research 22(2): 92- 9**	To assess the impact of coaching and mentoring delivered through a UK NHS development programme, evaluating the differences and similarities between coaching and mentoring relationships. To evaluate the impact	**Multi-method** Longitudinal study using semi-structured interviews and questionnaires with 15 coachees and 15 mentees.	Questions focused on the impact of coaching and mentoring on: - Career progression - Leadership and management development - Organisational impact - Career support - Career assets - Organisational support	Whilst both groups reported significant development with regard to career development, leadership skills and capabilities, mentees reported the highest level of development with significantly higher scores in leadership management and career impact.	Although the programme was evaluated using a small sample, it illustrates the influence of coaching and mentoring in the development of leadership skills and capacities for nurses.	Need to consider the impact of professional development models on development of leadership skills with Occupational Therapy.

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
	of the programme on the career and professional development of coachees and mentees.					
Nurse mangers in Australia: mentoring, leadership and career progression. **Moran, P. et al (2002) Canadian Journal of Nursing Leadership 15(2): 14-20**	To investigate the important factors which influenced and facilitated nurse managers entry to management positions with particular reference to the development of leadership characteristics.	**Quantitative** Questionnaire: 269 disseminated to nurse managers. 205 returned.	1) Had anyone influenced their development as a manager? If yes, identify the relationship or role of the person? 2) Who or what fostered their ongoing self -confidence? 3) Identify experiences which influenced leadership? 4) Why had nurses had become nurse managers? 5) Have there been factors in your personal life which have influenced career direction?	- A range of reasons why nurses move into management but little structure to cover planning and career progression. - Need for senior managers and the profession to identify individuals with potential and facilitate their movement into management positions	Highlights the need to develop strategies that fast track future nursing leaders to ensure continued involvement of nurses in the management of healthcare.	Research needed into the indicators which flag a successful leaders

Study	Aim/s of the study	Research Design	Research Question/s	Key Findings	Implications	How paper Informs the Research
Leadership in Occupational Therapy: Self-Perceptions of Occupational Therapy Managers **Fleming-Castaldy, R P. and Patro, J. (2012) Occupational Therapy in Healthcare. 26(2/3): 187-202**	To study the leadership characteristics of occupational therapy clinical managers.	**Quantitative** Survey which collected demographic information of participants and collected data on leadership practices using the Leadership Practices Inventory (LPI). Sample – 53 occupational therapy clinical managers.	1. Questions related to participant demographics. 2. Completion of a five category leadership self-perception inventory.	The mean score for LPI leadership categories ranged from 7.5 to 8.7 on a rating scale of 1equal to almost never and 10 equal to almost always. No association found between respondent demographics and LPI scores Participants reported that their leadership capabilities reflected their power to influence and lead Occupational Therapy in a climate of change and reform.	Strong leadership capabilities are influential in times of change/ reform.	Research needed into the characteristics of successful leaders
Moving to Trust Status: The experiences of staff of Occupational Therapy Departments. **Lloyd-Smith, W. (1997) British Journal of Occupational Therapy. 60(7): 309-14**	To investigate how staff from a trust and none trust unit perceived and experienced changes to the delivery of health and social care following the 1990 Community Care Act.	**Qualitative** Semi-structured interviews Sample – 15 NHS Occupational Therapists	Questions focused on participants views on the impact of moving to Trust status	Four key themes: - The need to justify and market the role of occupational therapy - Impact of trust status on staff roles and relationships - Staffs' understanding of the impact of trust status on department identity, concepts of leadership, and power and autonomy. - How trust status has shaped staff attitudes and opinions.	Findings highlight the important role of departmental leadership in system change	Need to consider the role of leadership in current NHS and Social Care reforms.

APPENDIX 2: SURVEY



A Survey of Occupational Therapists' Perceptions and Experiences of Clinical Leadership in Professional Practice

What is the survey about?

Thank you for participating in this survey about clinical leadership in Occupational Therapy; your views and experiences are extremely important.

Who should complete the questionnaire?

The questionnaire should be completed by qualified, Health and Care Professions Council (HCPC) registered Occupational Therapists.

Completing the questionnaire

The survey should take you about 15 minutes to complete. Please answer the questions carefully, following the instructions in each section. At the end of the survey you will be asked to consider participating in a complementary research interview. If you are happy to volunteer, please complete the contact form.

Return the completed questionnaire in the enclosed envelope by **12th December 2014**.

Your participation in the survey is voluntary and your responses will be kept confidential.

Queries

If you have any queries about this questionnaire, please contact me, Pameleta Ricketts, by telephone on 01384 244705 or via email at ntxprr@nottingham.ac.uk

Thank you

Section 1: About your professional education and training

1. In what year did you qualify as an occupational therapist? _____

2. Where did you train?

3. Please list your professional occupational therapy qualification(s), e.g. Diploma in Occupational Therapy

_____
_____
_____

4. Please list your membership of professional bodies or groups, if any.

_____
_____
_____

5. Do you hold a postgraduate qualification?

❒ Yes (please go to Q6)
❒ No (please go to Q7)

6. What is your highest postgraduate qualification, and in what subject?

❒ Postgraduate Certificate **in** _____
❒ Postgraduate Diploma **in** _____
❒ Masters Degree **in** _____
❒ MPhil **in** _____
❒ Doctorate / PHD **in** _____

7. In your current role, have any of the following been made available to you for postgraduate education? (Tick any that apply)

❒ Study Time
❒ Partial funding of course fees
❒ Full funding of course fees
❒ Expenses (e.g. Travel/accommodation)
❒ Other expenses (e.g. books/course materials)
❒ Not applicable

8. In your current role, have any of the following been made available to you for leadership training? (Tick all that apply)

❒ Study Time
❒ Partial funding of course fees
❒ Full funding of course fees
❒ Expenses (e.g. Travel/accommodation)
❒ Other expenses (e.g. books/course materials)
❒ Not applicable

Section 2: This section asks you about clinical leadership

Clinical Leadership is where clinicians draw on their specialist knowledge and skills to develop teams and ensure excellence in patient care.

9. On a scale of 0 to 5 (with 0 not important and 5 very being important): How important is clinical leadership to you in your career? (Circle one number)

0 1 2 3 4 5

10a. From your own experience please indicate the qualities that characterise an effective clinical leader. (Tick all that apply)

❒ Self-awareness
❒ Honesty
❒ Visionary
❒ Innovative
❒ Flexibility
❒ Accountability
❒ Other (please specify)

_____

10b. Which of these is most important in your opinion?

_____

11a. From your own experience please indicate the behaviours that characterise an effective clinical leader. (Tick all that apply)

❒ Motivating
❒ Influencing
❒ Directive
❒ Empowering
❒ Challenging
❒ Supportive
❒ Other (please specify)

_____

11b. Which of these is most important in your opinion?

_____

12a. From your own experience please indicate the skills that characterise an effective clinical leader. (Tick all that apply)

❒ Clinical Expertise
❒ Effective Communication
❒ Ability to Network
❒ People Management
❒ Resource Management
❒ Strategic Thinking
❒ Other (please specify)

_____

12b. Which of these is most important in your opinion?

_____

Section 3: About your current employment

13. From the following choices how would you describe your main employing organisation?

❒ NHS
❒ Social Services
❒ Higher Education
❒ Private Practice
❒ Other (Please specify): _____

14. What is your job title?

_____

15. What is your grade?

_____

16. What is the profession of your immediate Line Manager?

_____

17. How often do you have formal meetings with your Line Manager?

❒ Daily
❒ Weekly
❒ Monthly
❒ Never
❒ Other (please specify):

_____

18. What is the focus of these meetings? (Tick all that apply)

❒ Workload Management
❒ Budget Management
❒ Meeting Service Objectives
❒ Management of People
❒ Personnel Issues (e.g. Sickness Absence cover)
❒ Service Developments
❒ Your own Development Needs
❒ Other (please specify)

_____

19. Is there anyone other than your line manager that you go to for support in these areas?

❒ Yes (please go to Q20)
❒ No (please go to Q21)

20. What type of support do you receive? (Tick all that apply)

❒ Peer Support
❒ Coaching
❒ Mentoring
❒ Other (please specify):

_____

21. Do you manage a team?

❒ Yes (please go to Q22)
❒ No (please go to Q25)

22. Whom do you manage? (Tick all that apply)

❒ Occupational Therapists
❒ Other Health Professionals
❒ Support Staff
❒ Other (please specify):

_____

23. How often do you meet formally with your team?

❒ Daily
❒ Weekly
❒ Monthly
❒ Other (please specify):

_____

24. What is the focus of these meetings? (Tick all that apply)

❒ Service Delivery
❒ Service Development
❒ Professional Development
❒ Other (please specify):

_____

Section 4: Leadership development – What is important to you?

On a scale of 0 to 5 (with 0 not important and 5 very important): Circle one per question.

25. How important is 'on the job' training to your development as a Clinical Leader?

0 1 2 3 4 5

26. How important is mentorship to your development as a Clinical Leader?

0 1 2 3 4 5

27. How important is formal leadership training to your development as a Clinical Leader?

0 1 2 3 4 5

28. Have you encountered barriers to your development as a Clinical Leader?

❒ Yes (please go to Q29)
❒ No (please go to Q30)

29. From your experience, what have been the barriers to your development as a Clinical Leader? (Tick all that apply)

❒Limited opportunities for training
❒ Limited opportunities to gain experience
❒ Career Structure
❒ Limited opportunities for shared learning
❒ Other (please specify):

_____

30. In your opinion, what would support the development of Clinical Leaders in Occupational Therapy? (Tick all that apply)

❒ Training
❒ Experience
❒ Career Structure
❒ Opportunity for Shared Learning
❒ Other (please specify):

_____

31. Please feel free to add comments on any aspect of this questionnaire.

Would you be willing to take part in an interview with me that will explore this subject in greater depth?

Please tick the box if you would be willing to participate; then complete the attached Contact Form ❒

Please note that I may not be able to interview everyone that has indicated that they would like to take part in an interview.

Preferred contact:

❒ Email: _____

❒ Telephone: _____

Thank you for your participation in this survey.

Pameleta Ricketts

Please post this questionnaire back in the FREEPOST envelope provided

APPENDIX 3: SURVEY COVERING LETTER

School of Health Sciences
Post Graduate Office
The University of Nottingham
Queen's Medical Centre
Derby Road
Nottingham NG7 2HA

26th November 2014

Dear Participant

A survey of Occupational Therapists' Perceptions and Experiences of Clinical Leadership in Professional Practice

I am an Occupational Therapist undertaking a Doctorate in Health Sciences at the University of Nottingham. My research interest is clinical leadership and I am particularly interested in investigating Occupational Therapists' perspectives on clinical leadership. My supervisors are Professor Jane Seymour and Professor Avril Drummond.

The purpose of this letter is to invite you to participate in a survey which aims to seek your views on clinical leadership in occupational therapy and investigate what factors influence clinical leadership development in professional practice.
The questionnaire is for qualified Occupational Therapists only and should take about 15 minutes to complete. At the end of the questionnaire you are invited to participate in a complementary interview that will explore emergent concepts and themes from the survey in greater depth. If you are willing to be interviewed about this please complete the contact form.

Your participation in the survey is completely voluntary and your responses will be kept confidential. Completion and return of the questionnaire indicates your willingness to participate in the survey. Please return the completed questionnaire in the enclosed FREEPOST envelope by **Friday 12th December 2014**.

Thank you showing interest in my research, which I hope will contribute to the development of clinical leadership in professional practice.

If you require additional information or have any queries, please feel free to contact me at the above address, or by telephone on 01384 244705, or via email at ntxprr@nottingham.ac.uk

Yours sincerely



Pameleta Ricketts
Doctor of Health Sciences Student

APPENDIX 4: ETHICAL APPROVAL LETTER



The University of Nottingham

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

14th May 2014

Pameleta Ricketts
Doctorate of Health Sciences Student
c/o Professor Avril Drummond
Occupational Therapy
School of Health Sciences
B Floor, Medical School
QMC Campus
Nottingham University Hospitals
NG7 2UH

Dear Pameleta

Ethics Reference No: F08052014 SoHS OT
Study Title: Looking Back, Looking Forward: Perspectives on Clinical Leadership in Occupational Therapy.
Chief Investigator/Supervisors: Professor Avril Drummond, Rehabilitation and Ageing, School of Medicine Professor Jane Seymour, Sue Ryder Centre for Palliative and End of Life Care, School of Health Sciences
Lead Investigator/Student: Pameleta Ricketts, Doctorate in Health Sciences student.
Duration of Study: 2/6/14-31/5/15 12mths **No of Subjects** 1,410

Thank you for your recent application which was considered by the Committee at its meeting on 8th May 2014 and the following documents were received:

Clinical Leadership in Occupational Therapy:

- Med Sch REC Application Form version 1.0, Date: 10/04/14
- Protocol Final Version 1.0 10/04/14
- Invite to Study – WIMOTN Chair 10/04/14
- OTCL Participant Information Sheet for Interview Final Version 1.0 10/04/14
- Survey v8 10/04/14
- Consent Form Final version 1.0 Dte: 10/04/14
- Interview Guide v1.0, 10/04/14

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.

3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely



Dr Clodagh Dugdale
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Medical School Research Ethics Committee
Membership 2014/2015

*denotes attendance at 8th May 2014

Chair	Dr Clodagh Dugdale, Lecturer in Sports and Exercise Medicine, Division of Rheumatology, Orthopaedic and Dermatology, School of Medicine.*
School	**Representative**
School of Life Sciences	Dr Vince Wilson, Reader and Basic Scientist, Pharmacology Dr Kostas Tsintzas, Associate Professor, Human Physiology.*
School of Medicine	Dr David Turner, Clinical Associate Professor in Microbiology, Division of Medical Sciences and Graduate Entry Medicine*
School of Medicine	Dr Kimberly Edwards, Director of Postgraduate Courses/Epidemiologist, Division of Rheumatology Orthopaedics and Dermatology.* Dr Neil S Coulson,Associate Professor in Health Psychology, Division of Rehabilitation & Ageing.
School of Medicine-Non Clinical	Dr Philip Clark, Laboratory Manager, Pre-Clinical Cancer Studies, Division of Oncology* Dr Charlotte Billington, Research Fellow, Division of Respiratory Medicine Dr Debbie Palmer-Green, Research Fellow, Division of Rheumatology Orthopaedics and Dermatology*
School of Medicine-Derby	Dr Caroline Chapman, Associate Professor, Breast Surgery, Division of Medical Sciences and Graduate Entry Medicine. Dr Saoirse O'Sullivan, Associate Professor in Vascular Medicine, Division of Medical Sciences and Graduate Entry Medicine Derby.*
School of Medicine - Clinical	Dr Paul Maddison, Consultant Neurologist/Honorary Clinical Associate Professor, Queen's Medical Centre, NUH Dr Daren Forward, Consultant Orthopaedic Trauma Surgeon, Honorary Consultant Lecturer*
Primary Care	Dr Richard Knox, General Practitioner/ Part-time Lecturer Dr Christine Johnson, General Practitioner/Part-time Lecturer* Division of Primary Care, QMC Campus
School of Health Sciences	Dr Stephen Timmons, Associate Professor/Senior Lecturer, Division of Nursing.
Lay (Out of Faculty)	Professor Nigel White, Professor of Public International Law, School of Law, University of Nottingham. Lydia Davies-Bright, PhD Student, School of Law. Dr Andy Peters, Associate Professor, SPMMRC, School of Physics and Astronomy.* Susan Pritchard, Research Associate, SPMMRC, School of Physics and Astronomy

	Mary Beirne, Retired Mental Health Nurse, Birmingham and Solihull Mental Health Foundation Trust.*
Medical Students nominated by Medical student Society	To be appointed.
Postgraduate Student Member	Jyothika Kumar, PhD Student, Division of Psychiatry and Applied Psychology.* Charlotte Buchanan, PhD Student, SPMMRC, School of Physics & Astronomy
Administrator	Mrs Louise Sabir, Division of Respiratory Medicine, School of Medicine*

APPENDIX 5: PRE NOTIFICATION LETTER

School of Health Sciences
Post Graduate Office
Queen's Medical Centre
Derby Road
Nottingham NG7 2HA

6th October 2014

[name]
Occupational Therapy Network Chair
West Midlands Region

Dear [name]

I am an Occupational Therapist based in the West Midlands, undertaking a Doctorate in Health Sciences at the University of Nottingham. My supervisors are Professor Jane Seymour and Professor Avril Drummond. My research interest is clinical leadership; my study aims to seek Occupational Therapists views on clinical leadership in occupational therapy and investigate what factors influence clinical leadership development in professional practice. This study will be undertaken in two parts; part one will comprise a survey of qualified Occupational Therapists and part two will comprise complementary interviews with a smaller group; to explore emergent concepts and themes from the survey in greater depth.

The purpose of this letter is to request your permission, as Chair of the West Midlands Occupational Therapy Network, to recruit participants to this survey via the regional network. If agreeable, the aim would be to distribute questionnaires to West Midlands Occupational Therapists via the regional network contact list.

I believe that this research is both timely and relevant because Occupational Therapists can increasingly be found in clinical leadership roles; and it is hoped that findings may generate recommendations for future leadership training, development and practice in the current climate of change and reform.

Should you require further information about my proposed research, please do not hesitate to contact me at the above address, or via email at ntxprr@nottingham.ac.uk , or on 01384 244705.

Yours sincerely

Pameleta Ricketts
Doctor of Health Sciences Student

APPENDIX 6: INTERVIEW GUIDE

Interview Guide

	Question	Prompts
1	I would like to begin by asking you to tell me about your current role.	Length of time in role Roles and responsibilities
2	What influenced your move to your current role?	Who/What?
3	As you know, this interview is about clinical leadership in Occupational Therapy. What does the term clinical leadership mean to you?	May need to give a definition and then explore the interviewee's thoughts on this.
4	The information sheet you read earlier suggests that relatively little has been written about clinical leadership in Occupational Therapy. Do you have any thoughts on why that is?	
5	When you think of a leader, what comes to mind?	What makes a person a leader? What characteristics, skills, behaviours? Any particular person(s) that you have seen those characteristics in? Role model? Any particular individuals that you have regarded as good clinical leaders? Can anyone be a leader?
6	Do you consider yourself to be clinical leader?	Explore reasons why/why not? Would others see you as a leader?

	Question	Prompts
7	The terms leadership and management are often used interchangeably. I'm interested in finding out whether you think there is a difference between leadership and management.	Explore whether a manager can be a leader and vice versa.
8	What has influenced your views on leadership development?	Explore: - Experiences - Role model - Support (e.g. coach/ mentor) - Education opportunities - Training opportunities - Development opportunities - Other In what way? Barriers /facilitators
9	In your opinion, what are the most important factors influencing the development of clinical leaders in Occupational Therapy?	Are there profession specific training needs?
10	Thinking about the changes within Health and Social Care, is there any additional support that might be of benefit to the development of clinical leaders?	Is there anything from your own experience that would be helpful?
11	Is there anything that you wish to add in relation to any aspect of this interview?	Focus on anything else which the participant feels is important, that hasn't been covered. Chance to ask any further questions about overall issues arising, clarify any matters, and pick up on links between answers **~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~** **End by describing what will happen to the research - e.g. plans for publication.**

APPENDIX 7: PARTICIPANT INFORMATION SHEET

Participant Information Sheet
Final version 1.0: 10/04/14

Title of Study: Looking Back, Looking Forward: Perspectives on Clinical Leadership in Occupational Therapy

Study ID – OTCL

Name of Researcher: Pameleta Ricketts

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. Please read the following information carefully and discuss it with friends and colleagues if you wish. Take time to decide whether or not you wish to take part. Do feel free to ask if there is anything that is not clear or if you would like more information. My contact details are at the end of this sheet.

What is the purpose of the study?

This study seeks to explore your views and experiences of clinical leadership; focusing on what factors supports clinical leadership development in Occupational Therapy and what hinders development. Relatively little has been written about clinical leadership in Occupational Therapy, therefore my research aims to explore this topic. It is anticipated that this research will provide a more complete picture of clinical leadership from the perspective of UK Occupational Therapists; and that findings may be used to support leadership training, development and practice within a changing health and social care economy.

Why have I been invited?

You are being invited to take part in this study because you are a qualified Occupational Therapist based within the United Kingdom

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part please keep this information sheet. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you agree to take part you will be invited to participate in an interview which seeks to gain more detailed understanding of your thoughts and opinions of clinical leadership in Occupational Therapy. Your participation is completely voluntary; and if you are willing to volunteer for an interview you will be asked to complete a consent form. The interview should take about 60 minutes to complete and will take place in a mutually agreed venue. Interviews will be digitally recorded, then transcribed. I may need to contact you once more following interview to check accuracy of data.

What are the possible disadvantages and risks of taking part?

Taking part in this study should not cause upset or distress. However, your participation in the interview will take time out of your schedule, and this may be inconvenient. When arranging interviews I will try to find a time and venue that is convenient to you.

What are the possible benefits of taking part?

The information gained from your participation in this study may help identify targeted training and development that enhances the scope and practice of Occupational Therapy clinical leaders.

What if there is a problem?

If you have a concern about any aspect of this study, you can contact me, Pameleta Ricketts, and I will do my best to answer your questions. Alternatively, please contact Dr Aimee Aubeeluck, my project supervisor. If you remain unhappy and wish to complain formally, you should then contact the Ethics Committee Administrator, Mrs Louise Sabir, UoN Faculty of Medicine & Health Sciences Research Ethics Committee, C/O Faculty PVC Office, School of Medicine Education Administration, B Floor, Medical School, QMC Campus, Nottingham University Hospitals, NG7 2UH.

E-mail: louise.sabir@nottingham.ac.uk

Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the research will be kept **strictly confidential** and any identifiable details will be anonymised**.** Interview transcripts and supplementary information will be stored in a locked cabinet. Audio recordings and the notes from any discussion you take part in will be held in a safe place. Typed interview transcripts will be saved to a computer that is password protected.

Your personal data will be kept for two years after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). All other research data will be kept securely for 7 years. After this time your data will be disposed of securely.

What will happen if I don't want to carry on with the study?

Your participation is completely voluntary and you are free to withdraw from the study at any time, without giving a reason. However, it may not be possible for data already collected to be destroyed.

What will happen to the results of the research study?

This research will be written up as part of my higher degree qualification. In addition, results of the study will be published in a professional journal, so that learning can be shared widely. Results will also be published in an academic journal, to share with others how the study was conducted. You will not be identifiable in any report/ publication, as your details will be anonymised.

Who has reviewed the study?

This study has been reviewed by the University of Nottingham Medical School Ethics Committee.

Further information and contact details

Please feel free to contact me, Pameleta Ricketts or my project supervisor, Dr Aimee Aubeeluck, if there is anything you need answered. We will be happy to talk to you. Thank you very much for reading this information and thinking about this study.

Pameleta Ricketts 01384 456111 ext. 3263 ntxprr@nottingham.ac.uk

Dr Aimee Aubeeluck 01132 724906 Aimee.Aubeeluck@nottingham.ac.uk

APPENDIX 8: CONSENT FORM

CONSENT FORM
Final version 1.0: date 10/04/14

Title of Study: Looking Back, Looking Forward: Perspectives on Clinical Leadership in Occupational Therapy

REC ref: F08052014 SoHS OT

Name of Researcher: Pameleta Ricketts

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended. ☐
6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes.