Leadership Capabilities and Challenges in the Physiotherapy Profession in Ireland

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Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work. I agree to deposit this thesis in the University's open access institutional repository or allow the Library to do so on my behalf, subject to Irish Copyright Legislation and Trinity College Library conditions of use and acknowledgement.

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Summary

The physiotherapy profession in Ireland is experiencing a period of transition and change and is facing many challenges. The importance of leadership in healthcare has been recognised, however, to date there has been little research examining leadership in the profession of physiotherapy. The aim of this PhD thesis was to explore perceptions of leadership capabilities among physiotherapists in Ireland and to identify the leadership challenges facing the physiotherapy profession. A scoping review was conducted to explore the literature on leadership in physiotherapy. This review concluded that leadership in physiotherapy is an under-researched phenomenon but interest and research in the field are growing.

In the first study of this thesis, members of the Irish Society of Chartered Physiotherapists (ISCP) were surveyed about leadership and leadership development. The results demonstrated that physiotherapists in Ireland perceive communication and professionalism to be the most important leadership capabilities. A high percentage of the respondents perceived themselves to be a leader (74%) and the majority (53%) rated attaining a leadership position as very important or extremely important. Formal leadership training had been completed by 24.7% of respondents and informal leadership training had been completed by 32.8% of respondents. Participation in leadership development training was found to be associated with self-declaration as a leader and with placing importance on attaining a leadership position.

The first study demonstrated the leadership capabilities that the general physiotherapy population perceive to be important. The leadership capabilities of a specific cohort of potential physiotherapy leaders, physiotherapy managers, were investigated in the second study. This study was based on the leadership framework of Bolman and Deal (1991, 2008). In phase 1 of the study, physiotherapy managers were surveyed using the Leadership Orientations Survey. Results of the survey demonstrated that the physiotherapy managers used the human resource frame most often followed by the structural frame. Most respondents used only one frame or no frames at all and only a small number were found to use three or four frames. In keeping with the theory of Bolman and Deal, a statistically significant trend was found between the number of frames that a manager uses and their perceived effectiveness as a manager and as a leader. To explore the leadership capabilities of physiotherapy managers in more detail, in phase 2 of the second study semi-structured interviews were conducted with a purposive sample of physiotherapy managers. Analysis of these interviews

demonstrated that the managers predominantly used leadership capabilities associated with the human resource and structural frames. The managers' use of the political frame was more varied, some leadership strategies and behaviours associated with the political frame were reported, however there were also difficulties reported with capabilities in this frame. The symbolic frame was underused by the managers and there was less recognition of its importance. The managers in this study also identified challenges facing physiotherapy leaders and the physiotherapy profession. These challenges were: time constraints, lack of resources, other professions and changing structure.

In study III, the leadership capabilities of another cohort of physiotherapy leaders, physiotherapy clinical specialists and APPs, were explored. Analysis of these interviews demonstrated that the clinical specialists/APPs also predominantly worked through the human resource frame. The clinical specialists reported consistent use of capabilities associated with the structural frame whereas there was less prevalent use of political and symbolic frame leadership capabilities. A common theme in these interviews, however, was the concept of leading by example which falls within the symbolic frame. The clinical specialists/APPs reported the same challenges as those identified by the physiotherapy managers but also identified two additional challenges: ordering images and career structure.

In the final study, clinical physiotherapists' perceptions of the leadership capabilities of physiotherapy management in their workplace were investigated. Clinical physiotherapists were sent a paper-based survey which asked them to rate both the importance of 24 leadership capabilities and the effectiveness of physiotherapy management in their workplace at demonstrating them. Results of the survey demonstrated that ratings of importance of the leadership capabilities were significantly higher than ratings of effectiveness. The greatest difference between ratings of importance and ratings of effectiveness were found on the symbolic frame capabilities. Physiotherapy management were rated as most effective on leadership capabilities associated with the structural and political frames.

The results of this thesis suggest that physiotherapy managers and clinical specialists/APPs may benefit from training to further develop their leadership capabilities. This training should focus particularly on leadership capabilities associated with the symbolic frame. Further research is needed to guide the design and evaluation of these leadership development interventions.

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Publications from the work in this Thesis

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McGowan E and Stokes EK (2015) Perceptions of leadership in physiotherapy: A survey of members of the Irish Society of Chartered Physiotherapists. *Physiotherapy Practice and Research 36:97-106.*

McGowan E, Martin G and Stokes EK (2016) Perceptions of leadership: A comparison of physiotherapists' views in Ireland and Canada. *Physiotherapy Canada 68:106-113.*

McGowan E (2016) Clinician's commentary on Desveaux et al. *Physiotherapy Canada 68:59-60.*

McGowan E, Stokes E (In Press) An investigation into leadership and leadership development within the profession of physiotherapy in Ireland. *Physiotherapy Theory and Practice.*

McGowan E, Walsh C and Stokes EK (In Press) Physiotherapy managers' perceptions of their leadership effectiveness: a multi-frame analysis. Physiotherapy (Appendix X – pg YY-ZZ).

Published abstracts

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- McGowan E, Stokes E (2015) Perceptions of leadership: A comparison of physiotherapists' views in Ireland and Canada. *Physiotherapy 101: suppl 1;e978-979.*

- McGowan E, Stokes E (2015) An investigation into leadership and leadership development within the profession of physiotherapy in Ireland. *Physiotherapy 101: suppl 1;e979*

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- McGowan E, Martin G and Stokes EK (2016) Perceptions of leadership: A comparison of physiotherapists' views in Ireland and Canada. *Physiotherapy Canada 68: suppl 1; 3.*

- McGowan E, Stokes E (2016) Leadership Capabilities of Physiotherapy Managers: a Frame Analysis. *Physiotherapy Canada 68: suppl 1; 41.*

- McGowan E, Stokes E (2016) Physiotherapy Managers' Perceptions of Their Leadership Effectiveness. *Physiotherapy Canada 68: suppl 1;42.*

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List of Abbreviations

APA	Australian Physiotherapy Association
APP	Advanced Physiotherapy Practitioner
APTA	American Physical Therapy Association
CORU	Health and Social Care Professionals Council
CPA	Canadian Physiotherapy Association
CPD	Continuous professional development
CSP	Chartered Society of Physiotherapy
DNA	Did not attend
ESP	Extended Scope Practitioner
HSE	Health Service Executive
ISCP	Irish Society of Chartered Physiotherapists
LAMP	Leadership, administration, management and professionalism
LPI	Leadership Practices Inventory
MLQ	Multifactor Leadership Questionnaire
MRI	Magnetic Resonance Imaging
MS	Multiple Sclerosis
MSK	Musculoskeletal
NCHD	Non-consultant Hospital Doctor
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
OT	Occupational Therapy
PCCC	Primary, community and continuing care
PDP	Professional Development Plan
PNZ	Physiotherapy New Zealand
SOP	Standard Operating Procedure
TD	Teachta Dála (Member of Parliament)

UK	United Kingdom
USA	United States of America
WCPT	World Confederation for Physical Therapy
WTE	Whole Time Equivalent

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1. Chapter 1 – Introduction: Leadership in the Irish Healthcare System

The aim of this chapter is to provide the context in which this research project is situated. It provides details of the Irish health care system and the physiotherapy profession in Ireland. This chapter discusses the importance placed on leadership in healthcare, why it is needed in the profession of physiotherapy in Ireland, and consequently, why research is needed in this area. In light of the background presented in this chapter, the aims and objectives of this PhD and the chapter structure of the thesis are presented.

1.1. The Irish Health System

The Irish health system is a mixed system of funding and provision structures with services delivered through a combination of public, private and voluntary organisations (Brady and O'Donnell, 2010). Everyone is entitled to healthcare in public hospitals and 80% of the population use public health care services, while 50% of the population hold private health insurance (Carney, 2010). Private health care is delivered through independent private hospitals and in private wards in some public hospitals. Services such as preventative, rehabilitation, general practitioner care and specialist consultant appointments outside of the hospital setting, must be paid for by the individual (unless they are a medical card holder) or through private health insurance (Carney, 2010).

In the last decade Ireland experienced one of the most severe economic crises of any OECD country (Burke et al., 2016) which resulted in the country entering into an international bailout worth €85 billion (Burke et al., 2014) and reductions in health care spending of almost €4 billion between 2008 and 2014 (HSE, 2014). The prolonged austerity led to continuous cuts to health care budgets, declining resources and staffing, closed wards, and fewer inpatients and hospital beds, despite increasing demand for care (Burke et al., 2014). A new government was elected in 2011 which promised radical reform of the Irish health service including the end to the two tier system of access to healthcare where those with private health insurance have preferential access to care and services (Burke et al., 2016). In the Irish health service, 'two tier' references that people who have private health insurance or are able to pay privately can access diagnostic tests and treatment faster than those who cannot afford these options (Burke, 2009). To address this disparity, and ensure that access to healthcare is based on need and not income, the 2011 Programme for Government committed to a single-tiered

health service through the introduction of universal GP care and universal health insurance (Government, 2011). However, in an exploration of the policy, practice and implementation of health service reform in Ireland after the economic crisis, Burke et al. (2016) reported that there has been little progress made in achieving universal health coverage due to budgetary constraints and a lack of detail on mechanisms to achieve it. The general election in February 2016 resulted in the formation of a new government, a minority coalition between Fine Gael and several non-party TDs (Teahtaí Dála – MPs), although the durability of this arrangement has been questioned (Little, 2016). The Programme for Government published by the minority Government in May 2016 noted that further work needs to be conducted to explore the costs of different models before moving to a new system (Department of the Taoiseach, 2016). However, the new Minister for Health, Simon Harris, has recognised that "there is a need to establish a single-tier service where patients are treated on the basis of need rather than the ability to pay" (DOH, 2016).

The Health Service Executive (HSE) is the statutory body responsible for the provision of public health services in hospitals and communities across Ireland (HSE, 2016b). The HSE was established under the Health Act 2004. Currently the HSE employs approximately 102,000 whole time equivalents (HSE, 2016a). In its aim to deliver the best health service possible within the funding available the HSE has a programme of reform in place with a range of projects all aimed at improving health services (HSE, 2016a). However, it is facing many challenges as it strives to ensure optimal health and social care services for all. These include that the population is expected to grow by 4% between 2016 and 2021, the increasing number of people in the 85+ age group, the increasing burden of chronic disease (three quarters of deaths in Ireland are due to three chronic disease areas – cancer, cardiovascular disease and respiratory disease), the need to continue to reduce waiting times for services and improve access to diagnostic tests, and the need to keep up with advances in the development of medical technologies (HSE, 2016a).

A significant component of the reform of the Irish health system has been the expansion and development of primary care and community services. The primary care strategy was launched in 2001 and aimed to make primary care the central focus of the health system and transfer patient care services into the community via primary care teams (DOH, 2001). In this strategy, interdisciplinary primary care teams were identified as the core health service unit that would be responsible for meeting the health and social care needs of their populations. A goal was set to establish 400-600 primary care teams by

2011 (DOH, 2001). However, as noted by Kelly et al. (2016) progress to date has been slow; most of the original targets were missed and as a result the health service in Ireland is still beset by issues caused in part by a fragmented primary care infrastructure.

Carney (2010) outlined the challenges faced by healthcare professionals in Ireland during the economic downturn in 2008 and subsequent years of austerity. The key issues identified included reducing average length of stay, moving care from in-patient to out-patient settings, budgetary constraints, non-replacement of staff, the ageing population, the high birth rate, demand and capacity issues for hospital beds, pressure on accident and emergency departments, and keeping up with information technology innovations.

The on-going difficulties faced by the Irish health service have been decades in the making and have arisen due to an over-reliance on acute services, inadequate investment in community services, poor infrastructure and fragmentation of care (Brady and O'Donnell, 2010). The public perception of health care services in Ireland is negative (Burke, 2009) and there is a lack of trust as a consequence of the many scandals in relation to standards of care that have come to light in recent years (Brady and O'Donnell, 2010). These negative perceptions and lack of trust are another challenge that the health service in Ireland needs to address.

1.2. Physiotherapy in Ireland

In Ireland, physiotherapists work as autonomous professionals and may work independently or as part of a multi-disciplinary team (ISCP, 2012). A physiotherapist may specialise in many different areas including (but not limited to) rheumatology, musculoskeletal, respiratory care, paediatrics, women's health and veterinary practice. Physiotherapists in Ireland work both in the public and private sectors; across a range of workplaces including hospitals, community and primary care centres, special schools and private practice. Physiotherapists in Ireland are first contact practitioners and as such are able to accept referrals from all sources including service users (ISCP, 2010). Self-referral to private practice physiotherapy is well established, and while self-referral has been established in some Primary, Community and Continuing Care (PCCC) areas, in secondary care referrals have traditionally come from medical professionals (ISCP, 2010). In recent years, however, physiotherapists have been established as first contact practitioners in orthopaedic and rheumatology clinics (Murphy et al., 2013).

1.2.1. Physiotherapy professional organisation in Ireland

The Irish Society of Chartered Physiotherapists (ISCP) is a national, professional body recognised as the voice of physiotherapy in Ireland. The ISCP is responsible for accrediting entry to practice physiotherapy programmes in Ireland and is also the designated authority for the review and validation of qualifications obtained outside Ireland (ISCP, 2015b). As well as this, the ISCP provides advocacy and supports for its members, professional development opportunities and advice on professional issues and practice. Membership of the ISCP is not compulsory and the estimated number of practicing physiotherapists in Ireland is 3500 (WCPT, 2016). The ISCP is the sole Irish Member Organisation of the international physiotherapy professional organisation, the World Confederation for Physical Therapy (WCPT) and in Ireland the title 'chartered physiotherapist' can only be used by members of the ISCP or members of the Chartered Society of Physiotherapy (CSP), the professional body in the UK (ISCP, 2015a).

1.2.2. Regulation of the physiotherapy profession

The WCPT claims exclusivity to the professional titles "Physiotherapist" and "Physical Therapist" and asserts that these titles should only be used by individuals who hold qualifications approved by its member organisations (WCPT, 2011b). However, in the absence of regulation in Ireland another profession has attempted to claim the title "Physical Therapist" (ISCP, 2015a). Currently in Ireland anyone can call themselves a physiotherapist or physical therapist and not have any qualifications at all. As the terms physiotherapist and physical therapist are synonymous internationally and understood by the public to be the same thing both titles should be protected in the same register (Stokes, 2016). Legislation passed in 2005, the Health and Social Care Professionals Act, provided for regulation of the physiotherapy profession in Ireland (ISB, 2005). Under this Act the regulatory authority, CORU, was established to regulate twelve health and social care professions, including physiotherapy. CORU is establishing Registration Boards for each profession. When the Physiotherapy Registration Board was established in 2014 the Minister for Health decided, after a period of consultation, that both titles would be protected under one register with arrangements made for a once-off grandfather period to accommodate those currently calling themselves physical therapists (Stokes, 2016). However, the recent general election in Ireland has resulted in a delay in amending the legislation and thus the Physiotherapy Register has opened without the legislation to protect both titles (Stokes, 2016). At present, the ISCP is advising its members not to register until the amending legislation has been enshrined

into law and there is clarity about the assessment of professional competence for physiotherapists and physical therapists (ISCP, 2016c). The on-going confusion and lack of clarity regarding statutory registration and protection of the professional titles has meant that physiotherapy in Ireland is experiencing a period of uncertainty. This confusion is not limited to physiotherapy professionals but extends to the public and other health care professionals (ISCP, 2016b). The ISCP commissioned Millward Brown IMS to conduct surveys of public opinion in 2003 and 2008. The results demonstrated that the vast majority of respondents did not know that there was a difference between a physiotherapist and a physical therapist in Ireland or were incorrect in describing the difference (ISCP, 2016b). The ongoing issue of protecting the professional title and the confusion of the public and other health professionals pose major challenges for the physiotherapy profession in Ireland.

1.2.3. Physiotherapy practice in Ireland

This primary care strategy has led to a number of changes for the physiotherapy profession in Ireland (McMahon et al., 2014). These changes include the transfer of musculoskeletal physiotherapy to primary care, increasing demand for musculoskeletal physiotherapy services, and the role of the community physiotherapist changing from being predominantly domiciliary-based to being more clinic based (French and Galvin, 2016). In a qualitative study investigating the experiences of primary care physiotherapists in Ireland, French and Galvin (2016) found that the generalist role of primary care physiotherapy posed a challenge to physiotherapists in maintaining competence across different clinical areas.

The ISCP has also outlined challenges facing the physiotherapy profession in Ireland. Many of these are challenges being experienced by all health professionals in the health service in Ireland as previously described: changing demographics, changing disease patterns, increase in co-morbidities, the increasing need for the management of chronic disease, developing treatment technologies, patient expectations, reform fatigue among professionals and inadequate staffing levels (ISCP, 2014).

The development of specialised physiotherapy roles e.g. advanced physiotherapy practitioners (APPs) and extended scope practitioners (ESPs), is providing opportunities to expand the practice of physiotherapists (Yardley et al., 2008, CSP, 2016a). In Ireland, APP roles were created within the disciplines of orthopaedics and rheumatology to help

to address unacceptable waiting times (Murphy et al., 2013). Evidence is growing to support the cost and clinical effectiveness of physiotherapists working in advanced roles (Aiken et al., 2008, Desmeules et al., 2012, Van Rossen and Withrington, 2012) and of patient satisfaction with physiotherapists providing these services (Kennedy et al., 2010). Advanced practice roles have developed in new, innovative areas and through enhancement of the physiotherapy role in traditional areas of physiotherapy practice. The CSP in the UK has predicted that APP roles will continue to grow and develop as the profession responds to population needs (CSP, 2016a). In the UK, advanced physiotherapy practice has developed to include independent prescribing (CSP, 2013b), however this has not yet been achieved by the physiotherapy profession in Ireland. Working at this advanced level enables physiotherapists to have a larger sphere of influence which extends across professional and organisational boundaries (CSP, 2016a). Advanced roles may include a range of advanced skills including diagnostics and triage, invasive treatments (e.g. therapeutic injections), advanced care in a specialism (e.g. women's health), and complex case management (CSP, 2016a). The physiotherapy profession in Ireland must strive to ensure that it fully embraces the opportunities presented by advanced physiotherapy roles. To allow physiotherapists in these advanced roles to work most effectively they will need to be able to refer to other services to ensure efficient patient care e.g. radiology and laboratory services (ISCP, 2010). Progress in gaining rights in this area poses another challenge for the physiotherapy profession in Ireland.

Another issue that the physiotherapy profession has faced in recent years has been graduate unemployment (McMahon et al., 2014). In 2009, a moratorium on recruitment in the public services, which required that 6,000 WTEs be cut over three years (HSE, 2009a), had a direct impact on employment opportunities for physiotherapists (McMahon et al., 2014). This moratorium was revised to allow posts to be filled at staff grade level in primary care to try to meet the demands of community and primary care and ensure that the needs of children at risk, the elderly and those with disabilities are met (HSE, 2009b).

1.3. Leadership in healthcare

It is clear that professionals in the health care system in Ireland are experiencing a period of transition and change and, as a result, are facing many challenges. In times of uncertainty and change leadership is critical (Kotter, 1990, Kotter, 2012, Bevan and

Fairman, 2014). Effective leadership is considered to be of key significance in the reform of the Irish health service and to be essential in moving the health agenda forwards (Halligan, 2010). Many have advocated the importance of leadership in ensuring high standards of care, effective organisational processes and optimal results in healthcare. A report on management and leadership in the National Health Service (NHS) in the UK concluded that high quality leadership is needed at all levels to ensure that it can deliver the highest possible standard of care to patients (The King's Fund, 2011). Similarly, in a review of leadership and leadership development, West et al. (2015) concluded that effective leadership behaviours and strategies are fundamental to ensuring the delivery of high quality, safe and compassionate healthcare because leadership is the most influential factor in shaping organisational culture. From the other end of the argument, cases of failure of adequate care exposed in the media have, in part, been blamed on poor leadership (Hartley and Benington, 2010), as in the Francis Report which detailed the failings at the Mid-Staffordshire NHS Foundation Trust (Francis, 2013).

Hartley and Benington (2010) argue that while leadership may be seen as the current 'fashionable' solution to the complex challenges in healthcare there are several reasons why leadership should be taken seriously as part of long-term strategies for improvement and innovation. The challenges in healthcare are both complex and contested in that there is no clear agreement about the causes of or solutions to the problems and as such they require effort from a range of people, professions and organisations (Hartley and Benington, 2010). Health care organisations are complex social systems which require multiple external agencies to function e.g. professional organisations, educational institutions, insurance companies, pharmaceutical companies and patient advocacy groups (Halligan, 2010). Organisations must recognise contributions to leadership from individuals throughout the structure and not solely focus on the idealised view of the heroic leader (Turnball James, 2011).

To meet current healthcare needs a strong focus on developing leadership capacity is required (Thornton, 2016). Many health organisations have invested in leadership development programmes to try to improve leadership within their workforce (Edmonstone, 2013), for example the NHS Leadership Academy (NHS, 2016). In a review of leadership development in the NHS, West et al. (2015) reported that the evidence is variable for the effectiveness of specific leadership development programmes and that while some programmes work for some groups some of the time, evaluating their effectiveness, and the impact on patient care, is difficult. West et al. (2015) concluded that the challenges facing health care are too great and too many for

leadership to be left to chance and that therefore approaches to leadership development should be evidence-based and appropriate to the health care context.

1.4. Conclusion

The health system in Ireland is facing many complex and adaptive challenges as the country recovers from the economic crisis and addresses ongoing issues such as changing disease and population demographics. The physiotherapy profession in Ireland is also facing these challenges but it must additionally consider the challenges and opportunities specific to it as a profession. These challenges include the protection of the professional title, graduate unemployment, gaining prescription and ordering rights and the opportunity to broaden the scope of our profession through advanced physiotherapy roles. The importance of leadership in times of change and challenge is recognised in the scholarly and grey literature. Therefore, there is a clear need for leadership in physiotherapy in Ireland given the turbulent and changing times currently being experienced. To date there has been very little research on leadership in physiotherapy specifically (Thornton, 2016). Thus, this PhD will explore leadership in the profession of physiotherapy in Ireland. The aims and objectives of this thesis and the chapter structure are presented on the following pages.

1.5. Aims and objectives of this thesis

1.5.1. Overall aim

The overall aim of this research is to explore perceptions of leadership capabilities among physiotherapists in Ireland and to identify the leadership challenges facing the physiotherapy profession.

1.5.2. Study objectives

The objectives of this study are:

Objective 1 - *Study I*

- To investigate the perceptions of physiotherapists in Ireland of leadership and their participation in leadership development.

Objective 2 - *Study II*

- Phase 1 - To explore the leadership capabilities of physiotherapy managers by ascertaining which of Bolman and Deal's (2008) four frames these leaders use. To measure how physiotherapy managers rate their effectiveness as managers and as leaders, and to explore which factors are associated with self-perceived ratings of effectiveness as a manager and as a leader.
- Phase 2 – To further explore the perceived leadership capabilities of physiotherapy managers in Ireland using the four frames of the Bolman and Deal leadership model. Investigate the experiences of physiotherapy managers in Ireland of working in formal leadership positions and the challenges they face.

Objective 3 - *Study III*

- To describe the perceived leadership capabilities of physiotherapy clinical specialists/APPs in Ireland using the four frames of the Bolman and Deal leadership model. Explore the experiences of physiotherapy clinical specialists/APPs in Ireland of working in informal leadership positions and the challenges they face.

- To compare perceptions of leadership capabilities and leadership challenges between physiotherapists with different leadership characteristics (formal vs informal, managerial vs clinical).

Objective 4 – *Study IV*

- To explore clinical physiotherapists' perceptions of the leadership of physiotherapy management in their workplace.
- To compare the reported leadership capabilities of physiotherapy managers and physiotherapy clinical specialists/advanced physiotherapy practitioners with the leadership capabilities that their colleagues perceive to be important for physiotherapy management in their workplace to demonstrate.

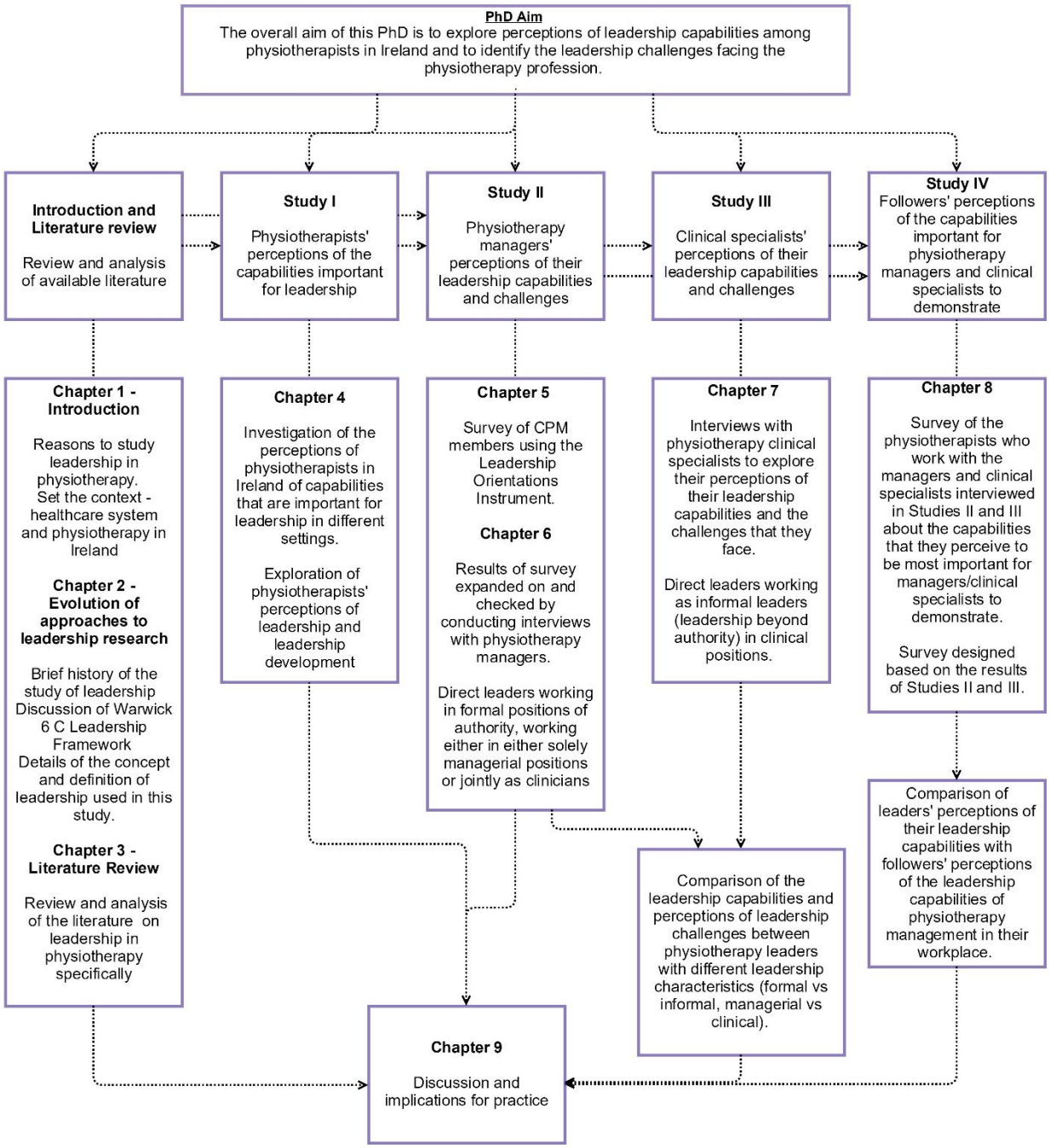


Figure 1-1 Chapter structure of PhD Thesis

2. Chapter 2 – Approaches to Leadership Research

The last 100 years of research into leadership have led to a voluminous body of literature, many different theories and several paradigm shifts (Day and Antonakis, 2012). Dominant approaches to the study of leadership have included traits, skills, competencies, styles, behaviours, situational, contingencies and relational approaches (Taylor, 2009, Hartley and Benington, 2010, Yukl, 2010, Kumar, 2013, Northouse, 2013). This introductory chapter does not intend to review all leadership theories because they are so numerous, but instead aims to demonstrate my awareness of the existence and evolution of these approaches to leadership and how they inform current thinking on leadership. As this thesis is situated in a healthcare field, attention has been paid to the suitability of these approaches in healthcare settings. This chapter also describes the framework upon which the thesis is structured and provides a description and justification for the choice of measurement instrument used and the leadership model employed.

2.1. Definitions of leadership

Despite the attention given to leadership and its recognised importance, it remains an elusive concept whose inner workings and specific dimensions cannot be specifically detailed (Howieson and Thiagarajah, 2011). A specific and widely accepted definition of leadership does not exist (Day and Antonakis, 2012). Stogdill (1974) noted that “there are almost as many definitions of leadership as there are persons who have attempted to define the concept”, and the number of definitions has continued to grow since Stogdill made his observation (Yukl, 2010). Even in the absence of a universal definition it is important to start with a working definition of leadership when conducting research to help delimit the areas of leadership with which a study is concerned (Day and Antonakis, 2012).

An early definition of leadership by Stogdill (1950) that is still considered to have value today (Hartley and Benington, 2010) is that “leadership may be considered as the process (act) of influencing the activities of an organised group in its efforts towards goal setting and goal achievement”. This definition is comprised of three elements that are common to many definitions: influence, group and goal (Parry and Bryman, 2006). Definitions of leadership have ranged from broad and complex to narrow and straightforward. For example, Maxwell (1993) describes leadership simply: “leadership is influence – nothing more, nothing less”, whereas Winston and Patterson (2006)

include over 90 variables in their 'integrative' model of leadership but state that even these many variables are not enough to fully understand leadership.

Within the health field, Goodwin (2006) argues for a definition of leadership based on a systems-wide view: "Leadership is a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: followers within the leader's own organisation, and influential players and other organisations in the leader's wider, external environment". Also within healthcare, Cummings et al. (2010) used Northouse's definition of leadership in a review of leadership styles and nursing outcomes. This definition described leadership as a "process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2004).

Similar to Northouse's definition was that used by Desveaux et al. (2012b) in their survey of Canadian physiotherapists. A leader was defined as 'an individual who influences the actions of another individual or group toward accomplishing goals and sets the pace and direction of change while facilitating innovative practice'. This definition was based on the writing of Turnball James (2011). It is focused on the leader as an individual but also acknowledges that leadership is a process of influence and that the ultimate aim is to achieve goals and facilitate change and development. Given the dearth of research on leadership in physiotherapy at the outset of my PhD (see Section 3.3) and because it had been previously used for research in physiotherapy, this definition was used as the definition of leadership for this research project.

2.2. Approaches to Leadership Research

Throughout the last century many have attempted to define effective leadership and what makes a good leader. Studies of leadership have included the investigation of traits, skills, behaviours and situations, and how they may contribute to leadership abilities. Northouse (2013) has written a comprehensive review and analysis of leadership theory and how it can inform and direct the way leadership is practised. Northouse (2013) outlined some of the major approaches to leadership research including traits, skills, style, situational, contingency, transformational and servant. This chapter is structured on these approaches and aims to introduce some of the predominant leadership concepts to give the background on which research in leadership is conducted today and to situate this research in the leadership literature.

2.3. Traits Approach

In the early 20th century, leadership research focused on traits to determine what made certain people great leaders (Day and Antonakis, 2012). Trait theory proposed that leaders are born with certain traits and possess innate abilities of power and influence (Halligan, 2010). The term trait refers to a variety of individual attributes including aspects of personality, temperament, motives and needs (Yukl, 2010). Examples include self-confidence, extroversion, and emotional maturity. The attempt to identify traits that differentiated 'leaders' from 'non-leaders' was one of the earliest scientific approaches to studying leadership (House and Aditya, 1997). In viewing leadership as a set of traits, the focus is on the individual, and leadership is conceptualised as a set of natural characteristics possessed by certain people (Halligan, 2010).

There have been many studies conducted using the trait approach to explore leadership and large lists of traits associated with effective leadership have been generated (Hartley and Benington, 2010). Evidence regarding the relationship between individual traits and leadership effectiveness has been mixed. As described by Yukl (2010), a major review of trait studies conducted from 1904 to 1948 found that the most commonly identified leadership traits included intelligence, initiative, honesty, interpersonal skills and self-confidence (Stogdill, 1948). However, the review failed to support the premise that to become a successful leader a person must possess a particular set of traits. Instead, Stogdill concluded that the importance of each trait depended on the situation and that no particular trait was necessary or sufficient to ensure leadership success in all situations (Yukl, 2010). The rejection of the trait approach was widespread and long lasting over the next 30-40 years (Zaccaro, 2007). However, better results were found with taking a traits approach once researchers began to include more relevant traits, to use better measures, and to take the situation into account (Yukl, 2010). In a later review, Kirkpatrick and Locke (1991) contended that "it is unequivocally clear that leaders are not like other people." In their qualitative synthesis of earlier research, Kirkpatrick and Locke suggested that leaders differ from non-leaders on six traits: drive, motivation, integrity, self-confidence, cognitive ability, and task knowledge.

Judge et al. (2002) conducted a major meta-analysis of 60 leadership and personality studies published between 1967 and 1998 to describe how five major personality traits are related to leadership. The main factors thought to make up personality, commonly called the Big Five, are neuroticism, extraversion, openness, agreeableness, and conscientiousness (Goldberg, 1990). Judge et al. (2002) found there to be correlations

between the Big Five traits and leadership; having certain personality traits is associated with being an effective leader. Extraversion was the factor most strongly associated with leadership followed, in order, by conscientiousness, openness, and low neuroticism. The last factor, agreeableness, was found to be only weakly associated with leadership.

Table 2-1 Description of the Big Five Personality Factors

Big Five Personality Factors	
Neuroticism	The tendency to exhibit poor emotional adjustment and experience anxiety, insecurity, vulnerability, and hostility.
Extraversion	The tendency to be sociable, active and assertive and to have positive energy.
Openness	The disposition to be imaginative, unconventional and autonomous.
Agreeableness	The tendency to be accepting, compliant, trusting and nurturing.
Conscientiousness	Comprised of achievement and dependability.

Source: Judge et al. (2002)

The strengths of the traits approach are that it has a large research base, that it offers an in-depth understanding of the leader component in the leadership process, and that it provides benchmarks against which individuals can evaluate their personal leadership attributes (Northouse, 2013). It is intuitively appealing because it fits with peoples' need to see their leaders as gifted people. However, problems have also been identified with the trait approach. Criticisms of this approach include its assumption that leaders are born rather than made (a perspective now deemed to be too simplistic), that it does not provide a definite list of leadership traits, and that it does not take context into account (Halligan, 2010, Hartley and Benington, 2010). As well as this, more contemporary understanding of personality is that many features of it may not be fixed but can be developed over time, according to life experiences and self-awareness (Hartley and Benington, 2010). As a result, overall, the view is that trait theory has limited applicability to understanding the leadership qualities of effective leaders (Parry and Bryman, 2006, Jackson and Parry, 2008, Hartley and Benington, 2010) and so, while traits continue to be of interest, research has moved on from looking at leadership traits to investigate leadership styles and behaviours.

2.4. Skills Approach

The skills approach is similar to the trait approach in that it takes a leader-centred perspective on leadership. However, in the skills approach there is a shift in focus from personality characteristics, which are viewed as innate and largely fixed, to an emphasis on the skills of leadership that can be learned and developed (Northouse, 2013). The drive for research on skills was initiated by the work of Robert Katz. Katz argued that skills are different to traits in that skills are what leaders can accomplish, whereas traits are who leaders are (Katz, 1955).

In Katz's (1955) three-skill approach the importance of certain leadership skills are deemed to vary depending on the leader's position in the organisation hierarchy. Technical skill refers to a person's knowledge of the work at hand, particularly involving methods, procedures, processes or techniques. Human skill is the ability to work with others and to build cooperative effort with their team. Conceptual skill refers to the ability to work with ideas and concepts and see the enterprise as a whole. For individuals operating at lower levels of management, technical and human skills are seen as most important. At the upper management level, it is considered most important for leaders to demonstrate conceptual and human skills. And for those who work at the top, conceptual skill becomes the most important for successful leadership.

The skills approach suggests that many people have the potential for leadership; if an individual is capable of learning from their experiences, they can acquire leadership (Northouse, 2013). Mumford et al. (2000) developed a skill-based model of leadership which examines the relationship between a leader's knowledge and skills and the leader's performance. At the heart of this skills model are three competencies: problem-solving skills, social judgement skills, and knowledge. However, the authors acknowledge that individual attributes, career experiences, and environmental influences also impact a leader's abilities.

Similar to Katz (1955), Mumford et al. (2007) investigated the skills needed by leaders at different levels of management. The researchers used a four-skill model (cognitive, interpersonal, business and strategic) to assess the skills of approximately 1,000 managers at the junior, middle, and senior levels of an organisation. The results demonstrated that cognitive and interpersonal skills were more important than business and strategic skills for those at the lower levels of management. As one progressed up

the career ladder, however, the execution of all four of the leadership skills became necessary.

Northouse (2013) discussed the strengths and criticisms of the skills approach. The strengths of the skills approach include that it frames leadership as a set of skills that can be learned and developed by many instead of just a select few, and that it provides a structure that can be used to frame the curricula of leadership development programmes. Criticisms of the skills approach include that the breadth of the skills extend beyond the boundaries of leadership (e.g. critical thinking, personality, and conflict resolution), and also that the model is weak in predictive value and does not explain how variations in skills affect performance. The model was also criticised for claiming not to be a trait model when, in fact, a major component in the model includes individual attributes, which are trait-like.

2.5. Behaviours/Style Approach

Dissatisfaction with trait theory also led to a greater interest in the behaviours of leaders from the mid-20th century onwards (Day and Antonakis, 2012). What leaders *do* rather than who they are was explored and clusters of behaviours commonly employed by leaders were examined (Hartley and Benington, 2010). This approach has been called the behaviours or style approach. This approach emphasises the behaviour of the leader thus distinguishing it from the trait approach, which emphasises the personality characteristics of the leader, and the skills approach, which emphasises the leader's abilities (Northouse, 2013). Similar to the skills approach the behaviours approach assumes that behaviours can be acquired and so there is a focus on leadership development (Hartley and Benington, 2010). This approach takes context into account, acknowledging that in some situations leaders need to be more task oriented, whereas in others they need to be more relationship oriented. The needs of followers are also recognised, some followers need leaders who provide a lot of direction, whereas others need leaders who show more care and support (Northouse, 2013).

Behavioural theorists contend that a good leader is anyone who adopts the appropriate behaviour (Halligan, 2010). Therefore, research in this area has attempted to determine the specific components of effective leader behaviour and how leaders combine behaviours to influence others (Northouse, 2013). The first studies regarding leadership style were conducted at Ohio State University and the University of Michigan in the

1940s. The Ohio State studies analysed how individuals behaved when they were leading a group. They developed a survey called the Leader Behaviour Description Questionnaire (LBDQ) (Hemphill and Coons, 1957). The LBDQ is composed of 40 statements and asks subordinates to identify how frequently their leaders engaged in certain types of behaviours (Bass and Stogdill, 1990). Researchers found that subordinates' results on the LBDQ clustered around two general types of leader behaviours: initiating structure and consideration (Stogdill, 1974). Initiating structure behaviours are focussed on shaping and progressing the task, whereas consideration behaviours are concerned with consideration of the social and emotional well-being of their team (Hartley and Benington, 2010).

Another evaluation of leader behaviour, the Managerial Grid (which has been renamed the Leadership Grid), was developed by Blake and Mouton (1964, 1978, 1985). Again, there were the twin themes of a focus on task and/or people. In the Leadership Grid, individuals are rated on a scale of one to nine on two components: concern for people and concern for production (Halligan, 2010). Based on these ratings the respondent will be assigned one of five leadership styles:

- Authority-compliance: heavy emphasis on task, low emphasis on people
- Country club management: heavy emphasis on people, low emphasis on task
- Impoverished management: low emphasis on task and people
- Middle-of-the-road management: balance of task and people
- Team management: heavy emphasis on task and people

There have been a wide range of studies in this area which validates and gives credibility to the basic tenets of this approach. It provides a broad conceptual map to aid the understanding of the complexities of leadership and has been used as a model by many training companies to develop leadership behaviours (Northouse, 2013). By assessing their own style and behaviours in light of task and relationship dimensions, leaders can learn a lot about themselves and how they come across to others, and ultimately how they could change their behaviours to become more effective (Northouse, 2013). The style/behaviour approach broadened the scope of leadership research beyond personal characteristics to include the behaviours of leaders and what they do in various situations.

However, this approach has been criticised. Bolman and Deal (2008) criticised Blake and Mouton's Leadership Grid for giving little attention to team members other than direct subordinates and for assuming that a leader who integrates concern for people with concern for task will be effective in almost all circumstances without taking into account structural, political and symbolic factors. Jumaa (2005) was critical of the style approach for having too little critical evaluation of when leadership works and when it does not, being too focused on correlating leadership style with satisfaction or productivity and being insensitive to explanatory conditions. Another criticism of this approach is that it failed to find a universal style of leadership that could be effective across tasks or situations (Day and Antonakis, 2012). However, this approach is not a refined theory that provides an organised set of recommendations for effective leadership behaviour. Instead it provides a framework to assess leadership in a broad way as behaviour with task and relationship dimensions (Northouse, 2013).

2.6. Competencies Approach

Related to the behaviour or style approach is the competencies approach. In the competencies approach the focus is on leadership qualities expressed in terms of behaviour, there is an assumption that competencies may be acquired rather than inherited, and the interaction between the context and the person is acknowledged (Hartley and Benington, 2010). The competency movement began with the work of McClelland (1973) and the McBer consultancy group in the 1970s on the concept of 'managerial competency' (Horton, 2002). In more recent years the competency approach has been transferred from management research into the leadership domain (Carroll et al., 2008). In a major study commissioned by the American Management Association in the early 1980s, Boyatzis (1982) used a competency framework approach to understand the behaviours of leadership and defined a competency as "an underlying characteristic of the person that leads to or causes effective or superior performance in a job". Boyatzis identified 19 behavioural competencies associated with above-average performance and grouped these into five competency clusters (goal and action management, leadership, human resource management, focus on others and directing subordinates).

Dulewicz and Higgs (2005) performed an extensive review of existing theories and their assessment tools to develop a new framework for assessing leadership competencies. From their review the authors grouped the diverse range of leadership behaviours into three broad categories; goal oriented, involving and engaging, which were appropriate

depending on the level of change to be achieved within an organisation. Additionally, 15 leadership dimensions were identified, which were then clustered under three competences of intellectual (IQ), emotional (EQ) and managerial (MQ). These 15 leadership dimensions were then used to structure the Leadership Dimensions Questionnaire.

Just as Dulewicz and Higgs (2005) highlighted emotional competences as core to effective leadership, a number of authors have identified the growing significance of emotional intelligence (Cacioppe, 1997, Melita Prati et al., 2003, Akerjordet and Severinsson, 2008). Emotional intelligence has been described as a concept which suggests that people vary in how attuned they are to emotional, and not just rational, aspects of life (Mayer and Salovey, 1993, Goleman, 1995). It involves the awareness of the feelings and moods of others, the ability to motivate oneself and persist in the face of difficulties, taking into consideration the emotions of other people, and regulating one's moods (Goleman, 1995, Yukl, 2010) It has been suggested as particularly important in healthcare where professionals are working with a range of emotions from patients, carers, and other professionals, their own emotions, and with the consequences of emotion on their work (Hartley and Benington, 2010).

The competencies approach helps to uncover the practices that contribute to effective performance in real situations (Hartley and Benington, 2010). In Hollenbeck et al. (2006), Silzer argues that the competency approach is helpful for both individuals and organisations because competencies specify a range of useful leader behaviours, summarise the experience of seasoned leaders, provide a tool that individuals can use for their self-development and can be used as a framework to select, develop and understand leadership effectiveness. Competency frameworks are now a widely used approach in looking at the qualities for effective leadership in healthcare (Hartley and Benington, 2010), for example the NHS Leadership Qualities Framework (NHS Leadership Academy, 2011).

However, Bolden and Gosling (2006) criticised the competency approach suggesting that it reinforces particular ways of thinking and behaving that ultimately limit the ability of individuals and organisations to engage with and demonstrate more inclusive and collective forms of leadership. They contend that the competency approach imposes a restrictive structure on the process of leadership. Hartley and Benington (2010) warn that there is a danger of competencies becoming a descriptive, idealised list that only a

superhuman could achieve, rather than a theory about how such skills contribute to effective leadership performance.

2.7. Contingency Approach

Contingency theories of leadership explain leadership effectiveness in terms of situational variables (Yukl, 2010). Contingency theories, also known as situational theories, recognise that leadership does not occur in a vacuum and thus take elements of the group or organisational situation into account (Halligan, 2010). This approach suggests that a leader's effectiveness depends on how well the leader's style fits the context (Northouse, 2013). Thus, to understand the performance of leaders it is essential to understand the context in which they lead. Context can put constraints on, but also provide opportunities for action, and so being able to 'read' the context is a pre-requisite for effective leadership (Hartley and Benington, 2010).

Fiedler's (1967) contingency model examined how contextual and situational variables influence behaviours. Fiedler proposed that leaders can improve their effectiveness by analysing their situation and then appropriately adjusting their behaviour (Halligan, 2010). Through analysing the style of hundreds of leaders, Fiedler was able to make empirically grounded generalisations about which styles of leadership were most and least effective for a given context (Northouse, 2013). Fiedler's results suggest that different leadership styles are more effective depending on the level of control that a leader has in a situation. To provide an objective measure of leader styles in the contingency approach, (Fiedler, 1967) developed the Least Preferred Co-worker (LPC) scale.

This LPC score is determined by asking the leader to choose a co-worker with whom they could work with least well and then to rate that person based on a set of adjective scales (Yukl, 2010). A critical rating of the co-worker will obtain a low LPC score, whereas a leader who is more lenient in their rating of the co-worker will obtain a high LPC score. The score on the LPC indicates whether someone is task motivated (low LPC) or motivated by relationships (high LPCs).

In contingency theory, situations are characterised in terms of three factors: leader-member relations, task structure and position power. Leader-member relations refers to the extent to which subordinates are loyal and relations are friendly and cooperative.

Task structure is the extent to which the requirements of a task are clear and defined. Position power is the extent to which the leader has the authority to evaluate subordinate performance and reward based on this. These three situational factors together are said to determine the favourableness of various situations in an organisation. Situations with good leader-follower relations, well-defined tasks and strong leader-position power have been rated as most favourable, and situations with poor leader-follower relations, unstructured tasks and weak leader-position power are deemed to be least favourable. Situations that fall between these two extremes are rated as moderately favourable (Yukl, 2010).

Contingency theory posits that certain styles are effective in certain situations. In both very favourable and very unfavourable situations low LPC leaders (task motivated) will be effective, whereas in moderately favourable situations high LPC leaders (relationship motivated) will be effective (Yukl, 2010). Although various interpretations of contingency theory have been made researchers are still unclear regarding the inner workings of the theory and this has been one of the main criticisms of this approach (Northouse, 2013). The model has also been criticised because it does not provide any guidance for training leaders how to adapt to the situation or how to change the situation (Nicholson, 2001, Yukl, 2010).

However, the contingency approach does also have many strengths as outlined by Northouse (2013). These include that contingency theory broadened understanding of leadership by highlighting the impact of situations on leaders. It is predictive and thus provides useful information about the type of leadership that is most likely to be effective in a certain context. Additionally, it does not require people to be effective in all situations but instead suggests that organisations should try to place leaders in situations suited to their style. Lastly, it provides data on leaders' styles that could be useful to organisations in developing leadership profiles.

2.8. Relational Approach

In the late 1970s researchers began to investigate the interaction and influence between leaders and followers and this led to the development of relational theory (Halligan, 2010). Relational theorists see leadership as a relational process that engages all participants and enables each individual to contribute to achieving the vision (Halligan,

2010). Specific leadership theories that fall under the relational leadership category are servant, transactional and transformational leadership theories.

2.8.1. Transformational and Transactional Leadership

The transformational leadership style has become prevalent in leadership research and practice in recent years (Hartley and Benington, 2010, Fischer, 2016, Thomson et al., 2016). Transformational leadership theory developed alongside transactional leadership theory from initial research by Burns (1978) but there has been more empirical research on the version of the theory formulated by Bass (1985, 1996) than on any of the others (Yukl, 2010). The distinction between transformational and transactional leadership is the essence of the theory. The two types of leadership were defined in terms of the behaviours used to influence followers and the effects of the leader on followers (Yukl, 2010).

Transactional leadership is focused on the exchange process between the leader and their followers based on what the leader possesses and what the follower wants in return for providing their services (Hartley and Benington, 2010). Transactional leaders tend to focus on the present situation and are adept at maintaining the smooth and efficient running of the organisation. They are particularly good at traditional management functions such as planning and budgeting and maintain stability within the organisation rather than promoting change (Halligan, 2010). In contrast to this, transformational leaders have the ability to bring about significant change in the organisation's strategy and culture by focusing on intangible qualities such as vision, shared values and ideas. They stimulate followers to transcend their own interests for the greater good of the group, organisation or society (Halligan, 2010). Bass (1985) noted that transformation and transactional leadership are distinct but not mutually exclusive styles. Transformational leadership increases follower performance and motivation more than transactional leadership, but effective leaders use a combination of both types (Yukl, 2010).

Kouzes and Posner (1987) have developed a model of transformational leadership. This model was developed from an analysis of personal best cases and is now known as the Five Practices of Exemplary Leadership. The five practices are: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable others to Act, and Encourage the Heart. From their analysis they have developed the Leadership Practices Inventory (LPI) which

is now one of the most widely used leadership assessment questionnaires in health care literature (Halligan, 2010).

Another transformational leadership model is Bass and Avolio's (1994) Model of Transformation. This model outlines four key approaches used by transformational leaders:

- Idealised influence - behaving in ways that result in them being role models for their followers, demonstrating high standards of moral and ethical conduct
- Intellectual stimulation - challenging thinking, including followers in the process of addressing problems, encouraging imagination and creativity
- individualised consideration - identifying individuals' needs and desires, personalising interactions with followers, and giving feedback and coaching
- Inspirational motivation - motivating and inspiring others around them by providing meaning and challenge, displaying enthusiasm and optimism

Bass and Avolio developed a behaviour description questionnaire, the Multifactor Leadership Questionnaire (MLQ), to identify leaders' use of transformational and transactional leadership behaviours (Bass and Avolio, 1995).

There has been considerable research on transformational leadership and its impact on subordinates and colleagues since the 1990s. Evidence is beginning to accumulate for the effectiveness of transformational leadership in a variety of different settings (Northouse, 2013) including health care (Gilmartin and D'Aunno, 2007, Cummings et al., 2010, Fischer, 2016, Thomson et al., 2016). Research for the theories of transformational leadership has generally been supportive but few studies have investigated the underlying influence processes to explain the positive relationship found between leader behaviour and follower performance (Yukl, 2010). Yukl (2010) proposed that more research is needed to investigate the underlying influence processes of transformational leadership and to determine the conditions in which different types of transformational behaviour are most relevant. Similarly, Antonakis (2012) concluded that research that considers contextual effects as well as individual factors is needed to allow a fuller understanding of transformational leadership.

Strengths of the transformational leadership approach include that it emphasises the importance of emotional as well as rational processes, and of symbolic actions (Yukl, 2010). The transformational leadership model takes into account the impact of leader behaviour on those they aim to influence (Hartley and Benington, 2010). Northouse

(2013) discussed the intuitive appeal of the transformational approach because it fits with society's perception of what leadership means and because it provides a broader view of leadership that includes the leaders' attention to the needs and development of followers.

Criticisms of the transactional and transformational leadership models have also been noted (Hartley and Benington, 2010, Northouse, 2013). Yukl (2010) criticised the transformational model because it does not examine how leaders influence change or consider their involvement in strategic leadership. Yukl (2010) also noted that transformational leadership theory emphasises the influence of leaders on followers without paying attention to reciprocal influence processes and shared leadership. Another potential limitation of this model concerns one element of transformational leadership, 'idealised influence'. Idealised influence is behaviour that arouses strong follower emotions and identification with the leader. This can be problematic if the attribution of exceptional abilities to the leader undermines a group's sense of its own empowerment and abilities, and may ultimately lead to unhealthy dependencies on the leader (Hartley and Benington, 2010). Finally, Antonakis (2012) highlighted that researchers have not demonstrated that transformational leaders are actually able to transform people and organisations. Studies have yet to clearly establish a causal link between transformational leaders and change in organisations.

2.8.2. Servant Leadership

Servant leadership has been described as 'leadership upside-down' (Daft, 2005); servant leaders transcend their own interests to serve the needs of others, help others to grow and develop, and view the fulfilment of others as their principal aim. The concept of servant leadership was developed by Greenleaf (1977). Greenleaf advocated that the primary responsibility of leaders is service to followers and that providing meaningful work for employees is as important as providing quality services or products. Servant leaders must listen to followers, attend to their needs, learn about their aspirations, and share in their frustrations (Greenleaf, 1977).

Daft (2005) described four basic precepts of servant leadership: put service before self-interest, listen first to affirm others, inspire trust by being trustworthy, and nourish others in order to help them become whole. Until recently there was little empirical evidence on servant leadership and most writing on the topic was prescriptive, focusing on what

leadership should ideally be, rather than descriptive, reporting on what servant leadership is in practice (Van Dierendonck, 2011). Yukl (2010) listed the following as key values of servant leadership: integrity, altruism, humility, empathy and healing, personal growth, fairness and justice, and empowerment.

Servant leadership has been said to resemble the idealised influence and intellectual stimulation concepts of transformational leadership (Liden et al., 2008). However, Stone et al. (2004) argue that a difference between these approaches lies in the extent to which the leader is focused on the organisation or the followers; servant leadership is concerned with what is best for the followers, whereas transformational leadership emphasises the vision of the organisation. Servant leadership has been used extensively in training and development and many organisations use ideas from servant leadership because the content is straightforward and accessible to employees at all levels within organisations (Northouse, 2013). Servant leadership has been advocated as an appropriate model for health care settings due to health professionals' desire to serve others and because it contrasts with approaches where one wants to be a leader first and foremost (Halligan, 2010). Trastek et al. (2014) presented servant leadership as the best model for health care because it focuses on trust and empowerment in both health team relationships and patient relationships. By helping other health professionals to work towards and achieve their goals, servant leaders can inspire high performance and innovation throughout healthcare.

However, servant leadership has also faced criticisms. The title 'servant leadership' may create semantic discord and diminish the potential value of the approach (Northouse, 2013). As well as this, ongoing debate among servant leadership scholars regarding the core dimensions of the process has meant that researchers have been unable to reach a consensus on a common definition or theoretical framework for servant leadership (Van Dierendonck, 2011). Within the healthcare setting it has been acknowledged that while there is a great deal of alignment with this model when working with a team in caring for patients, it does not fit every situation. Servant leadership may lack the speed needed when an issue is urgent, and may also not be the best model when addressing conflict (Trastek et al., 2014).

The strengths and weaknesses of the approaches to leadership described in this chapter are summarised in Appendix III (pg 420-421).

2.9. Clinical Leadership

Clinical and health care environments pose unique challenges for leadership stemming from a combination of both environmental and organisational factors (McAlearney, 2006). These factors include: diverse regulatory influences, fragile budgets, multiple hierarchies of professionals, divisions between administrators and clinicians, and the varied employed and contracted worker populations. Recognition of the complex challenges and diverse role of leaders working in a health care context has led to the development of the concept of clinical leadership. The term clinical leadership originated from the nurses who became managers but has grown to include anyone with a clinical background who has a leadership role (Griffiths et al., 2010). Clinical leadership is most concerned with the effective delivery of health care at the front-line; it is about facilitating evidence-based practice and improved patient outcomes through local care (Millward and Bryan, 2005).

In the UK, the idea of clinical leadership is a central theme in current health service policy (Ham and Hartley, 2013, Mulla et al., 2014). The importance of clinical leadership for the future viability and success of the NHS has been stated many times and with increasing frequency in recent years (Storey and Holtie, 2013). Effective clinical leadership has been accepted as having an important role to play in ensuring optimal patient care (Nicol et al., 2014) and improving services to achieve higher levels of excellence (Jonas et al., 2011).

Clinical leadership is a 'contested' concept and seeking a consensual definition can be a difficult activity (Edmonstone, 2009, Daly et al., 2014). Clinical leaders have been defined as front line health care professionals who have retained some clinical role but also have significant involvement in matters of strategic direction, operational resource management and collaborative working (Edmonstone, 2005). Storey and Holtie (2013) outlined the functions of clinical leadership to include: bringing clinicians on board with regime changes and maintaining their engagement, providing technical expertise to ensure plans are feasible and beneficial from a patient perspective, as well as underpinned and valuable from a clinical standpoint, and to ensure integration of care services. In a summary of the literature, Stanley (2012) identified seven clinical leadership characteristics including clinical expertise, direct involvement in clinical care, communication and interpersonal skills, role-modelling and motivating, delivering and improving high standards of care, empowering others and being values driven.

Often the concept of leadership is viewed in a structural way synonymous with someone's position in the organisation. However, it has been proposed that understanding leadership purely based on position is inappropriate (Millward and Bryan, 2005). Olsen and Neale (2005) highlighted the need for clinical leadership at all levels, and particularly in the clinical teams delivering day-to-day care on hospital wards. However, for clinical leaders some "positional authority" may be important to build professional credibility (Millward and Bryan, 2005). Martin (2000) argues that to demonstrate effective leadership an appropriate balance between managerial authority and a more facilitative, collective approach must be sought, and that the right balance will vary according to the context and circumstances. Edmonstone (2009) suggested that clinical leadership differed from managerial leadership in that clinical leaders tend to use persuasion and personal power rather than hierarchical power. While some clinical leaders may hold formal positions of authority, primarily the influence of clinical leaders comes from their clinical credibility and capacity for collaboration (Daly et al., 2014).

2.10. Management and Leadership

In considering leadership theory and how it has developed over the last century, it is important to also consider the complementary and contradictory process with which it is so often associated, namely management. Balance is needed in clarifying the distinction between leadership and management, while also recognising the overlap between these concepts (Hartley and Benington, 2010). An individual can be a manager and not demonstrate leadership, or can be a leader without being in a managerial role (Yukl, 2010). Kotter (1990) wrote that leadership and management are different; they are two distinctive and complementary systems of action and both are necessary for success in complex organisations. Management is concerned with coping with complexity: providing order and consistency, planning and budgeting, organising and staffing, and controlling and problem-solving, whereas leadership is about coping with change: setting a direction, aligning people, and motivating and inspiring (Kotter, 1990). While management relationships are based on formal authority, where a manager's power comes from their position of authority, leadership is based on personal influence and a leader's power may come from their personal character (Halligan, 2010).

Daft (2005) advocated that managers and leaders are not inherently different types of people; many managers have the abilities and qualities required to be effective leaders. Similarly, Yukl (2010) acknowledged that many scholars view leading and managing as

distinct roles or processes but do not assume that leaders and managers are different people. Many studies of leadership have been based on managers, so clearly managers are also assumed to be leaders (Hartley and Benington, 2010). Gosling and Mintzberg (2003) describe leading and managing as distinct but complementary activities and perceive the separation of the two processes – management without leadership and leadership without management, as harmful.

It is often difficult to distinguish between the terms 'leadership' and 'management' in healthcare organisations because many roles require managers to lead and expect leaders to manage (Halligan, 2010). Job titles may not accurately reflect the true nature of the role or of the individuals in that position. The dichotomy of leadership and management does not adequately capture the realities of leadership and management in practice because there is so much overlap between these roles (Yamasaki, 1999). Health care organisations have been described as 'disconnected hierarchies' with an inverted power structure in that the people in the lower rungs of the hierarchy have greater influence over day-to-day decision making than those at the top (Ham, 2003). However much of the research in general, and in health care, has focused on the upper levels of the hierarchy (Halligan, 2010). Further research is needed to examine the extent to which these theories of leadership are transferable to people working at different levels of the health care system.

2.11. Leadership Development

Can leadership be learned? The extensive volume of literature, research and development courses on the subject of leadership indicate that it is generally assumed that leadership can be learned. Leadership development practices have been defined as "educational processes designed to improve the leadership capabilities of individuals" (McAlearney, 2006). There is now considerable evidence from a variety of sources that many leadership skills can be developed, even in those who may have less natural aptitude than others (Burke and Cooper, 2006, Warren and Carnall, 2010, Day, 2012).

The need to develop leaders in today's rapidly changing healthcare environment has been recognised (Blumenthal et al., 2012, Macphee et al., 2012, Swanwick and McKimm, 2012, West et al., 2015). In the past, junior doctors absorbed leadership skills "by osmosis" from their chiefs, but this model is no longer appropriate for the effective working of multidisciplinary teams (Olsen and Neale, 2005). In a review of eight

leadership development programmes in the NHS, Edmonstone (2013) found that a variety of development methods were used including: workshops, action learning sets, mentoring and coaching, taught modules and work-based improvement projects. Leadership development can occur alone and be entirely self-directed, or can be as part of a team participating in schemes or undertaking formal qualifications (Warren and Carnall, 2010).

In an extensive qualitative study of leadership development challenges, McAlearney (2006) interviewed 35 healthcare experts and completed 55 organisational case studies. The results demonstrated that there was considerable debate about the optimal way to develop leadership and no agreement on the best approach to take. Time constraints, interference with their clinical workload, and decreased productivity from lost patient visits were reasons for reluctance to participate in leadership development training given by the health care professionals. Additionally, within healthcare organisations financial constraints may lead to leadership development being less of a priority. Overall the author concluded that healthcare organisations can develop better leaders by considering the context of their organisation and the challenges associated with leadership development in healthcare (McAlearney, 2006).

In leadership development the emphasis has traditionally been on formal training and education programmes but more recently there has been increasing recognition of the role of a wider range of knowledge and skill generating activities both formal and informal (Hartley and Benington, 2010). Significant investments are made by healthcare organisations to develop leaders and so there is an obvious need to evaluate these leadership development programmes to assess whether the stated intentions have been achieved (Edmonstone, 2013). Boaden (2006) provided a critical analysis of a leadership development intervention within the NHS. The core programme of this leadership training incorporated half-week blocks of teaching every two to four months, service improvement projects, learning sets and a support website. Analysis of participant evaluation reports provided evidence of improvement in a variety of transactional skills and transformational leadership characteristics. Participants reported a greater understanding of the needs of the NHS and there was evidence that practical insights had been applied in the workplace. Overall the programme was deemed to have contributed to significant personal development which continued to have an impact on participants' roles and influence, as well as their career paths.

Given the complex, multi-faceted nature of an intervention like a leadership development programme, the attribution of cause and effect can be problematic despite innovative evaluation designs (Hardacre et al., 2010). In healthcare, leadership development programmes have conventionally been evaluated based upon the feedback given by programme participants, often expressed at the end of the programme (Edmonstone, 2013). However, the retrospective nature of this evaluation approach makes it difficult to gain an accurate impression of the impact that a programme may have had on its' participants and their work (Edmonstone, 2013). Attempts to quantify precisely the benefits of leadership development programmes have remained elusive and historically most organisations have not closed the loop between linking leadership development, changes in behaviour and organisational outcomes (Hernez-Broome and Hughes, 2004). Some programmes attempt to map the subsequent career progression of participants, others ask participants for continuous feedback throughout the programme, and for some progress markers (such as 360^{o} assessment) are used before, during and after the programme. However, given that participants are aware of the inputs that have taken place, it is unlikely that a truly objective assessment of leadership development can be carried out this way (Edmonstone, 2013).

While there is little contention that certain personality types appear to assume leadership roles more easily, all professionals can learn some of the techniques and behaviours that are essential for effective leadership and thus develop their leadership ability (Warren and Carnall, 2010). There remains a debate over the degree to which leadership can be taught, and how to conduct such teaching, but there is agreement that "leadership clearly requires personal commitments on the part of the learner" (Doh, 2003). Edmonstone (2013) contended that the closer the match between the organisational culture and the values which the programme embodies, the greater the likelihood of participant buy-in and therefore success of the leadership programme. Trastek et al. (2014) advocated that healthcare students should be enabled to pursue leadership development through programmes appropriate for their professional needs, and that this leadership development should continue throughout their working careers.

2.12. The Warwick 6 C Leadership Framework

From this brief report of the evolution of approaches to leadership theory and research it is evident that there are a wide range of influences on leadership, including personal characteristics, behaviours, relationships, organisational context and situational

challenges, which must be considered when writing and investigating leadership. For this reason, a framework which incorporates many of these factors will be used to structure this research. Hartley and Benington (2010, 2011) criticised contemporary leadership writing for taking a simplistic individualistic perspective with little integration of the different approaches and contended that a conceptual framework to analyse leadership as a dynamic process within a complex, adaptive system was needed if leaders and potential leaders are to take an overview of the field.

The lack of satisfactory integration of existing theories of leadership led Hartley and Benington (2010) to develop the Warwick 6 C Leadership Framework. This framework is a relatively new model which allows analysis in a more rounded, comprehensive way. It is an analytical framework rather than a single theory and covers a range of aspects of leadership taking into account the key elements affecting leadership processes and outcomes (Hartley and Benington, 2011). The framework provides a lens through which to scrutinise leadership, enables questions to be explored from different perspectives and aids the marshalling of ideas and evidence to inform practice (Hartley and Benington, 2010).

This framework is relevant to both those in formal leadership positions and those who demonstrate leadership through influencing the thinking and actions of others. It was designed with a focus on healthcare but it draws on evidence, theories and insights from the general leadership literature (Hartley and Benington, 2011). The literature which informed the design of this framework came from a range of sources including: examination of recent academic literature on leadership in healthcare, recommendations of pertinent articles, books and reports from academic experts in the field of leadership and/or healthcare, and the authors' wider knowledge of the leadership literature to introduce theories and ideas that are currently absent from the healthcare field (Hartley and Benington, 2010). As well as this, the authors regularly checked their writing and ideas with healthcare practitioners from a range of backgrounds to ensure that the ideas were accessible, practical and useful.

There are 6 elements in this analytical framework (Hartley and Benington, 2010, 2011).

- **Concepts** - are used to define leadership; different authors place different emphasis on different aspects of leadership. The concept of leadership may involve the personal qualities of the leader, the leadership positions in the organisation, and/or the social processes of leadership. The definition of

leadership influences how leadership behaviours, processes and outcomes are viewed.

- **Characteristics** - of the roles and resources that have an impact on leadership influence. Explores the similarities and differences of formal and informal leadership roles and processes; whether direct (face-to-face) leadership and indirect (operating through a chain of command or distributed network) are distinct; and the impact of different sources of legitimacy (e.g. based on expertise, an elected role, a managerial role, a professional role).
- **Context** – the setting in which leadership occurs. Context creates opportunities for but also places constraints on action, and is a source of potential leverage for leaders. Leaders influence and interpret their contexts through sense-making and the framing of issues and ideas. Context is crucial to understanding the processes and consequences of leadership.
- **Challenges** - of leadership in terms of the goals, values and aims of leadership. In clarifying the purposes of leadership, the challenges to be addressed come to the fore. The kind of leadership required may vary according to the type of challenge to be addressed. The key role of leadership in analysing and framing the problem to be addressed is increasingly being recognised.
- **Capabilities** - of leadership, the range of skills, knowledge, experience, mind-sets, attributes and behaviours that are associated with superior performance within particular contexts or in addressing specific challenges. The qualities, actions and behaviours that are thought to distinguish 'leaders' from 'followers' and to lead to the success of teams.
- **Consequences** - the extent to which the claims of a link between leadership and performance are justified in terms of both causation and the attributional processes. Evaluation of the impacts, outcomes and consequences of leadership in the current complex and dynamic context.

While all 6 components of this framework will be considered in this research the focus will be on the characteristics and capabilities of, and challenges facing, leaders in physiotherapy. The leadership capabilities of physiotherapists will be investigated in each of the studies of this research project. Capabilities include the attributes, skills, knowledge, mind-sets, qualities and behaviours of leaders (Hartley and Benington, 2010). The perceptions of the general physiotherapy profession of the importance of certain leadership capabilities are investigated in Study I. In Studies II and III the

perceptions of physiotherapy managers and physiotherapy clinical specialists of their leadership capabilities are explored. In the final study, Study IV, the perceptions of clinical physiotherapists of the leadership capabilities of physiotherapy management (physiotherapy managers and clinical specialists) in their workplace are investigated.

Characteristics of leadership in physiotherapy will be explored in Studies II and III. The characteristics component recognises that there are different types of leadership rather than assuming that there is a generic form of leadership (Hartley and Benington, 2010). There is a distinction between formal and informal leadership (with authority and beyond authority), direct and indirect leadership, and clinical and non-clinical leadership. The distinction between formal and informal leadership was based on that described by Heifetz (1994) who argued that the basis of authority provides different opportunities for, and constraints on, demonstrating leadership. Informal leadership has a different base and therefore a different set of responsibilities associated with it (Hartley and Benington, 2010). The physiotherapy managers in Study II all demonstrate formal leadership and some work clinically while others work solely in their managerial position. The clinical specialists/APPs in Study III demonstrate informal leadership, or leadership beyond authority, and as their title suggests all have clinical roles. Direct leadership occurs where there is frequent, interpersonal contact and direct leaders are able to get to know all the team-members. In contrast, indirect leadership occurs where the relationship is too distant to be based on personal interaction and is instead based on influence through the chain of command (Hartley and Benington, 2010). Physiotherapy managers demonstrate direct leadership with their team, whereas physiotherapy clinical specialists/APPs may demonstrate both direct and indirect leadership. Direct leadership with the physiotherapists and other health professionals that they work with clinically and indirect leadership through the influence they may have on the wider physiotherapy and multidisciplinary teams.

The challenges facing the profession of physiotherapy will also be explored in Studies II and III. Participants in the interviews in Studies II and III discuss the challenges facing leaders in the physiotherapy profession. Comparisons are made between different types of physiotherapy leaders (as differentiated based on the characteristics component of this framework) to explore the challenges that physiotherapy leaders are facing.

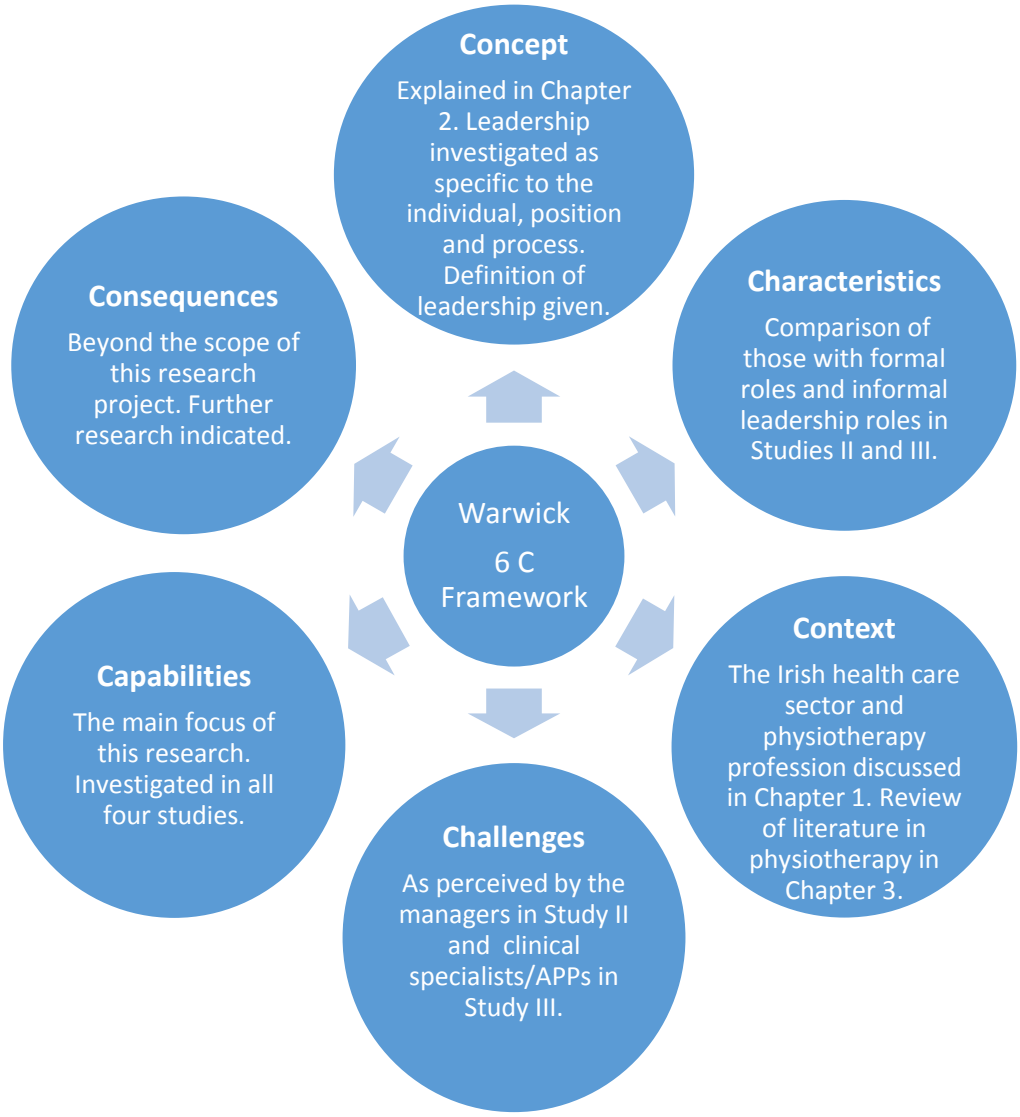


Figure 2-1 Warwick 6 C Framework applied to this PhD

The other components of the Warwick 6 C Leadership Framework will also be considered in this PhD and are displayed on figure 2.1 which demonstrates how the framework structures this research.

Regarding the concept of leadership in this research there is perceived to be value in evaluating leadership in terms of the person, the position and as a social process, and so all three approaches are used. Considering leadership according to position and those in specific roles or ranks is valuable in that leadership is likely to vary according to level in the organisation and scope of the post (Hartley and Benington, 2010). However, if leadership is considered to be entirely about those in formal positions, the opportunity to

think about the influence and impact of informal leaders is lost. For this reason, the concept of leadership in terms of the person is used in Study I. In Study II, leadership is primarily conceptualised in terms of the position. In Study III leadership is conceptualised in terms of both the person and the position; these leaders do have specific positions (clinical specialists) however they are not positions of formal leadership authority and so much of the focus is on how they use their personal influence to lead. Lastly, in Study IV leadership as a social process is investigated as the relationship between leader and followers is the focus.

In the conceptualisation of leadership in this research there is recognition of the different but complementary and overlapping roles of management and leadership. As described in Section 2.10, leading and managing are different roles and processes but an individual can be effective at both management and leadership. For this reason, physiotherapy managers are deemed to be suitable subjects for investigating the leadership of physiotherapists in formal leadership roles. As well as this there is recognition that while managers are potential leaders in the physiotherapy profession they are not the only cohort who may demonstrate leadership. Leadership is broader than management because it involves influence in a variety of contexts, not just those based on formal authority (Hartley and Benington, 2010). Consequently, the leadership practices of physiotherapy clinical specialists and APPs are investigated in Study III.

Day and Antonakis (2012) propose that leadership can be described as both (a) an influencing process (and its resultant outcomes) between the leader and followers, and (b) how this influencing process is explained by the leader's characteristics and behaviours, follower perceptions, and the context within which the leadership process occurs. This broad definition includes the most commonly used definitional factors: the leader as person (characteristics and traits), leader behaviours, the effects of a leader, the interaction process between a leader and follower(s), and the importance of context (Bass, 2008). For this reason, it has been chosen as the broad concept of leadership that will be used in this research.

The context in which this research is centred has been discussed in Chapter 1 where the health care system in Ireland and specifically the physiotherapy profession in Ireland were explored. The review of the literature of leadership in physiotherapy in Chapter 3 will also give further detail of the context of this research by demonstrating the base on which this research is grounded.

The consequences of leadership are largely outside the scope of this PhD. However, this component is mentioned by participants in Studies II and III and themes related to this are discussed in these chapters. It is anticipated that conclusions from this research will help to form the basis of further research which may investigate the consequences of leadership in physiotherapy in more detail.

2.13. Instruments to assess leadership

As well as having a model to provide structure for this PhD, a specific measure of leadership behaviours was needed. Several models were considered in choosing an instrument to assess leadership in an objective way. These survey instruments will be briefly discussed, and their strengths and criticisms, before the model that has been chosen, Bolman and Deal's Four Frame Leadership Model, is described.

The Multifactor Leadership Questionnaire (MLQ) is a validated and efficient measure of transformational leadership behaviours. Designed by Bass and Avolio (1995) this questionnaire has been widely used in the leadership literature, including studies of health care professionals (Morrison et al., 1997, Gellis, 2001, Horwitz et al., 2008). Another positive of this instrument is that it is easy to administer, takes only 15 minutes to complete and can be conducted online (Bass and Avolio, 1995). However, there were three main reasons why this measure was not chosen for this project. Firstly, it specifically measures transformational and transactional leadership behaviours which would have limited the scope of this study. Rather than restricting the investigation to a particular leadership theory, an instrument that was not confined to a specific style was considered more useful. As well as this, the transformational leadership approach does not consider task-oriented behaviours relevant for effective leadership or the political aspect of leadership (Yukl, 1999). Another reason that this measure was not chosen was the cost associated with purchasing permission to use the survey instrument for research.

The Leader Adaptability and Style Inventory was developed by the Centre for Leadership Studies, Ohio University (Hersey and Blanchard, 1974). The survey was later renamed the Leader Effectiveness and Adaptability Description (Graeff, 1983). The survey describes twelve situations and asks respondents to read each item carefully, think about what they would do in each circumstance, and then circle the letter of the action choice that they think would most closely describe their behaviour in the situation presented

(Graeff, 1983). This survey has a smaller body of research behind it than the MLQ and, additionally, did not appear to translate as easily into the healthcare sector. Many health care professionals demonstrate leadership in their roles without having formal leadership roles or people reporting to them. However, the situations in this survey describe managing subordinates and thus some healthcare professionals may find it difficult to respond to these situations through their frame of leadership. As well as this, in a critical review, Graeff (1983) questioned the instrument's ability to accurately measure leadership style and suggested that it would be more useful for teaching students or people doing management seminars. Therefore, the Leader Adaptability and Style Inventory was not chosen as the leadership instrument for this research.

Dulewicz and Higgs (2005) developed the Leadership Dimensions Questionnaire to assess leadership competencies relevant to the context, and in particular the context of change, in which the leader operates. This questionnaire is based on the premise that a leadership style needs to be matched to the context of the change and that this "fit" is a determinant of both leader performance and follower commitment. The Leadership Dimensions Questionnaire is made up of three main constructs; cognitive abilities (IQ), emotional intelligence (EQ), and managerial competencies (MQ). The results relate 15 dimensions of leadership to three leadership styles (engaging, involving and goal-oriented) and in turn to the degree of volatility of organisational change faced by the leader (Dulewicz and Higgs, 2005). This survey is concerned with leadership in a context of change, while this is the case in healthcare, a more general measure of leadership style was necessary for this research project. Another reason that this questionnaire was not chosen was that it was deemed to be quite complicated consisting of 15 scales made up of 189 questions.

The Leadership Practices Inventory (LPI) is an evidenced-based questionnaire developed by Kouzes and Posner (1988). The LPI was developed through a triangulation of qualitative and quantitative research methods and has a large research base across many different industries to support it (Kouzes and Posner, 2002). The questionnaire contains 30 behavioural statements, six for each of the Five Practices of Exemplary Leadership as described by Kouzes and Posner (1987). These five practices are: challenging the process, inspiring a shared vision, enabling others to act, modelling the way, and encouraging the heart. Participants rate their personal leadership behaviours using a 10-point scale; the higher the scores, the more frequently the individual perceives themselves to demonstrate the behaviour (Kouzes and Posner, 2002). Evaluation of the questionnaire's psychometric properties has demonstrated the instrument's construct

and concurrent validity, and internal reliabilities for the five leadership practices are very good and consistent over time (Kouzes and Posner, 2002). However, despite the strengths of this questionnaire, this instrument was not chosen because it is mostly focused on the leader-follower relationship aspect of leadership (Kouzes and Posner, 2012), rather than taking a broader view of leadership. The five practices consider the human relationships involved in leadership and the symbolic aspect of leadership, however the political aspect of leadership (e.g. negotiating agreements, networking, influencing and persuading others) is not explored in this model. As well as this it is necessary to request permission to use the survey and this may take 4-6 weeks to be granted. It is also a relatively costly instrument at $10 per survey (Kouzes and Posner, 2016b).

The leadership model of Bolman and Deal provides a framework on which to investigate the leadership styles or frames that a leader uses. Bolman and Deal's four frame model incorporates aspects of the behavioural, contingency and relational approaches to leadership. However, reframing offers the opportunity to go beyond constricted, oversimplified views of leadership (Bolman and Deal, 2008). In their framework, Bolman and Deal contend that an individual's behaviour is determined by their frame of reference and the way that they see the world (Bolman and Deal, 1991). First developed in the 1980s (now in its fifth edition), Bolman and Deal's four frame model divides leadership behaviours into four distinct frames; structural, human resource, political and symbolic (Bolman and Deal, 2008). A frame is a mental model; a set of ideas and assumptions that shape how an individual defines and ascribes meaning to a situation and ultimately what actions are taken (Bolman and Deal, 2008). Bolman and Deal's framework is constructed on the assumption that an individual's behaviour mirrors their internal cause maps or theories for action (Bolman and Deal, 1991).

Bolman and Deal (1991, 2008) have described the four frames of their framework as follows. The structural frame emphasises goals, efficiency, co-ordination and hierarchy. Leaders working through the structural frame set clear directions, hold people accountable for results, co-ordinate activities using policy and rules, and try to solve organisational problems by developing new policies or restructuring. The human resource frame is focused on human needs and relationships. Human resource leaders view people and the shaping of relationships as critical to the functioning and success of an organisation and lead through facilitation and empowerment. Openness, caring, listening and motivating others are important in the human resource frame. In the political frame organisations are viewed as arenas of continuing conflict and competition for

scarce resources. Leaders using the political frame network to secure resources, navigate conflict, form coalitions and mediate between interest groups. Political frame leaders assess the distribution of power in their organisation and think carefully about the key players and their interests. The symbolic frame focuses on meaning, belief and faith, and how humans make sense of the chaotic, ambiguous world in which they live. Symbolic leaders instil a sense of enthusiasm and commitment through their charisma and vision, and understand the importance of using stories, rituals and ceremonies to inspire others. Each of the frames is powerful and coherent individually but collectively they make it possible to reframe. Reframing is a powerful tool for generating new ideas, finding different strategies and gaining clarity when addressing problems (Bolman and Deal, 2008). In their research, Bolman and Deal found that the ability to use multiple frames is associated with greater effectiveness as a leader (Bolman and Deal, 1991, 1992a, 2008). They contend that individuals who are able to use more than one frame, and thus have more choices available, will be more effective than those with a narrow perspective when addressing organisational issues (Bolman and Deal, 2008).

The Leadership Orientations Index (LOI) is a questionnaire that identifies the frames that an individual uses and which predominates (Bolman and Deal, 1990). The Bolman and Deal framework allows problems or gaps in leadership practices to be identified but also provides solutions about the ways in which these gaps can be addressed (Sasnett and Clay, 2008). While this model could be considered to be old (it was developed in the 1980s), it has an extensive body of research behind it and Bolman and Deal's book explaining their model, 'Reframing Organisations', is now in its 5th edition (Bolman and Deal, 2013). This model was chosen as a framework for Study II and Study III for several reasons. It has been used to examine the leadership styles of occupational therapy programme directors, nursing chairpersons, radiation therapy programme directors and medical residency programme directors (Miller, 1998, Mosser and Walls, 2002, Turley, 2002, Sharpe, 2005, Sasnett and Clay, 2008) and thus allows for comparison with other healthcare disciplines. It is a relatively simple framework to understand with only four distinct frames yet it is powerful enough to capture the subtlety and complexity of leadership (Bolman and Deal, 2014), and comprehensive enough to enough to give the researcher a good grasp of the leadership practices of an individual or group.

This model also acknowledges the overlapping roles of leadership and management which is important because in Study II it is the leadership capabilities of managers that are being investigated. Another strength of this framework is that it has been used for both quantitative and qualitative research. Given the complexity of leadership, no

questionnaire will ever give a truly comprehensive representation of someone's leadership practices (Bowen, 2004). Including a qualitative component that is based on the same framework allows more in-depth exploration of the leadership capabilities of the participants in Studies II and III.

2.14. Conclusion

This chapter has outlined how the concept of leadership and approaches to leadership research have evolved over the last century. Research has moved from an individualistic approach, focused on the characteristics and traits of an individual, to one that views leadership as a process and considers the role of followers and the context in which leadership occurs. Given the wide range of influences that need to be considered when writing and investigating leadership the Warwick 6 C Leadership Framework is used to structure this research. This framework considers the concept, context, characteristics, capabilities, challenges and consequences of leadership. In this chapter the concept of leadership used in this research was described. The context within which this research is situated is explored in the first and third chapters of this thesis. The characteristics and capabilities of physiotherapy leaders and the challenges facing them are the key focus of this research and will be examined in subsequent chapters.

3. Chapter 3 – Literature review: Leadership in the profession of physiotherapy

The aim of this chapter is to describe the methodology and results of a scoping review of the literature on leadership and leadership development in the profession of physiotherapy. Reviews of leadership and leadership development within the professions of nursing and medicine (Wong and Cummings, 2007, Cummings et al., 2010, Frich et al., 2015) have been conducted but this has yet to be undertaken in the field of physiotherapy. In this scoping review the research question was:

- What is known from the existing literature about leadership and leadership development in the profession of physiotherapy?

As this was the first review of leadership in physiotherapy, a scoping review was conducted. This approach enables the mapping of key concepts underpinning a research area and is useful when the research area is complex and has not previously been comprehensively reviewed (Arksey and O'Malley, 2005). The research question was broad in nature in keeping with the suggested approach for a scoping review (Daudt et al., 2013). The review also reported on what physiotherapy organisations are doing to promote leadership and leadership development programmes in the profession. An earlier version of this review (articles until early 2014) has been published in Physical Therapy Reviews (Appendix I – pg 370-379). This review has subsequently been updated to include articles published up until July 2016 and it is this updated review that is presented here.

3.1. Materials and Methods

A systematic and comprehensive scoping study was undertaken to review the literature on leadership in the profession of physiotherapy following the five stages of Arksey and O'Malley (2005). Daudt et al. (2013) have suggested the definition of a scoping study as follows: “Scoping studies aim to map the literature on a particular topic or research area and provide an opportunity to identify key concepts; gaps in the research; and types and sources of evidence to inform practice, policymaking, and research”. Unlike a systematic review which will typically focus on a well-defined question and identify appropriate study designs in advance, a scoping review tends to address broader topics where different study designs may be applicable (Arksey and O'Malley, 2005). The aim of a scoping review is to be as comprehensive as possible in identifying studies appropriate to the

research question. However, this leads to a limitation of the scoping review methodology; there is no formal assessment of the quality of the studies (Elliott et al., 2016). Yet Njelesani et al. (2011) have argued that this can be an advantage because a wider and more comprehensive range of published material is included. This review included grey literature, e.g. documents from physiotherapy professional bodies, as well as published articles, due to the dearth of peer-reviewed literature. The use of transparent and rigorous methods to identify the relevant literature enables readers to evaluate the quality and completeness of the data set (Elliott et al., 2016).

3.1.1. Inclusion criteria

Inclusion criteria:

- Published after 1990
- Both 'leadership' and 'physiotherapy' or 'physical therapy' were themes
- Articles in peer-reviewed journals
- Policy or practice documents relating to leadership and leadership development from professional physiotherapy organisation websites.
- English language publications

Exclusion criteria:

- Articles which mentioned 'leadership' only in passing or which only described specific leaders
- Articles about leadership in healthcare more generally and not physiotherapy specifically (where the results from the physiotherapy participants were combined with those of other participants and not reported separately)
- Articles about physiotherapy/physical therapy assistants
- PhD theses, commentary pieces on other articles, magazine articles, book reviews, focused symposia and notes to the editor
- Articles from hand therapy journals

3.1.2. Search Strategy

A comprehensive search of five electronic databases (CINAHL, PubMed, ABI Inform, EMBASE and Scopus) was conducted. A medical librarian assisted in developing and adapting the electronic search strategy. The journals Physical Therapy Education and Physiotherapy Canada were also searched due to the number of citations coming from these journals. Search terms were adapted for use with each database. Key terms used in the search included 'Leadership AND Physical Therapy', 'Leadership AND Physiotherapy', 'Leadership AND Physical Therapy Specialty', 'Leadership AND Physical Therapy Modalities', 'Physical Therapy Specialty AND Practice Management/organisation and administration AND Professional Practice', 'Physiotherapy manager AND Leader', 'Physiotherapy AND Healthcare Management AND Management', 'Healthcare Management AND Physiotherapy AND Leadership', 'Organization and Management AND Professional practice AND Physiotherapy', 'Delivery of Healthcare AND Physical Therapy Specialty' and 'Management and Organisation AND Physical Therapy AND Professional Practice'. The full list of search terms for each database are displayed in appendix IV (pg 422-423).

Each citation was initially screened to check for eligibility on the basis that leadership and physiotherapy/physical therapy were themes or significant components of the articles. This narrowed the search results to 107 articles which were further checked to ensure that they met the inclusion and exclusion criteria above. Articles which appeared to meet the eligibility criteria were read and evaluated as to whether they were appropriate for inclusion. Where there was only a conference abstract available the author was contacted to request the full-text of relevant studies. Two full-text articles, two conference posters and a magazine article were received from authors following these requests. One author (Alkassabi et al., 2015) did not respond to the query regarding a full-text of their work. Articles which reported on the same study were included as a single entry as displayed in Appendix IV (pg 424-430). A manual search of the reference lists of each included article was conducted for relevant articles. The websites of various professional physiotherapy bodies (APTA, APA, CPA, CSP, ISCP, PNZ, and WCPT) were also searched for policy and practice regarding leadership and leadership development.

3.2. Results

The stages of the literature search are displayed in Figure 3.1 and presented based on a PRISMA Flow Diagram (Moher et al., 2009). The search strategy returned a total of 1798 articles (1630 with duplicates removed) and an additional 15 articles were identified in the search of the grey literature. The manual search of the Journal of Physical Therapy Education (1999-2016), Physiotherapy Canada (2008-2016) and the reference lists of included articles from the database search yielded 20 further studies.

Following initial screening, 107 full-text articles were considered for full-text review. Of these, 54 articles were excluded based on the inclusion and exclusion criteria as detailed in Figure 3.1. The remaining 53 articles included in this review are summarised in Appendix IV (pg 424-430). Four studies had multiple publications included for review. Desveaux et al. (2012a) and Desveaux and Verrier (2014) reported on the same survey data, as did Chan et al. (2015) and Desveaux et al. (2016). Palombaro et al. (2011) and Black et al. (2013) reported on the same student-led probono physiotherapy clinic project. Larin et al. (2011) and Larin et al. (2014) reported on the survey results of the same physiotherapy students at different time points in their education programmes.

The search of the physiotherapy professional body websites yielded 15 documents. Of these documents nine were excluded; eight because they were magazine articles and one because leadership was not a theme. The six documents included from the grey literature search are summarised in Appendix IV (pg 431).

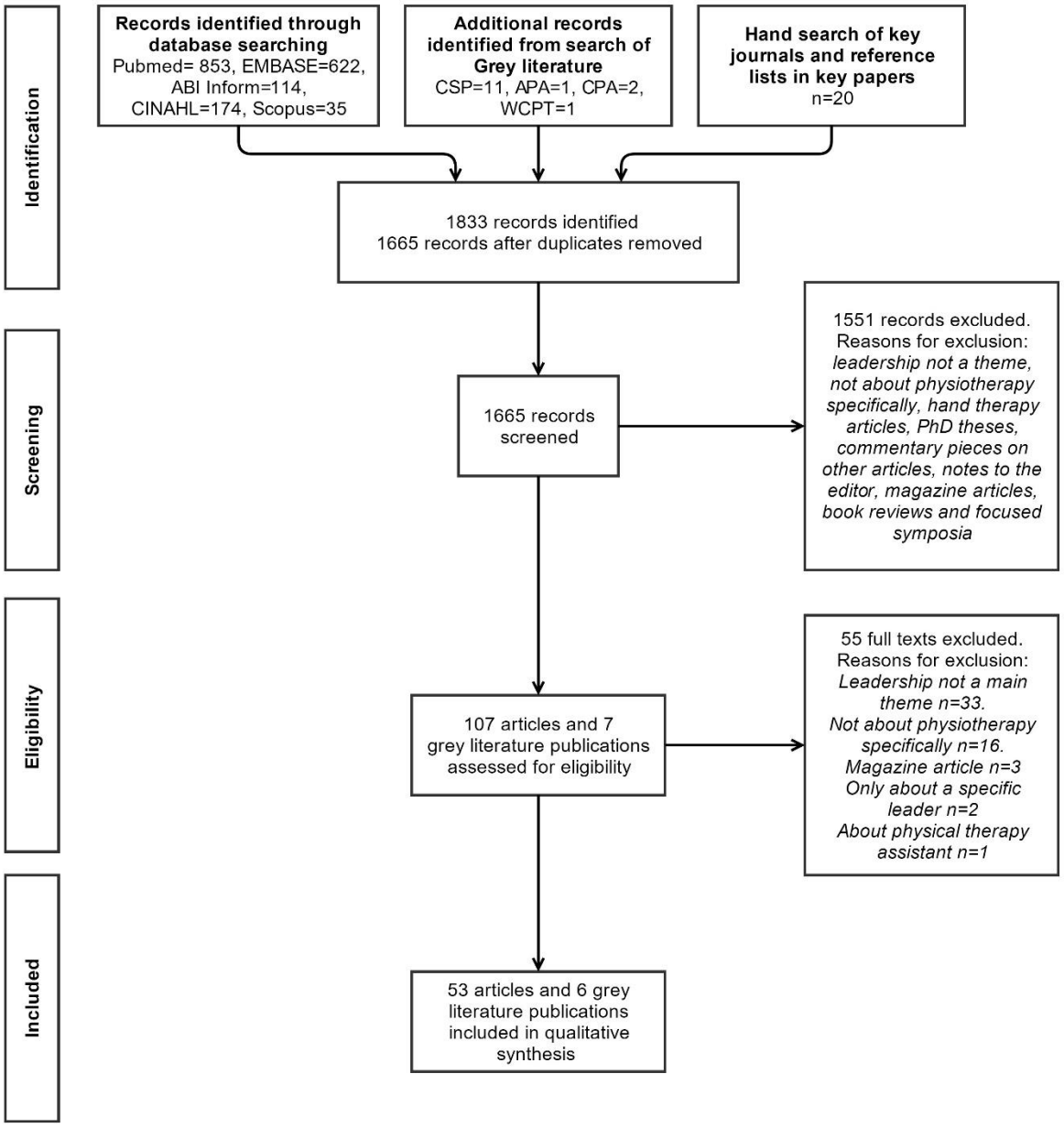


Figure 3-1 PRISMA Flow diagram showing stages of literature review

The included articles were read and summarised. Using content analysis, potential themes were listed for each article. Once all articles had been summarised the potential themes identified were listed and compared. Similar themes were grouped together and renamed where appropriate. Subthemes were also formed where there were similar themes grouped together. The articles were then listed under the relevant themes and subthemes. Themes that had few articles listed under them were adapted to allow them to be included within another theme or were discarded. This qualitative synthesis of the included studies yielded eight themes (displayed in Table 3.1). The results of the

literature review are presented here using these themes and subthemes and are discussed in Section 3.3.

Table 3-1 Identified themes in literature review articles

Themes	Subthemes
Definition of leadership	
Need for leadership	Effects of leadership
Leadership roles	Formal and informal leadership roles Clinical leadership Academic leadership
Leadership opportunities and challenges	
Impact of gender	
Impact of setting	
Leadership capabilities	Leadership characteristics and skills Leadership style
Leadership development training	Pre-registration leadership training Physiotherapy Professional Organisations

3.2.1. Definition of leadership

Defining leadership is an elusive task and there are many definitions varying across industry, setting and culture (as discussed in Section 2.1). This review found several definitions of leaders or leadership in the physiotherapy literature (displayed in Table 3.2); however, a definition of leadership was not given in the majority of the articles.

Table 3-2 Definitions of leaders/leadership in the physiotherapy literature

Article	Definition of a leader/leadership
Chan et al. (2015)	Leaders defined as those who held a title or position e.g. academic lecturer, board member of a professional physical therapy association, professional practice leader, or administrative or managerial position.
CPA (2012)	A leader is defined as someone who leads successful and sustainable change, holds multiple lenses and perspectives, strengthens and builds relationships, inspires and engages others to grow and learn, leads across and navigates complex systems, asks questions with a generative and learner lens, and reflects on and senses what is needed most in a system
Desveaux et al. (2012), Desveaux and Verrier (2014)	A leader is an individual who influences the actions of another individual or group toward accomplishing goals and sets the pace and direction of change while facilitating innovative practice
Lopopolo et al. (2004), Schafer et al. (2007)	Leadership is to use strategies and processes to move staff and subordinates to action in a desired direction
Massey (2006)	Leadership is 'influencing'
Miller and Tuekam (2011)	Listed suggested professional leadership activities including: teaching students, giving courses, guest speaker for patient/community or professional groups, membership of professional associations, committee work, mentoring and professional consultation activities and receiving awards.
Thornton (2016)	Leadership is the art of motivating a group of people to achieve a common goal

The definition used by the Leadership Division of the Canadian Physiotherapy Association (CPA), was provided in the context of developing leadership education and competencies of the profession (CPA, 2012). As discussed in Section 2.2, Desveaux et al. (2012a) based the definition of a leader in their survey of Canadian physiotherapists on the work of Turnball James (2011). A simpler definition of leadership was used by Lopopolo et al. (2004) and Schafer et al. (2007). Lopopolo et al. (2004) conducted a Delphi study to investigate the importance placed on Leadership, Administration, Management and Professionalism (LAMP) skills and the level of knowledge and skill in these areas expected of physiotherapy graduates in the USA. Schafer et al. (2007) built on the work of Lopopolo et al. (2004) and used a survey to investigate the administration and management skills expected of physiotherapy graduates. In both studies leadership

was being investigated as a component of managerial and administration skills and not as a separate concept. This may explain why such a simplistic definition, and one which does not adequately reflect the complexity of leadership, was given in these studies. As noted by LoVasco et al. (2016) in a study which explored the perceived leadership practices of year 1 DPT (Doctor of Physical Therapy) students, LAMP constructs are made up of leadership, administration, management, and professional skill and knowledge which limits the applicability of findings from LAMP studies to questions regarding leadership alone.

Massey (2006) also defined leadership in a simple way. In his 2006 APTA Presidential address, Massey used John C Maxwell's definition: leadership is 'influencing'. Based on this definition Massey argued that all physiotherapists can be leaders because every day we have the opportunity and ability to influence. An alternative way of defining leadership in physiotherapy is provided by Miller and Tuekam (2011) who gave a list of suggested leadership activities (see Table 3.2) in their investigation of a portfolio for recording professional activities including leadership. In a study comparing the strengths of physiotherapists in leadership positions with those who were not in leadership positions, Chan et al. (2015) defined physiotherapy leaders according to their formal positions and/or achievements. While this approach of identifying leaders by their position and/or achievements was necessary for this study it would not be an appropriate way to define leaders in physiotherapy more generally because there are potentially many physiotherapists demonstrating leadership who are not in formal leadership roles.

In a recent review of current thinking and practice commissioned by the CSP (Thornton, 2016), the King's Fund Commission definition of leadership was given. However, this review also appreciated that leadership was a lot more complicated than this and that there are many different concepts and theoretical perspectives of leadership. This review explained that leadership is situated in context and expressed through both formal and informal relationships, across and within organisational boundaries. LoVasco et al. (2016) also recognised the complexity of the construct of leadership and acknowledged that there are a number of theories and variations in the definition of leadership. While these authors did not give a definition of leadership in their study of the perceived leadership practices of first year DPT students they did advocate that developing consensus on a definition of leadership in physiotherapy would benefit the profession. A common definition of leadership in physiotherapy research would allow comparison across studies and thus facilitate the development of leadership curricular content (LoVasco et al., 2016).

3.2.2. Need for leadership

A commonly expressed opinion running through the articles in this literature review was the importance of leadership and that it is needed in the physiotherapy profession. As discussed in Sections 1.3 and 2.9, the need for leadership in healthcare has been recognised. El-Din (1998) wrote that the future of physiotherapy depends on its leaders because what is characteristic of the leaders becomes characteristic of the profession. In the 2002 Pauline Cerasoli Lecture, Ferretti (2002) recognised the fast pace of change in healthcare today and argued that leadership is critical to advance contemporary practice. The Pauline Cerasoli Lecture is given annually by the winner of the Pauline Cerasoli Lectureship Award in the USA. This award acknowledges a physical therapist who has distinguished himself/herself as an educator, administrator, practitioner and/or mentor (APTA, 2012a). Similarly, the Linda Crane Memorial Lecture Award is given in recognition of an individual's significant contributions to the practice of physical therapy in the USA (APTA, 2012b). In the 2010 Linda Crane Memorial Lecture, Hayes (2010) spoke of the importance of leadership to ensuring excellence in physiotherapy education, and for the same lecture in 2011 Lovelace-Chandler (2011) discussed of the need to develop leaders in practice, the profession, and research and education. Gersh (2006) argued that there is a need for physiotherapists to lead by example, collaborate with other leaders to enhance healthcare delivery, and advocate for and empower patients. Similarly, in an opinion piece about a DPT programme in Australia, Dean and Duncan (2016) wrote of the need to prepare innovative leaders in physiotherapy to ensure future transformative physiotherapy practice that can respond to ever-evolving healthcare systems. However, these opinion pieces and lectures are only the perceptions of individuals and thus may not be generalizable to the opinions of the wider physiotherapy profession.

In a survey of three groups of physiotherapy managers, Schafer (2002) found that 'leader' was rated as one of the top five most important work categories for physiotherapy managers across three managerial settings (hospital, private practice and education). Similarly, in a Delphi study of physiotherapy managers, Lopopolo et al. (2004) found that leadership was a top-rated managerial function. Bulley and Donaghy (2005) described the competencies that sports physiotherapists should demonstrate. The importance placed on leadership was reflected by the fact that four of the eleven competencies related to professional leadership. The competencies underwent a rigorous review and revision process with input from international experts and the resulting competency

document was adopted by the International Federation of Sports Physiotherapy in 2004. The competencies related to professional leadership were: life-long learning, professionalism and management, dissemination of best practice and promotion of fair play and anti-doping practices. However, no definition of professional leadership was given in this study which limits its value in the context of other leadership literature. In a study investigating direct access in physiotherapy, Bury and Stokes (2013) advocated that professional leadership has an important role to play in facilitating change and advocacy for the physiotherapy profession. The Physical Therapy and Society (PASS) meeting was convened by the APTA in 2009 to explore “how physical therapists can meet current, evolving, and future societal health care needs” and brought together leaders from physiotherapy and other professions (Kigin et al., 2010). The PASS participants recognised that leadership is needed if physiotherapists are to meet emerging healthcare challenges but that this goal will require substantial change in how we think, act, and work together (Kigin et al., 2010). Similar to this, LoVasco et al. (2016) concluded that it was important to develop leadership skills in physiotherapy students to achieve the vision of the APTA and address health care challenges in their exploration of the leadership practices of DPT students. These studies demonstrate there has been some recognition of the importance of leadership for physiotherapy individuals and the physiotherapy profession.

The importance of leadership to the profession of physiotherapy has also been recognised by physiotherapy professional bodies. The CSP (2012a) wrote about the importance of leadership as opposed to leaders in an effort to share this concept beyond those with formal roles and encourage all members of the profession to engage in leadership. The CPA (2012) in its curriculum for the development of leadership core competencies recognised that physiotherapists in public practice positions now require a great degree of leadership skill and knowledge and that private practice physiotherapists require the ability to act as leaders in their business. In a report on the future of the physiotherapy profession, the Australian Physiotherapy Association (APA) (2015b) discussed the need for strong clinical and service leadership to compete for resources, drive innovation, and advocate for the profession. The leadership development opportunities provided by these professional bodies for their members are discussed later in this chapter.

3.2.3. Effects of leadership

While there have been many articles stating the importance of leadership to the physiotherapy profession to date there is very little published evidence to back up these assertions. In recent years, critical scholars sceptical of the benefits of leadership have suggested that research should focus less on what leadership is and more on what it does (Martin and Learmonth, 2012). Leadership can have a variety of effects on individuals and groups, e.g. empowerment, job satisfaction, performance and retention, but in healthcare a major goal is to improve services for patients (Vance and Larson, 2002). Research on the effect of leadership on physiotherapy outcomes, e.g. changes in organisational outputs, improvements in patient care, is limited. Only two studies which investigated the effects of leadership in physiotherapy were identified in this review. Boak et al. (2015) employed a case study methodology using qualitative and quantitative methods in an analysis of the introduction of distributed leadership and team working into a physiotherapy department in the UK. Distributed leadership and improved team working were found to be central to a number of system changes that were initiated by the department which led to improvements in patient waiting times for therapy. However, as a single case study these results may not be transferable to other contexts.

Cho and Varona (2015) reported on how a structural change in a healthcare organisation and the creation of leadership positions led to improved clinical practice. The redesign project created a centralised model for practice leadership which increased access to expert clinical support for the frontline staff across the region. The practice support team aimed to provide vision and leadership by ensuring safe and competent practitioners, advancing physiotherapy practice and striving for excellence. The authors reported that this improved the quality and efficiency of clinical leadership resources which had a positive impact on the quality of patient care delivered. There was increased involvement of therapists engaging in knowledge translation, clinical research and quality improvement projects. However, only limited details of this study were accessible to this review because although the authors were contacted to request a full-text, only a poster and conference abstract were available.

3.2.4. Leadership roles

Another theme in the articles was leadership roles: clinical leadership, academic leadership, and formal and informal leadership.

Richardson (1999) highlighted the importance of clinical leadership to the physiotherapy profession in the 1999 APTA Presidential Address. Richardson argued that physiotherapists must lead the way and inspire change to ensure that the physiotherapy profession remains competitive in a rapidly changing environment of practice and reimbursement. The World Confederation for Physical Therapy (WCPT) policy document, Description of Physical Therapy, states that the scope of physiotherapy practice is not limited to direct patient/client care but also includes advocating for patients/clients and for health, supervising and delegating to others and leading (WCPT, 2011a).

In the 2006 APTA Presidential Address, Ben Massey highlighted the leadership of clinical physiotherapists (Massey, 2006). A physiotherapist does not need to have the title of manager or director to improve practice within a clinic. What is needed is "the ability to lead by example and show others what can be accomplished clinically and professionally by raising one's own skill level and competence" (Massey, 2006). The importance of clinical leadership was also emphasised by Cleather (2008) in the 2008 Enid Graham Memorial Lecture. This lecture is given annually by the recipient of the Enid Graham Award, the most prestigious award bestowed by the CPA. This award recognises the recipient's excellence in the physiotherapy profession in Canada (CPA, 2016a). In the 2008 lecture, Cleather detailed the contribution of clinical physiotherapists, and not just academics, to leadership within the profession. Cleather believes that clinicians need to be effective leaders if they are to run a successful clinic or department, and that clinical leadership will be needed if physiotherapists are to be part of the decision making process in the delivery of healthcare (Cleather, 2008).

Rothstein (2003) described a divide between physiotherapy leaders in the clinical environment and physiotherapy leaders in academic centres. Rothstein advocated the importance of clinical leaders and that physiotherapy leaders should be physiotherapists first and foremost. Both academic programmes and clinical organisations should be led by physical therapists with adequate credentials and records of achievement. There were several other articles in this review focused on leadership in academic settings in physiotherapy (Dumont, 1998, El-Din, 1998, Rothstein, 1998, Sanders, 1998, Schmoll, 2000, Perry, 2002, Buccieri et al., 2012, Hinman et al., 2014, Tschoepe and Davis, 2015, Desveaux et al., 2016). In an opinion piece on academic team leadership, Sanders (1998) spoke of the importance of physiotherapy leaders in education; their impact on faculty members and role as role models in the profession. The elements needed to be an effective leader in physiotherapy education were described and included: create a

vision, establish goals and objectives, build team co-operation, foster commitment and self-confidence through trust and create opportunities. In the 2000 Pauline Cerasoli Lecture, Schmoll (2000) also spoke about the need for academic leaders to create a vision. Schmoll advocated for leadership that is empowering rather than controlling, and that decision making should occur at the lowest appropriate level e.g. faculty determining teaching assignments rather than administrators, and students being responsible for establishing a final exam table.

Dumont (1998) wrote about the student experience of leadership in physiotherapy education and perceived physiotherapy education to involve two types of leadership: organisational leadership and professor/student relationships beyond those established in the classroom. Organisational leadership related to the structure and philosophy of the programme. Professor/student relationships pertained to mentorship relationships beyond the classroom. Dumont perceived fostering leadership in students to be an important role of physiotherapy educators. El-Din (1998) wrote of a physiotherapist's experience of being an academic leader. This commentary piece explored the author's style of leadership and the importance of integrity, vision, courage and the ability to effect change. El-din concurred with the views of Dumont in advocating that the true responsibility of a leader is to build leadership in others.

In an invited commentary, Rothstein (1998) warned of a lack of leaders in physiotherapy academia in the USA and reported that there were few faculty members prepared to assume leadership positions as chairs, heads or directors of physiotherapy education. While this article is now old, a more recent study from the USA by Hinman et al. (2014) suggests that the problem of retaining leaders in physiotherapy programmes is ongoing. A survey was used to investigate the reasons why administrators of physiotherapy education programmes had vacated their post. The most frequently cited reasons for leaving included: perceived lack of resources or support, excessively high workload, inadequate compensation, promotion to another position and inability to hire adequate faculty. Hinman advocated the importance of addressing the high attrition rate of physiotherapy academic leaders arguing that leadership is key to achieving outcomes in physiotherapy education.

Perry (2002) surveyed programme administrators and faculty about the importance of specific roles and responsibilities of programme administrators. Several of the top-rated roles were related to leadership: act as faculty advocate to higher administration, monitor standards, develop goals, motivate faculty and exhibit informal faculty leadership.

However, the leadership aspect of the role was not explicitly discussed in this article. While informal faculty leadership was rated as one of the top ten most important roles no definition of this role was provided.

In designing a survey to evaluate the performance of directors/administrators of physiotherapy education programmes Buccieri et al. (2012) included 'leadership and collaboration' as one of the sections of the survey recognising that this is a core aspect of their role. Examples of role responsibilities in the 'leadership and collaboration' category were: serving as a change agent, providing vision, demonstrating effectiveness in negotiation, marketing, public relations, and advocacy. Tschoepe and Davis (2015) reported on a forum convened by American Council of Academic Physical Therapy (ACAPT) to discuss the future of physiotherapy education. The keynote speaker, Dr Gangone, spoke of the need for physiotherapy educators to engage in their own personal leadership development to ensure the progression of education agendas.

Desveaux et al. (2016) compared the leadership characteristics of physiotherapists in academic (n=36) and managerial roles (n=52) using the Clifton StrengthsFinder survey. Academics and managers were found to share similar core characteristics with slight variations in secondary characteristics; 'Harmony' and 'Connectedness' were more prevalent for managers, 'Intellection' and 'Empathy' were more common in the academics group. The most prevalent strengths for both academics and managers were the 'Learner' and 'Achiever' characteristics. Desveaux et al. (2016) concluded that individuals in leadership roles in the profession of physiotherapy share similar core characteristics irrespective of their leadership role. However, this study only compared the leadership of managers and academics. As there are many other physiotherapy leaders in different types of roles further research could expand on this study to include those in clinical leadership positions.

There was variation in the articles included in this review as to whether they related to formal or informal leadership positions. Formal leadership positions included those of physiotherapy consultants and physiotherapy managers. Stevenson (2011) described the role of physiotherapy consultants as encompassing four key areas: clinical expertise, professional leadership and consultancy, education and development, and practice and service developments linked to research and evaluation. Professional leadership was said to permeate every aspect of the job. Physiotherapy consultants lead by example, act as role models through regular teaching sessions, provide mentorship to staff, participate in peer reviews, write for publication and present at conferences. In a

feasibility study aiming to pilot and test a diary for recording consultant activity, leadership was also seen as a key function of the consultant's role (Richardson et al., 2008). Leadership activities reported in the study included: implementing service development, development of staff, facilitating the multidisciplinary team (MDT), Board-level input, mentoring staff, chairing meetings, national level input, and strategic planning.

Lai (2009) investigated the challenges and education needs of physiotherapists in formal leadership roles in the Greater Toronto Area in Canada using an online survey. These roles included professional practice leader, co-ordinator, director, manager, clinical practice leader and senior physiotherapist. The participants perceived multitasking, problem-solving, priority management, organisation, and interpersonal skills to be the most important skillsets for their roles. Lifshitz (2012) detailed his experience in a formal leadership role, Chief Sports Physiotherapist and Medical Director of the Israel Football Association. One of the major challenges that Lifshitz met when assuming this position was resistance to a sports physiotherapist, rather than a physician, being the medical director of the football association. There was a need to justify his appointment by demonstrating that physiotherapists can possess leadership skills as well as medical practitioners (Lifshitz, 2012).

The CSP has published a briefing paper on the contribution of physiotherapy managers and leaders to the healthcare system (CSP, 2012a). This briefing paper was about both physiotherapy managers and leaders and no distinction was drawn between the two concepts. This suggests that the CSP recognises that physiotherapy managers provide leadership but physiotherapists who are not in a managerial role can also provide leadership. The report argues that because of their clinical backgrounds and experience of the healthcare system physiotherapy managers and leaders are in a pivotal position to influence and contribute to the redesign, innovation and sustainability of successful change. The CSP has also published a report detailing their position on advanced practice in physiotherapy (CSP, 2016a). This report discussed how leadership is an important aspect of the roles of advanced physiotherapy practitioners (APPs) and physiotherapy consultants. APPs use leadership skills to develop and deliver co-ordinated patient centred services, hold high levels of personal autonomy, lead professional and policy networks to encourage collaboration, apply advanced skills and knowledge, and share information and ideas to enhance practice. APPs were said to provide clinical leadership rather than direct line management for physiotherapists.

As described in Section 3.2.3, Cho and Varona (2015) reported that the creation of named leadership roles in a physiotherapy team led to improvements in clinical practice and the quality of patient care that clinicians deliver. Role-specific leadership was also described by Bulley and Donaghy (2005) who detailed the competencies that a sports physiotherapist should demonstrate. Chan et al. (2015) defined physiotherapy leaders according to their formal positions and/or achievements as described in Section 3.2.1. The Clifton StrengthsFinder survey was used by Chan et al. (2015) to compare the strengths of physiotherapists in leadership roles and those who do not have leadership roles. Leaders were found to most frequently exhibit the strengths of 'learner', 'achiever', 'responsibility', 'input' and 'strategic,' whereas non-leaders most frequently displayed strengths of 'learner', 'achiever', 'input', 'relator' and 'harmony'. There was substantial overlap between the leadership profiles of leaders and non-leaders. Chan et al. (2015) suggested that future research should investigate whether leadership strengths vary depending on the type of leadership position. The narrow definition of leaders and non-leaders used in this study may have had an impact on the results. Some of the respondents classified as non-leaders may actually demonstrate excellent leadership in their work but may not have fit into the categorisation defined in the study. Chan et al. postulated that the substantial overlap between leaders and non-leaders may be explained by the fact that the physiotherapy role is a professional role in itself, thus physiotherapists are likely to display leadership strengths irrespective of position.

Regarding informal leadership, a taskforce set up in 1999 to develop a position on the professional development of LAMP skills in physiotherapists expressed the belief that LAMP skills are required of all physiotherapists and are necessary for the development of the effective professional, not just those with management titles (Kovacek et al., 1999). In a published lecture, Feitelberg (2004) spoke of his opinion that all physiotherapists are or can be leaders and that leadership in the profession often happens naturally. In Feitelberg's view leadership is about collaborating to move the profession forwards and you do not need a title to participate. Gersh (2006) also recognised that a formal position was not necessary to demonstrate leadership in physiotherapy in an article which advocated for a model of servant leadership. Servant leaders rely on trust to get things done rather than using formal authority and power.

The articles in this theme demonstrate that there are different types of leadership role within the physiotherapy profession including academic, clinical and managerial. Informal leadership, or leadership from those not in formal leadership positions, has also been recognised.

3.2.5. Leadership opportunities and challenges

A small number of articles discussed leadership opportunities and/or challenges for the physiotherapy profession. In a published lecture, Cleather (2008) encouraged physiotherapists to take advantage of the opportunities for leadership and described opportunities and challenges facing the physiotherapy profession in Canada including: ordering x-rays, triage and emergency room practice, competition from increasingly active professional groups, accountability to the consumer and changing technology.

Opportunities for growth of the physiotherapy profession were also recognised by participants at the PASS meeting (Kigin et al., 2010). As discussed in Section 3.2.2, the PASS meeting was convened to explore how physiotherapists can meet current and future societal health needs. Opportunities identified at this meeting included: involvement in decision making in health delivery, ensuring direct access to physiotherapy, development and implementation of new technologies, and health promotion and wellness. The need for leadership to address these opportunities was also recognised – to examine each opportunity, set up a strategic plan, provide an opportunity of openness, and promote innovation (Kigin et al., 2010). Dean et al. (2011) viewed health promotion as an important area of growth for physiotherapy in their report on the First Physical Therapy Summit on global health. This summit was convened at the 2007 WCPT Congress to vision practice, education and research in physiotherapy in the 21st century. It was concluded that the physiotherapy profession should have a leading role in preventing, reversing and managing lifestyle related disease.

As discussed in Section 3.2.4, Lai (2009) surveyed physiotherapy leaders in Greater Toronto Area about the challenges they face in their role. Most commonly cited were lack of protected time for the leadership position, lack of formal authority to influence change, and challenges in staff support and development. Rather than focusing on challenges at an individual level, the APA have published a report articulating eight strategic drivers that will present both opportunities and challenges for the physiotherapy profession in Australia (APA, 2015b). These strategic drivers include: changing population needs, heightened consumer expectations, a changing workforce, new models of care, new service providers, health system reforms, limited system resources and advances in technology. The report included strong clinical and service leadership as one of seven key features that will be needed if the physiotherapy profession is to successfully meet these challenges.

3.2.6. Impact of gender

The gender bias that exists in the attainment of leadership positions has been recognised in the literature on leadership in healthcare (Lantz, 2008, Fontenot, 2012); however, relatively little has been written on the effect the female dominance of physiotherapy has on leadership within it. As a predominantly female profession (Schofield and Fletcher, 2007, APTA, 2011, HCPC, 2013), it seems counterintuitive that being female may be a potential limiting factor in assuming a leadership position. However, research in the similarly female-dominated profession of nursing has found that this may be the case (Simpson, 2004, McMurry, 2011). The subtle gender bias that still exists in many organisations, as well as in society, may undermine women in the process involved in becoming a leader (Ibarra et al., 2013). McMurry (2011) explored male under-representation in the nursing profession and found that men were given fair, if not preferential, treatment in hiring and promotion decisions. Men benefit from their minority status by being given differential treatment and being associated with a more careerist attitude to work (Simpson, 2004).

Rozier and Hersh-Cochran (1996) examined the gender differences of physiotherapy managers in terms of leadership roles using a questionnaire. Some differences in leadership style were noted; female managers preferred to use a transformational supervisory style, and males demonstrated more masculine leadership. However, overall female physiotherapy managers differed only slightly from their male counterparts. The authors concluded that the similarities in leadership characteristics in male and female physiotherapy managers highlight the gender discrepancy in appointment to managerial positions. This study only investigated the leadership roles of physiotherapy managers, it would be interesting to compare the leadership roles of physiotherapists in other leadership positions or of those without formal leadership positions.

Raz et al. (1991) conducted in-depth interviews to identify gender-related values, perceptions and experiences of female physical therapists. One finding of this study was that women who assume dual roles as primary caregivers and career women often must make compromises in career development, advancement, income and time at home. Women's dual responsibilities are responsible for the limited time and energy available to them to pursue leadership positions (Raz et al., 1991). A commonly expressed opinion was that there is a tendency within physiotherapy and medicine for men to disproportionately assume leadership positions. However, this study was limited by the

fact that the interviews were only conducted with female physiotherapists; there were no male physiotherapists interviewed to allow comparison.

While these studies are now relatively old, more recent research by Desveaux et al. (2012a) found that in a survey of Canadian physiotherapists which asked 'Do you perceive yourself to be a leader?', male gender was significantly associated with self-declaration as a leader. While this more contemporary research suggests that gender may still be a factor in the leadership activities of physiotherapists, the studies of Chan et al. (2015) and LoVasco et al. (2016) do not support this. Chan et al. (2015) found that gender did not significantly influence the strengths in a physiotherapist's leadership profile and LoVasco et al. (2016) found that gender did not have a significant effect on the self-perceived leadership practices of students in the first year of their DPT programme. However, it is worth noting the gender bias in these three studies; the majority of participants in each study were female.

3.2.7. Impact of setting

Another factor thought to influence leadership in physiotherapy is the setting in which it occurs. The CSP report on current thinking on leadership in physiotherapy practice recognised that leadership is situated in a context and thus must respond to and be defined by that context and situation (Thornton, 2016). Leadership is socially constructed through complex interactions between the context in which it occurs and the people involved and therefore these factors must be taken into account (Thornton, 2016). Context was said to include organisational factors such as location and sector, and people factors such as culture and working relationships.

In a review based on both a literature search and the author's personal experience as a physiotherapy manager within a children's hospital in the UK, Brazier (2005) hypothesised on the contextual factors that influence leadership behaviour. A transformational leadership style was facilitated by organisations with organic structures, whereas bureaucratic organisations encourage a more transactional style. Organic structures rely on personal bases of power that are developed on respect and expertise. In contrast, bureaucratic organisations use rigid departmentalism, high specialisation and centralised authority. Hierarchical structures, high staff turnover and a lack of resources were reported to inhibit creativity and innovation. Brazier concluded that organisations need to be mindful of the environmental context to nurture and develop

their leaders and managers. However, as these theories are based on the experiences of one workplace they may not be generalisable to the healthcare system more generally.

Work setting was also investigated as a factor influencing leadership in the work of Desveaux et al. (2012a) and Desveaux and Verrier (2014). In this study members of the CPA completed a survey which asked them to rate the importance of 15 leadership characteristics in three settings; the workplace, the healthcare system and society, and also whether they perceived themselves to be a leader. Almost 80% of respondents perceived themselves to be a leader. A significant association was found between working in private practice or education and self-declaration as a leader. Working in private practice was also significantly associated with perceived importance of business acumen as a leadership skill in the workplace for physiotherapists working in Canada. This has implications for physiotherapy education programmes in Canada highlighting the need for business education to ensure that students recognise the business aspects of their practice whether in the public or in the private sector. The importance of business-related skills to physiotherapists had previously been recognised by Kovacek et al. (1999). As described in Section 3.2.4, a taskforce was convened by the APTA to develop a position on professional education related to LAMP skills. The taskforce suggested integration of the development of business skills with the processes used to develop clinical skills. An interesting analogy made by Kovacek et al. (1999) was that the process of clinical problem solving is the same as the problem solving activities related to LAMP skills. The five steps of examination, evaluation, diagnosis, prognosis and intervention are the same; it is the specific content of each stage that is different due to the nature of examining organisations rather than patients.

Desveaux and Verrier (2014) found that there was a difference in the perceived importance of leadership characteristics between the workplace and society in a further analysis of the survey data. Respondents consistently rated leadership characteristics as more important in the workplace than in society, and this difference was significant for all 15 leadership characteristics investigated. Desveaux and Verrier (2014) hypothesised that the lesser importance placed on leadership attributes at the societal level may reflect the current mind-set of physiotherapists, i.e. they are more focussed on leadership in their immediate workplace than in society. Physiotherapists need to recognise leadership roles and opportunities for advocacy beyond their immediate work environment to achieve professional growth and strengthen their impact and influence in the healthcare system and society (Desveaux and Verrier, 2014).

3.2.8. Leadership capabilities

Many of the articles included in this review investigated or discussed the leadership capabilities needed in physiotherapy. These capabilities came under different headings and descriptors in the literature: characteristics, skills, traits, competencies, behaviours and styles.

3.2.8.1. Leadership characteristics and skills

In the 2002 Pauline Cerasoli lecture, Ferretti (2002) spoke of the competencies that leaders in physiotherapy need including: capacity to relate and synthesise diverse ideas, jargon-free language, the ability to stimulate partners' creativity and a capacity to identify ways to combine diverse resources. In a later Pauline Cerasoli lecture, Feitelberg (2004) listed the leadership traits in that played an important part in developing the APTA and ensuring the growth of the profession. These traits included courage, initiative, integrity, tact, effective communication and to lead by example.

As described above, Desveaux et al. (2012a) surveyed physiotherapists in Canada on their perceptions of the importance of leadership characteristics. The survey used in this study was developed based on a literature review of leadership characteristics in both business and healthcare settings. The leadership characteristics most often rated as extremely important by the respondents were communication, professionalism and credibility across all three settings. The authors reported that this finding was contrary to existing healthcare literature where three leadership characteristics consistently associated with effective leadership were emotional intelligence, vision and business acumen.

Lopopolo et al. (2004) used the Delphi method to investigate the knowledge and skills that physiotherapists need in the areas of LAMP. The top-ranked component categories were communication, professional involvement and ethical practice, delegation and supervision, stress management, reimbursement sources, time management and healthcare industry scanning. The authors concluded that LAMP skills are a part of every clinical practice in which physiotherapists work and that they form the foundation for the growth and development of physiotherapy services.

While not exactly leadership characteristics, Chan et al. (2015) investigated the strengths of leaders and non-leaders. As described in Section 3.2.4, leaders most frequently exhibited the strengths of 'Learner', 'Achiever', 'Responsibility', 'Input' and 'strategic', and were significantly more likely than non-leaders to exhibit the strength 'Achiever'. The Clifton StrengthsFinder defines the 'Achiever' strength as 'a constant drive for accomplishing tasks'. Chan et al. theorised that physiotherapists in leadership roles may be more likely to possess this strength given the expectation within their roles for them to lead others towards successfully accomplishing the tasks necessary to achieve their vision. In further analysis of the same data, Desveaux et al. (2016) found that 'Learner' and 'Achiever' were the most prevalent strengths for both physiotherapy academics and physiotherapy managers. Desveaux et al. (2016) explained the prevalence of the 'Learner' strength by the expectation for physiotherapy leaders to engage in continual learning to ensure they can meet the increasing demands of healthcare delivery and education.

LoVasco et al. (2016) investigated the leadership practices of DPT students in the first year of their course using the Leadership Practices Inventory (LPI). The LPI is an assessment tool devised by Kouzes and Posner (2016a) where respondents rate 30 behaviour statements to identify their use of five leadership practices. The leadership practices of the DPT students in order from highest to lowest were Enable, Encourage, Model, Challenge and Inspire. The Enable leadership practice is defined as, '*I develop cooperative relationships among the people I work with.'* The finding that Enable is the primary leadership practice of the students may demonstrate that the students have good interpersonal and teamwork skills. The Encourage and Model practices relate to '*I praise people for a job well done'* and *'I set a personal example of what I expect of others',* respectively. These practices reflect behaviours such as uplifting the spirit, celebrating values and victories, and leading by example, which the authors perceived to be important aspects of physiotherapy practice. The Challenge practice related to '*I seek out challenging opportunities that test my own skills/abilities'. LoVasco et al. (2016)* suggested that the lower scores on the Challenge practice may have been because the students are unwilling to take risks and/or experience failure as they are new to the profession. The Inspire practice was rated lowest of the leadership practices. Inspire was defined as '*I talk about future trends that will influence how our work gets done'.* As novices, physiotherapy students lack knowledge about healthcare policy and the factors that influence the physiotherapy profession, making it difficult for them to envision how the profession will develop in the future (LoVasco et al., 2016). This study provides a baseline for how physiotherapy students perceive their leadership behaviours. However,

the LPI as an instrument to measure leadership practice is limited in that it is focused on activities associated with the symbolic and human resource frames (Bolman and Deal, 2008) and does not take into account leadership practices that would be associated with the political and structural frames.

Regarding academic leadership, Rothstein (1998) spoke of the need for leaders in education to demonstrate courage, knowledge and risk-taking. While El-Din (1998) also spoke of the importance of courage in a lecture about the experience of being a leader in physiotherapy education, vision and integrity were also highlighted as important. However, these lectures are only the opinions of individuals and more research is needed to investigate the capabilities needed by physiotherapy leaders in different contexts.

Healthcare students' perceptions of the leadership abilities of physiotherapy students were investigated in two articles. Hean et al. (2006) found that doctors were most highly rated for leadership skills in a study which surveyed health and social care students about their perceptions of other healthcare professions. In this study, physiotherapists were not rated as highly on leadership as doctors, midwives or social workers. In a later study, Ateah et al. (2011) investigated students' perceptions of other healthcare professions before and after they completed an inter-professional education intervention or an inter-professional immersion experience intervention. The Student Stereotypes Rating Questionnaire was used to rate seven professional groups on nine characteristics including leadership. Physicians were again most highly rated for their leadership ability and were the only profession rated as 'high' for the leadership trait at the baseline survey. However, after the immersion experience all seven professions were rated as 'high' for leadership. Of note though, after the intervention physiotherapists were rated as joint lowest for their leadership skills. However, the numbers in this study were small which limits the generalisability of the results.

3.2.8.2. Leadership styles

This review found articles that discussed or investigated several different types of leadership style in physiotherapy including: transformational, servant, resonant, shared and distributed. Transformational leadership has been advocated as an appropriate leadership style by the CPA. The Leadership Division of the CPA has published a checklist for leadership which discusses the skills necessary to demonstrate

transformational leadership (CPA, 2015a). Here transformational leadership was defined as ‘behaviours that transform and inspire others to perform beyond expectations while transcending self-interest for the good of the organisation’. Emotional intelligence and appreciative inquiry are viewed as essential components of transformational leadership.

Alkassabi et al. (2015) investigated the effect that leadership style has on physiotherapists’ job satisfaction. The Multifactorial Leadership Questionnaire (MLQ) was used to measure 69 physiotherapists’ perceptions of the leadership style of their supervisors in private or government hospitals in Saudi Arabia. The MLQ is a 36-item questionnaire which measures a range of transformational, transactional and passive-avoidant behaviours. No correlation was found between job satisfaction and leadership style. Participants were generally satisfied with their supervisors and perceived their leadership style to be more transformational or transactional than passive-avoidant. However, only an abstract of this article was available and so the details of this study were limited.

Wylie and Gallagher (2009) also used the MLQ in their investigation of the use of transformational leadership skills in allied health workers in Scotland. Significant differences in transformational leadership were identified between the individual allied health professions surveyed (physiotherapists, occupational therapists, radiographers, podiatrists, speech and language therapists and dietitians). Radiographers and podiatrists scored consistently lower across the range of transformational behaviours than the other professional groups. The authors suggested that an explanation for the difference between professions may relate to the degree of conformity expected of different work situations. Radiographers and podiatrists often have to adhere to strict protocols due to their use of ionising radiation and scalpels, respectively. This style of work requires strict adherence to protocol which may help to explain the lower transformational scores. Physiotherapists, in contrast, work in a less prescriptive environment allowing better development of individual consideration and inspirational motivation. In this study the self-report version of the MLQ was used. The self-report nature of the questionnaire in this study should be taken into account in the interpretation of the results and the authors recommend that future studies should also survey participants about their supervisors (Wylie and Gallagher, 2009).

Another leadership style that has been suggested as apt for the physiotherapy profession is the theory of servant leadership (Gersh, 2006). Servant leadership is a leadership theory that was introduced by Robert Greenleaf in the 1970s (Greenleaf, 1977).

Greenleaf placed ‘going beyond one’s self-interest’ as a core principle of servant leadership and asserted that servant leaders were genuinely concerned with serving their followers (Van Dierendonck, 2011). Gersh (2006) argued that values and behaviours associated with professionalism in physiotherapy: empathy, trust, compassion, caring, community building and empowerment, also reflect the principles of servant leadership: a focus on others’ needs, partnership between the leader and the served, and the empowerment of others in the process of leadership. However, this opinion piece only reflects the views of one individual and to date there have been no studies investigating the effectiveness of the servant-leadership style in physiotherapy.

While not strictly a leadership style, Thomson (2010) wrote about using humour as a management style in an ethnographic study. Over an eight-month period a physiotherapy team in a UK NHS hospital was observed and then interviews were conducted with the physiotherapy team members. Humour was used as a leadership strategy by the senior physiotherapists to help them deal with minor transgressions, persuade the team to adopt certain strategies, guide the team in its practice and build relationships within the team. Overall, humour was viewed as an effective strategy for leadership and a resource to facilitate negotiation and change because it creates a sense of affiliation and enhances team cohesion in the face of constant change.

Wagner et al. (2014) explored resonant leadership and the effect it has on spirit at work. Spirit at work is described as an employee work attitude that arises as a consequence of employees finding their work meaningful and fulfilling (Kinjerski and Skrypnek, 2008). Occupational therapists and physiotherapists were surveyed to test a theoretical model linking perceptions of resonant leadership, structural empowerment and psychological empowerment to their experiences of spirit at work, job satisfaction and organisational commitment. In this study, resonant leadership was described as being focused on achievement through relationship building, and investing time and energy to handle workplace emotions and develop relationships (Cummings, 2004). The results demonstrated that resonant leadership had a significant effect on job satisfaction, structural empowerment, psychological empowerment and spirit at work. The authors concluded that interventions by leaders who practice resonant leadership have the potential to create healthy workplaces that foster spirit at work. However, the authors cautioned that the small sample size was a limitation of the study which must be considered.

Shared leadership was perceived by healthcare students (including physiotherapists) to be the most appropriate leadership style in a hypothetical patient case study. Byrne and Pettigrew (2010) surveyed occupational therapy, physiotherapy and speech and language therapy students about teamwork, leadership and the role of the speech and language therapist. While the majority of students identified shared leadership as the most appropriate, a minority felt that there should be one clear leader, with the doctor being chosen as the leader most often in this case. However, the small numbers in this study and the fact that the students were only presented with one case study must be taken into account when interpreting these results; the students may not have chosen shared leadership in other instances. Similar to shared leadership is distributed leadership. Distributed leadership has been recommended as an appropriate leadership style in physiotherapy in a report by the CSP (Thornton, 2016). Distributed leadership was described as empowering others with shared responsibilities; it goes beyond individual leaders in senior roles and embraces all levels of staff (Thornton, 2016). The report views distributed leadership as a model that embraces a more current view of leadership and recognises that the NHS has adopted distributed leadership as a key strand of policy (Martin et al., 2015). The report concluded that distributed leadership was needed in physiotherapy to provide excellence in care and ensure effective use of resources.

Boak et al. (2015) investigated the introduction of distributed leadership and teamwork to a physiotherapy department in the UK. The main change to the service was the reorganisation of the physiotherapy teams into specialist teams with considerable devolution of responsibility to each team. This change led to greater interdependence and shared responsibility between the teams and together they jointly developed standardised treatment and assessment protocols. These changes led to an improvement in patient waiting times for physiotherapy and the high level of patient satisfaction in the care they receive was maintained. While these results suggest that the successful integration of distributed leadership into a workplace may improve services for patients, this was only a single case study, and as such, results may not be transferable to other organisations.

3.2.9. Leadership development

Development of leadership skills was called for by Dean et al. (2011) at the First Physical Therapy Summit on Global Health. The Summit was convened at the 2007 WCPT

Congress to assess practice, entry-level education and research in the twenty-first century. Ideas and recommendations about how physiotherapists may be better prepared to work in the area of lifestyle-related conditions included providing learning opportunities for the development of leadership skills. It was envisioned that with better leadership skills physiotherapists will be able to petition and work with government and to increase the existing profile of physiotherapy.

The self-reported education needs of physiotherapy leaders have been investigated by Lai (2009). Physiotherapists in leadership roles have expressed a lack of preparatory training when entering these roles, as well as a scarcity of continuing educational opportunities to develop their management skills. An interest in further leadership education was indicated by over 80% of respondents to the survey and the five highest-ranked learning needs were change management, strategic planning, project management, programme development and programme evaluation.

This review found no studies which directly evaluated leadership development activities in qualified physiotherapists. However, Jones et al. (2008) compared the professional development and leadership activities of physiotherapists who had completed a clinical residency programme with physiotherapists who had not completed this programme. The APTA has established structured post-professional education programmes (clinical residency and fellowship programmes) similar to those in the medical model. Residency trained physiotherapists demonstrated more leadership activities compared to non-residency trained physiotherapists including: guest lecturing, being a clinical faculty member, instructing a physiotherapy intern, and attainment of more Board certifications. The authors concluded that graduation from a clinical residency programme is associated with enhanced leadership activities. However, a few limitations of the study must be taken into account. Only a small number of possible leadership activities were looked at in this study, the participants could have been engaging in other leadership activities which were not reflected in the survey. It must also be considered that this effect was not due to the residency training programme. Physiotherapists who choose to participate in a residency training programme may be more likely to choose to participate in leadership activities. Another study which indirectly explored the effects of leadership development training in physiotherapists was that by Wylie and Gallagher (2009). As previously reported this study explored the transformational leadership characteristics of allied health professionals. The results of this survey demonstrated that allied health professionals who had completed prior leadership development training reported significantly higher aggregated leadership scores.

3.2.9.1. Leadership development of physiotherapy students

There have been more articles which have discussed or investigated leadership development in physiotherapy students. Several authors have recommended that leadership development begin during entry-to-practice physiotherapy courses. As reported by Kovacek et al. (1999), the taskforce convened by the APTA which aimed to develop a position on professional education in physiotherapy related to LAMP processes recommended that leadership and management skills be developed in all phases of student preparation. Ferretti (2002) recommended that leadership be integrated into planned learning experiences for students. In the 2010 Linda Crane Memorial Lecture, Hayes (2010) suggested that a leadership academy was needed to build a cadre of leaders for the next generation and spoke of the importance of mentoring in the development of leadership skills. Similarly, in a later Linda Crane Memorial Lecture, Lovelace-Chandler (2011) recommended the adaptation of current curricula to include options for the development of leaders in the profession, practice and education. Residencies and opportunities to specialise were suggested as ways to promote leadership in practice. Improved collaboration, more postdoctoral positions and encouragement to do higher degrees were suggested to foster leadership in research and education, and courses and internships on professional leadership were suggested to prepare students to assume roles within professional organisations and thus demonstrate professional leadership. Greene-Wilson advocated the potential benefits for the profession if leadership skills are developed in physiotherapy students, including delivering professionals who are comfortable with collaboration and capable of assuming leadership roles in the healthcare system, and recommended that leadership development be made explicit and intentional in all professional education programmes (Tschoepe and Davis, 2015). LoVasco et al. (2016) recognised that while the content and approaches to teaching leadership in entry-level healthcare education vary widely there is an expectation that entry-level programmes, including physiotherapy programmes, will prepare students to assume leadership responsibilities and that development of leaders should begin early in a student's career.

As discussed above, Lopopolo et al. (2004) used a Delphi survey of physiotherapy managers to define the range of LAMP knowledge and skills required of physiotherapists upon graduation. Physiotherapy graduates were expected to have good understanding of the concepts of leadership theory but to require assistance in performing tasks related to them. Similarly, Schafer et al. (2007) looked at the administration and management skills needed by physiotherapists upon entry to practice. New graduates were expected

to be moderately proficient in skills associated with leading and directing meaning that they should require minimal assistance with tasks in this area. Schafer et al. (2007) therefore recommended that skill development in this area should be included in physiotherapy education courses.

Jackson (2012) recommended that students should be provided opportunities to engage in community service events and interaction with other healthcare professionals to enable them to develop leadership skills. The 7 C's Model for Leadership Development for Social Change was recommended as a model to facilitate leadership development. Here, students completed a university health fair service learning project, off campus community service activities and other volunteer opportunities. The model encompasses seven domains: consciousness of self, congruence, commitment, collaboration, common purpose, controversy and citizenship. While this model is suggested as an effective way to facilitate development of skills necessary to function as a leader in the community, no objective measure or even self-report of leadership ability was employed to support this theory.

To date there have been a small number of studies which have investigated leadership development in physiotherapy students. Wilson and Collins (2006) documented the development of students involved in a new educational module where students assumed dual roles as student clinicians and student managers. When answering open ended questions about their learning from the experience, the most frequently reported improvements were about leadership: how to adapt leadership skills depending on team profile and how to get the best out of group members. It was concluded that 'safe' practice in leading small groups may allow students to develop interest and new skills in leadership. Palombaro et al. (2011) and Black et al. (2013) reported on a similar study in the USA where they investigated the experiences of students involved in setting up and running a pro bono physiotherapy clinic. Leadership opportunities and mentorship from alumni supervising physiotherapists were important components of the experience. Overall participation in the project was found to be a meaningful experience by the students and helped to develop leadership skills. A limitation of this study (and the study by Wilson and Collins) was the absence of objective data regarding the development of leadership and administrative skills.

An objective measure of leadership skills was employed by Larin et al. (2011, 2014) who compared the development of emotional-social intelligence, caring and leadership in physiotherapy and nursing students. The Self-Assessment Leadership Instrument (SALI)

was used in this study; it is a self-reported measure of leadership characteristics where respondents are asked to rate 40 leadership behaviours as to how often they behave in that manner on a five point Likert scale. There was no significant change in the leadership scores from baseline measurement (at the start of their entry-to-practice physiotherapy course) to after their first clinical affiliation (Larin et al., 2011) or from baseline measurement to the final months of their course (Larin et al., 2014) for either the physiotherapy or nursing students. The authors concluded that leadership may need to be specifically targeted in the curricula for improvements to be observed and that educators should examine specific educational strategies to enable students to develop skills in this area. Noronha et al. (2016) found that there was a decrease in the self-reported leadership abilities of physiotherapy students between the start and the end of the first year of their education programme. The Professionalism Attitudes and Behaviours Questionnaire was developed for this study. It measures student professionalism attitudes and behaviours across the six global areas of professionalism: altruism, accountability, excellence, duty, honour and integrity, and respect for others. The authors hypothesised that decrease in self-reported leadership abilities of the physiotherapy students may have been because the physiotherapy students started the programme perceiving themselves to be leaders due to the competitive nature of the application process. By the end of their first year, however, they would have had a lot of experience of group activities which may have taught the students to take a more collaborative approach.

In contrast, Dean and Duncan (2016) described the efforts made by the Macquarie University DPT programme to ensure the development of attributes, knowledge and skills in healthcare leadership. This programme was designed to integrate new models of care, present the challenges of modern healthcare, develop outstanding clinical skills and prepare innovative leaders. The Leadership, Advocacy and Policy course within this programme aims to develop leadership skills for transformative practice. It is future-oriented; each module highlighting the changing health systems and the need for physiotherapy to continually adapt and transform. The authors suggest that this Leadership, Advocacy and Policy course could provide a useful model for the redesign of courses and curricula to prepare physiotherapy students nationally and globally to be innovative and accountable healthcare professionals.

3.2.9.2. Leadership development activities of physiotherapy professional bodies

Physiotherapy professional bodies internationally have recognised the need to provide opportunities for leadership development to their members. The leadership development opportunities offered by six physiotherapy professional organisations are summarised in Table 3.3. These six organisations were included because they are English speaking.

The APA has a Leadership and Management group which provides leadership development opportunities, including guest lectures, and brings together a network of physiotherapists to allow sharing, discussion and solving of problems facing leaders in physiotherapy (APA, 2016). As described in Section 3.2.5, the APA (2015b) has outlined the need for strong leaders in its report on the future of the physiotherapy profession in Australia. In this report, training in leadership skills was seen to be a core role of the APA to ensure the future success of the physiotherapy profession in Australia. The APA has recognised that professional development should equip the workforce with more than just clinical skills but should also include business, management and leadership skills.

The APTA has a Leadership Development Committee which has defined four core leadership competencies for physiotherapists who wish to develop their leadership skills (APTA, 2016). These are: vision (set a clear direction and move the group forward), self (the personal traits, characteristics and behaviours that facilitate best leadership practice), function (knowledge of the structure, function and organisation of the association), and people (effectively mobilise work force to achieve outcomes). The APTA's Leadership Development Committee has curated resources on their website to help physiotherapists to improve their leadership skills.

The APTA has a speciality component, the Section on Health Policy and Administration (HPA), which provides leadership training for physiotherapists through the Institute for Leadership (HPA, 2016b). The Educational Leadership Institute (ELI) Fellowship is a year-long programme incorporating online and onsite education. The Fellowship is aimed at novice and aspiring physical therapy programme directors and includes mentoring, teaching and peer networking opportunities. The online education component encompasses nine modules and there are three face-to-face education components. Additionally, the participants develop, refine and implement a leadership project relevant to their academic institution. The HPA also offers the LAMP Leadership Development Certificate Programme. This certificate curriculum includes structured self-assessment

of leadership abilities, identification of skills needed to lead successfully, empowerment and mentoring through applied leadership activities (HPA, 2016a).

The CPA has a special interest group, the Leadership Division, that provides educational material related to leadership, offers workshops and other professional development opportunities, provides grants/awards to members and encourages research in the field of leadership (CPA, 2016b). The Leadership Division has developed the 'Framework for Professional Development of Leadership Core Competencies' (CPA, 2012). This evidence-based curriculum is targeted at working physiotherapists and designed to develop key leadership skills in both aspiring leaders and those already in formal leadership roles. Current development opportunities include a 3-part webinar series on key concepts in leadership development identified in the framework: emotional intelligence, appreciative inquiry and transformational leadership.

Within the CSP, the Leaders and Managers of Physiotherapy Services (LaMPS) is a professional network. LaMPS offers its members mentoring, a forum for debate, access to a variety of expertise, and support in leadership or management challenges (CSP, 2016b). This professional network runs a national study day, gives its members access to regional business meetings and lectures, and publishes a newsletter three times a year. In its report on the current thinking on leadership in physiotherapy (Thornton, 2016), the CSP recognised the need for leadership development and reported that current evidence suggests that development is more effective where there are learning opportunities that support learning from experience, embracing both self-awareness in the individual and collaborative activities. The report advocated a distributed/shared leadership model. This model will require physiotherapists at all levels to embrace leadership responsibilities and thus necessitates leadership training. The report also suggested that leadership development across professional boundaries could be considered important to ensure that physiotherapists can participate fully in inter-professional structures and working. However, the report also questioned the extent of the responsibility of the professional body to provide the leadership training (Thornton, 2016). Despite this, starting in January 2017, the CSP is running a year-long leadership development programme aimed at band 6 and equivalent members (CSP, 2016c). This programme will include four 1-day development workshops, action learning sets, the design and implementation of a patient improvement project, and personal reflection.

In Ireland, the ISCP has an employment group, Chartered Physiotherapists in Management (CPM), which has recently incorporated leadership issues into their

Constitution (CPM, 2015). However, membership of this group is restricted to physiotherapists in management or leadership roles. There is no leadership specialist interest group for other ISCP members. In 2016, the Eastern Branch of the ISCP ran a 3-part leadership lecture series covering topics: ‘Managing performance and developing people’, ‘Lead from where you are’ and ‘Managing upwards and influencing change’ (ISCP, 2016a). However, this was a one-off series and the ISCP currently does not offer any other leadership development programmes or courses.

Table 3-3 Comparison of leadership development training offered by physiotherapy professional bodies internationally

Country	Professional Body	Leadership Special Interest Group/Section	Leadership Development Programmes
Ireland	Irish Society of Chartered Physiotherapists	Chartered Physiotherapists in Management – open only to those in leadership or management role	Leadership lecture series run by Eastern Branch of ISCP
United Kingdom	Chartered Society of Physiotherapists	Leaders and Managers in Physiotherapy Services (LaMPS) – Full membership open to managers of physiotherapy services only; affiliate membership open to anyone with an interest in management/leadership	Mentoring National Conference and Leadership study days
United States	American Physical Therapy Association	Section on Health Policy and Administration –open to all members	Educational Leadership Institute Fellowship – year long fellowship LAMP Leadership Certificate Programme – structured self-assessment of leadership abilities, identification of tools to lead successfully, empowerment, mentoring through applied leadership activities
Canada	Canadian Physiotherapy Association	Leadership Division – open to all members	Leadership webinar series Grants/awards to fund projects/courses related to leadership
Australia	Australian Physiotherapy Association (APA)	Leadership and Management Group - open to all members	Regular Meetings and guest speakers Networking opportunities
New Zealand	Physiotherapy New Zealand (PNZ)	District Health Board (DHB) Leaders – members must be leaders, advisors or managers of DHB physiotherapy services	Leadership presentations at PNZ biennial conference

3.3. Discussion

This comprehensive scoping review has explored the published literature base of leadership in physiotherapy. While there were 53 articles included in the qualitative synthesis overall leadership in physiotherapy is an under-researched phenomenon. Of the 53 articles included, 18 were opinion pieces, published lectures or editorials and thus only gave the perspective and experiences of individuals rather than being grounded in research findings. There were 28 original research studies included, however, in the majority of these leadership was not the central aspect of the study and was instead a component or a finding. A minority of the original research articles (n=10) were primarily focused on examining the concept of leadership in physiotherapy. These studies mostly came from the USA and Canada and used surveys.

This scoping review has revealed that there are many gaps in the literature on leadership in physiotherapy but it has also demonstrated that the interest in this phenomenon is growing. Of the 28 original research studies identified, the majority had been conducted in the last ten years (n=21) and half had been conducted since 2011. It is anticipated that this trend will continue and that the literature base for leadership in physiotherapy will continue to grow.

The importance of leadership is increasingly being recognised by the physiotherapy profession with leadership development opportunities being offered by professional bodies. Several of the articles in this study recognised the importance of leadership to the profession, however, there has been very little research conducted to explore the effects of leadership in physiotherapy on patients, professionals or organisations. In the nursing profession, Cummings et al. (2010) found that leadership styles focused on people and relationships (as opposed to those that were task focused) were associated with higher nurse job satisfaction. Additionally, in a review of the relationship between nursing leadership styles and patient outcomes, Wong et al. (2013) found evidence of positive relationships between relational leadership and a variety of patient outcomes including lower patient mortality, medication errors, restraint use and hospital-acquired infections, and higher patient satisfaction.

At present, there is no accepted definition of leadership in physiotherapy. As noted by LoVasco et al. (2016) a consensus on a definition of leadership would benefit the profession. More research is needed to explore perceptions of the concept of leadership

in physiotherapy to aid the development of a definition of leadership on which to base the content of leadership development programmes for physiotherapists. Several different types of leadership have been explored in the literature including academic, professional and clinical. Both formal leadership, where physiotherapists are in defined leadership roles, and informal leadership, where physiotherapists lead through personal influence have been recognised. Leadership is context-specific and thus the professional and organisational context in which it is enacted must be taken into account and explored rather than solely focusing on leadership in terms of competencies, attributes and values (Turnball James, 2011). Further exploration of the similarities and differences of physiotherapists in different leadership roles is needed.

When looking at leadership it is important to consider the challenges that require leadership. Hartley and Benington (2010) purport that by identifying the challenges to be addressed the purposes of leadership can be clarified. A small number of studies have described opportunities and challenges facing the physiotherapy profession that will require leadership at an individual and professional level, however these have not been adequately explored. Identified challenges for the profession include ensuring direct access, gaining autonomy to order x-rays, changing population needs, new technologies, heightened consumer expectations and competition from other professional groups. Challenges for physiotherapy leaders at an individual level have been found to include lack of protected time for leadership activities, lack of formal authority, challenges in staff support and development. The leadership challenges facing physiotherapists in different roles and the physiotherapy profession require further investigation.

There has also been some research to investigate the leadership characteristics that are perceived to be most important in physiotherapy, and to explore leadership styles in physiotherapy. However, the lack of a common framework or terminology makes comparison between individual studies difficult. Similar to the field of nursing (Cummings et al., 2010), relational leadership styles (e.g. servant, transformational, resonant) which focus on relationships with others and effective communication have been suggested as appropriate approaches to leadership in physiotherapy. Further research is needed in this area to describe the leadership capabilities demonstrated by physiotherapists and to identify those deemed most effective in physiotherapy. Investigation of the leadership capabilities of physiotherapists may contribute to better understanding of current leadership practice and thus enable appropriate training programmes to be developed.

Leadership development in physiotherapy students has been explored but there has been very little published on leadership development in physiotherapists. Experiential learning and the incorporation of leadership development into projects or activities have been suggested as potential ways to foster leadership skills in physiotherapy students however further research using objective measures is needed. To date there is little evidence of the efficacy of leadership development programmes in physiotherapy. In a systematic review of factors contributing to nursing leadership, Cummings et al. (2008) reported that in nine studies examining participation of nurses in leadership development programmes all reported significant positive influences on observed leadership. While results like these may be transferable to physiotherapy, good quality studies are needed to support the call for leadership development training.

3.4. Conclusion

Leadership in physiotherapy is an under-researched phenomenon. However, interest and research in this field is growing. Developing leadership within the profession of physiotherapy has the potential to improve both job satisfaction among professionals and the services provided to patients. The importance of leadership is increasingly being recognised by the physiotherapy profession with leadership development opportunities being offered by professional bodies and the body of research has grown in recent years. Further research is warranted in many aspects of leadership to explore perceptions of this concept in the profession, investigate leadership capabilities of physiotherapists in different leadership positions, identify the leadership challenges facing the physiotherapy profession and evaluate the effect of leadership on physiotherapy professionals, the physiotherapy profession, healthcare organisations and patients.

3.4.1. Boundaries of this research project

This literature review has demonstrated that there is limited research on the topic of leadership in physiotherapy. Therefore, this research project is exploratory in nature and aims to set the foundations on which further research projects can be built. It is hoped that it will provide information about current perceptions and practices of leadership in physiotherapy in Ireland. It is limited to surveying and interviewing physiotherapists rather than also seeking the opinions of other healthcare professionals or patients. It also focuses mainly on self-perceived leadership capabilities rather than objectively measuring individuals' leadership capabilities. Also, as discussed in Section 2.12, this

research project does not aim to investigate the consequences of leadership, but instead focuses on the characteristics and capabilities of leaders in physiotherapy. These aspects of leadership research will need to be investigated in subsequent projects.

4. Chapter 4 – An investigation into leadership and leadership development within the profession of physiotherapy in Ireland.

4.1. Introduction

The aim of this chapter is to outline the methodology and results of the first study of this PhD thesis. Study I was a cross-sectional study which used a nationwide survey to explore the concept of leadership from the perspective of physiotherapists in Ireland. The review of the literature in Chapter 3 demonstrated that there is a dearth of literature on the phenomenon of leadership in the profession of physiotherapy. One original research study that had been conducted was that by Desveaux et al. (2012) who had investigated Canadian physiotherapists' perceptions of leadership. As the first step in gaining greater understanding of leadership from an Irish physiotherapists' perspective, the study by Desveaux et al. (2012a) was replicated in an Irish context. Investigating leadership from the perspective of the general physiotherapy profession in Ireland provided initial, exploratory information about physiotherapists' perceptions of leadership and a base on which to plan future research into leadership in physiotherapy.

As described in Chapter 3, Desveaux et al. (2012a) found that communication, professionalism and credibility were the leadership capabilities most highly rated by physiotherapists in Canada, and that almost 80% of respondents perceived themselves to be a leader. Desveaux et al. (2012a) referred to the factors investigated in the survey as 'characteristics', however to avoid confusion with the Warwick 6 C Leadership Framework (see Section 2.12) (Hartley and Benington, 2010) in this report they will be referred to as leadership capabilities. Another finding in the study was that there was an association between working in private practice and perceived importance of business acumen. At the commencement of this study, no similar research had been conducted in Ireland and thus there was no information on the perceptions of Irish physiotherapists of leadership capabilities and leadership roles.

The scoping review in Chapter 3 also demonstrated that there were no studies investigating the leadership development activities of physiotherapists. Exploration of the leadership development of physiotherapists was needed to provide information on whether physiotherapists were engaging in leadership development activities, and, if they were, to provide information on the different types of leadership development they were participating in. Hence, the aim of the study was to investigate the perceptions of

physiotherapists in Ireland of leadership and their participation in leadership development. The objectives were to:

(1) Measure the proportion of physiotherapists in Ireland who perceive themselves to be a leader and identify factors associated with self-declaration as a leader - gender, highest level of education, years of experience, leadership development training, work setting, and supervisory role.

(2) Measure the level of importance physiotherapists in Ireland place on attaining a leadership position and identify factors associated with the level of importance placed on attaining a leadership position – gender, highest level of education, years of experience, leadership development training, work setting, and supervisory role.

(3) Measure the proportion of physiotherapists in Ireland who have had formal or informal leadership development training and describe the nature of the training.

(4) Describe and compare the leadership capabilities which physiotherapists in Ireland believe to be most important in various settings - the workplace, in the healthcare system, and in society.

(5) Compare perceptions of the importance of business acumen between physiotherapists who work in private practice with physiotherapists who do not work in private practice.

(6) To explore and identify common themes in the views of leadership of physiotherapists in Ireland.

The results of this study have been published (McGowan and Stokes, 2015, McGowan et al., 2016, McGowan and Stokes, 2016) and are contained in appendix I.

4.2. Methodology

4.2.1. Study Design

A cross-sectional, nationwide study was performed of members of the Irish Society of Chartered Physiotherapists (ISCP). The ISCP is the sole physiotherapy professional body in Ireland (see Section 1.2.1). Membership of this organisation is not compulsory for physiotherapists in Ireland therefore this survey group is a proportion of the total number of physiotherapists in Ireland. The total number of physiotherapists in Ireland is estimated to be about 3,500 (WCPT, 2016). Ethical approval was granted by Trinity College Faculty of Health Sciences Ethics Committee (see Appendix II – pg 415).

4.2.2. Respondent recruitment

The ISCP has a formal process for approving surveys. Permission to survey members of the ISCP was obtained from the ISCP Board. Once this permission had been obtained the survey was circulated to members of the ISCP (n=2,787). Student members were excluded because of their limited experience working in a clinical environment.

4.2.3. Survey instrument

The survey (Appendix V – pg 432-442) was based on that by Desveaux et al. (2012a). The survey was internet based and created using Survey Monkey. The original survey was designed using information obtained through a literature review on leadership characteristics described in healthcare and business settings (Desveaux et al., 2012a). Permission to use the survey was sought and obtained from the survey authors. The original survey consisted of two sections. The first section asked for personal and workplace demographic details. The second section asked participants to rate how important they perceive fifteen leadership qualities to be in different settings – the workplace, the healthcare system and society - using a 5 point Likert-type scale ranging from 'not at all important' to 'extremely important'. Workplace referred to the physiotherapist's primary practice environment. The healthcare system referred to the level of hospital administration and networks that govern the overall operation of healthcare. Society referred to the broader environment in which the community functions. The final question asked participants whether they perceive themselves to be a leader. If a respondent answered 'yes' to this question, then they were said to self-declare or self-identify as a leader.

Adaptations were made to the original survey to make it applicable to Irish participants. These adaptations included altering slightly the workplace categories in the question where participants were asked which setting(s) they work in so that they were representative of the workplaces of physiotherapists in Ireland. As Ireland does not have the same diversity of rural and urban environments present in Canada, the question from the original survey relating to geographical location was removed. As well as these adaptations, additional questions were added to the survey. Based on the recommendations for further research given by Desveaux et al. (2012a) a question was added to the survey which asked participants to indicate the other professions with whom they work. If the respondent indicated that they worked with two or more other professions, they were considered to work in a multi-disciplinary team (MDT). A second

question added to the demographics section of the survey asked respondents how long ago they had graduated from their entry-to-practice degree. This question was added to investigate whether there was an association between self-perception as a leader and level of experience.

A third section consisting of three questions was added to the survey for this study. The first question asked participants to rate how important attaining a leadership position was to their overall sense of career success. This question stemmed from the study by Rozier et al. (1998) where members of the APTA were surveyed on their perceptions of career success. Rozier et al. (1998) found that 'appointment or election to a leadership position in a professional organisation' was not deemed important to overall career success for physiotherapists in the USA. The second question asked if they had participated in any leadership development training, formal or informal, and to specify what this had been if they had. To date there has been no research on the leadership development activities of physiotherapists in Ireland, this question was added to address this gap. The third question was an open box which asked, 'Are there any comments you would like to make about leadership or leadership development?'. This open comment box was added to allow participants to share their views on leadership and thus provide initial, exploratory data on the current perspectives of leadership of physiotherapists in Ireland.

To ensure the readability and clarity of the survey, it was piloted on five physiotherapists known to the PhD candidate. One adaptation was made to the survey based on their feedback. The leadership term 'contingent reward' was changed to 'adaptability' as respondents felt that this term more accurately fit the given definition. The definition was 'to deal with change and adversity and to adjust to different situations'. The wording of the definition was not changed from that used in the Canadian study. Apart from this change in leadership term, the leadership capabilities investigated in this study were the same as those in the survey by Desveaux et al. (2012a).

In this study a leader was defined as "an individual who influences the actions of another individual or group toward accomplishing goals and sets the pace and direction of change while facilitating innovative practice". This definition was the same as that used by Desveaux et al. (2012a) and remained visible to participants at the top of their screen as they completed the survey.

4.2.4. Distribution of the survey

An administrator in the ISCP acted as a gate keeper and circulated an email inviting members to participate in the survey in November 2013. The communication contained a short description of the project and an embedded link to the survey. The first page of the survey provided details of the study and informed participants that by clicking the link to begin the survey they were giving informed consent. Reminder emails were sent by the ISCP administrator two weeks after the initial information to encourage participation in the study. The survey was available to participants 24 hours a day during the data-collection period.

4.2.5. Statistical Analyses

The data was downloaded in a spread sheet form (Microsoft Office Excel) using Survey Monkey and analysed using the Statistical Package for the Social Sciences (SPSS) version 21 (IBM Corp., Armonk, NY). Non-parametric statistical tests were used to analyse the data because the data consisted of a combination of ordinal and categorical data.

To address the first and second objectives, frequency distributions and percentages were obtained for the leadership variable and for responses to the question about the importance placed on attaining a leadership position. Pearson's chi square test was performed to investigate which factors (gender, time since graduation, highest qualification achieved, workplace, working within an MDT, supervision of students and development training) were associated with self-declaration as a leader and which factors were associated with importance placed on attaining a leadership position. The significance level was set at $p<0.05$ under the hypothesis that no association exists. Statistical significance was determined by comparing observed values in the Chi square to expected values under the null hypotheses (no association between the variables in question).

Due to low counts in certain categories, low frequency data were pooled into new categories. This ensured that the expected frequency in each cell of the Chi square was greater than 5 and thus enabled the use of the Chi square test. This included pooling those whose highest qualification was a PhD or a DPT into the same category. These qualifications were pooled together because of the low numbers in these categories and because they are the highest qualifications that a physiotherapist can attain and thus can

be considered to be an equivalent level of qualification for the purposes of this analysis. The ratings of importance of attaining a leadership position were also pooled. Responses to this question were pooled into three categories: ‘extremely important’ (ratings of 5) ‘very Important’ (ratings of 4) and ‘not important’ (ratings 1 – not at all important, 2 – not very important, 3 – neutral).

Participants were able to indicate more than one workplace setting when responding to the question, ‘Which setting or settings do you currently work in?’. For this reason, when using Pearson’s chi square test to investigate if there was an association between workplace and self-declaration as a leader, and workplace and rating of importance of attaining a leadership position, separate analyses were run for each workplace category. For example, when investigating if there was an association between working in private practice and self-declaration as a leader the data were pooled into two categories; ‘Private practice’ and ‘Not private practice’ depending on the whether the participant indicated that they worked in private practice or not.

Due to a flaw in the online survey the participants were able to tick more than one answer when answering the question, ‘How important to you is attaining a leadership position (within your employment or professional association) to your sense of overall career success?’ Ten respondents indicated two answers when answering this question. The data from these ten respondents were removed for the analysis of this question.

Descriptive statistics (frequency and percentage) were obtained for the leadership development training variable, and the types of development activities completed, to address the third objective. To investigate if there was an association between having completed any leadership training (as well as separately investigating formal and informal training) and self-declaration as a leader, or between having completed any leadership training and rating of the importance of attaining a leadership position, the data was pooled into two categories; ‘any training’ and ‘no training’. If a respondent had answered ‘yes’ to having completed formal or informal leadership training, they were put into the ‘any training’ category.

To address the fourth objective, frequency distributions and percentages for the ratings of each capability were obtained for each setting. Within each setting, the capabilities were sorted in descending order from the capability with the highest percentage rating of ‘extremely important’ to the capability with the lowest percentage rating of ‘extremely important’. The Mann Whitney U-test was used to investigate if there was a difference in

the ratings of importance of the capabilities between the settings with significance set at $p<0.05$.

A capability of particular interest to Desveaux et al. (2012a) was business acumen. To address the fifth objective, Pearson's chi-square analyses were performed to investigate whether an association existed between working in private practice and ratings of business acumen. The threshold for statistical significance was set at $p<0.05$, with the assumption that no association exists. Few respondents answered 'not at all important' or 'not very important' when rating the importance of the business acumen. Therefore, to enable analysis the data for this question was pooled into three categories: 'extremely important' (ratings of 5) 'very Important' (ratings of 4) and 'not important' (ratings 1 – not at all important, 2 – not very important, 3 – neutral).

4.2.6. Thematic Analysis

To address the sixth objective responses to the open comment box were analysed using a thematic analysis approach. Thematic analysis is a method for identifying, analysing and reporting patterns or themes in qualitative data. It provides a flexible and useful means of analysing data which can provide a rich and detailed account, and can be particularly useful when you are investigating an under-researched area, or with participants whose views on the topic are not known (Braun and Clarke, 2006). As this is the case with leadership in physiotherapy (see Chapter 3), thematic analysis was the qualitative method chosen. Other advantages of thematic analysis include that it can usefully summarise key features of a body of data, and that it can highlight similarities and differences across a dataset (Braun and Clarke, 2006). Responses in the open comment box were copied into a Microsoft Word document and the entire text was included in the analysis. Each participant's response in the comment box was labelled TCD followed by a number. Each label, TCD1, TCD2 etc., referred to a unique respondent. The coding and analysis process followed the six phases described by Braun and Clarke (2006). In keeping with Braun and Clarke (2006), a theme was said to capture something important about the data in relation to the research question and to represent a patterned response or meaning. The refinement of the analysis resulted in overall themes and related subthemes within these.

- *Familiarising yourself with the data* - comments were read several times to allow familiarisation with the data.
- *Generating initial codes* - small sections of data were named and summarised. This open, inductive analysis generated initial codes from the data. Inductive analysis is a process of coding the data without trying to fit it into a pre-existing coding framework (Braun and Clarke, 2006).
- *Searching for themes* - similar codes were grouped into themes and subthemes to form a codebook (appendix VIII – pg 467-468). Codebook then used by the PhD supervisor to independently code the comments. The PhD candidate and PhD supervisor met to discuss the coding of the transcripts and the codebook. Following this discussion, the themes were reviewed and refined and the subthemes were collapsed into these themes as appropriate.
- *Reviewing themes* - coding procedure repeated by both the PhD candidate and the PhD supervisor using these refined themes and subthemes. Coded data extracts for each theme were collated and reviewed by the PhD candidate to ensure they formed a coherent pattern. The findings were discussed by the two researchers and agreement was reached on themes and the coding of the data after minor clarifications. Adjustments were made to the themes and subthemes as necessary following this discussion.
- *Defining and naming themes* - The final agreed themes and subthemes were named and applicable segments of data were arranged under each theme and subtheme. The identified themes were checked against the data to ensure that they were representative and suitable extracts were chosen to illustrate and support them.
- *Producing the report* - The final stage of the analysis was the write-up and production of the report.

4.3. Results

There were 615 responses which gave a response rate of 22.1%. Of these responses 525 had completed the survey and so were included in the analysis. The demographic details of the respondents are displayed in Table 4.1. The reported percentages were calculated based on the total responses to each question and do not include respondents who skipped that question.

Table 4-1 Demographic details of respondents

Factor (n=number of responses to question)	**Number** (Percentage)
Gender (n=525)	Male; 93 (17.7%) Female; 432 (82.3%)
Workplace (n=524)	Private practice; 194 (37.0%) Public hospital; 165 (31.5%) Private hospital; 38 (7.3%) Primary Care; 85 (16.2%) Education; 39 (7.4%) Other; 89 (17.0%)
Supervisory status (n=522)	Yes; 247 (47.3%) No; 275 (52.7%)
Working in MDT (n=517)	Yes; 387 (74.9%) No; 130 (25.1%)
Highest qualification (n=522)	Diploma; 49 (9.4%) Bachelor; 283 (54.2%) Masters (taught); 133 (25.5%) Masters (research); 42 (8.0%) PhD; 11 (2.1%) DPT; 4 (0.8%)
Time since graduation (n=520)	<2 years; 37 (7.1%) 2-5 years; 107 (20.6%) 6-10 years; 93 (17.9%) 11-15 years; 89 (17.1%) 16-20 years; 67 (12.9%) >20 years; 127 (24.4%)
Any leadership training (n=521)	Yes; 216 (41.5%) No: 305 (58.5%)
Formal leadership training (n=523)	Yes; 129 (24.7%) No; 394 (75.3%)
Informal leadership training (n=519)	Yes; 170 (32.8%) No;349 (67.2%)

4.3.1. Objective 1 - Self-declaration as a leader

To the question, 'Do you perceive yourself to be a leader?' there were 523 responses. Of these 74.0% (n=387) answered 'yes' and 26.0% (n=136) answered 'no'. Results of the Chi square analyses of factors potentially associated with self-declaration as a leader are displayed in Table 4.2. No significant difference was found in Chi square analyses between self-declared leadership status and gender, workplace, practising as part of an MDT, or supervision of students.

A significant association was found between leadership declaration status and highest degree attained ($p<0.001$). In the chi square, a greater number of respondents with taught Masters (observed n=112), research Masters (observed n=37) or doctorate degrees (observed n=13) perceived themselves to be leaders than expected (n=98.5, 31.1 and 10.4 respectively). A smaller number of respondents with diplomas (observed n=30) or bachelor degrees (observed n=193) perceived themselves to be leaders than expected (n=35.5 and 209.5 respectively).

A significant association was also found between leadership declaration status and the length of time since graduating ($p=0.001$). A greater number of physiotherapists who had graduated 6-10 (observed n=77), 11-15 (observed n=71), 16-20 (observed n=50), or >20 years ago (observed n=99) perceived themselves to be leaders than expected (n=69.1, 66.1, 49.1 and 93.6 respectively). A smaller number of physiotherapists who had graduated <2 (observed n=24) or 2-5 years (observed n=64) ago perceived themselves to be leaders than expected (n=27.5 and 79.5 respectively).

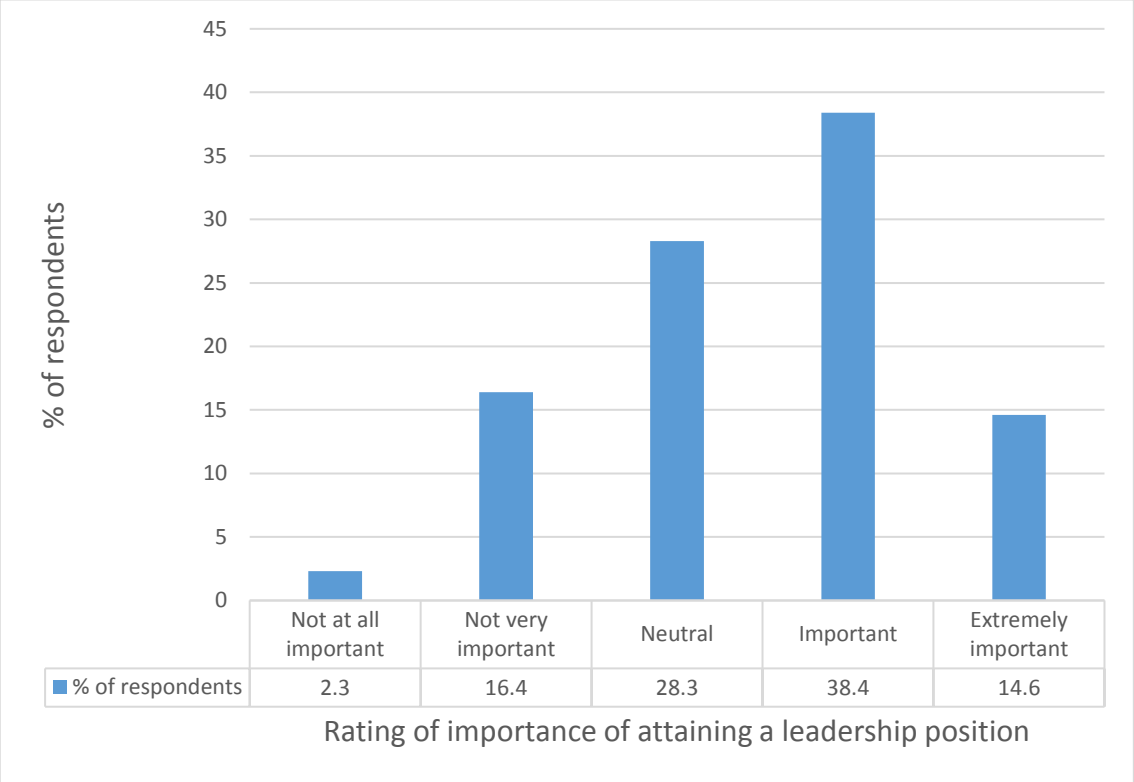
Table 4-2 Pearson's chi square analysis of factors and self-declaration as a leader

Factor (n=number of responses in analysis)	**Self-declaration as a leader**		
	Chi Square	**Degrees of freedom**	**p-value**
Gender (n=523)	2.405	1	0.121
Workplace (n=522)			
Private practice	2.685	1	0.101
Public hospital	0.270	1	0.603
Private hospital	1.490	1	0.222
Primary care	2.654	1	0.103
Education	2.413	1	0.120
Supervisory status (n=520)	3.154	1	0.076
Working in MDT (n=515)	0.253	1	0.615
Highest qualification (n=520)	22.403	4	<0.001
Time since graduation (n=518)	19.687	5	0.001
Any leadership training (n=519)	48.152	1	<0.001
Formal leadership training (n=521)	18.625	1	<0.001
Informal leadership training (n=517)	47.658	1	<0.001

4.3.2. Objective 2 - Importance of attaining a leadership position

Respondents were asked to rate how important attaining a leadership position was to their overall sense of career success. The results are displayed in Figure 4.1.

Figure 4-1 Percentages of ratings of importance of attaining a leadership position



* Ten responses to this question were excluded because the respondents had selected two boxes when answering the question. Two respondents skipped this question.

Results of the chi square analyses of factors potentially associated with perceived importance of attaining a leadership position are displayed in Table 4.3. No significant association was found between the importance placed on attaining a leadership position and gender, workplace, supervising students, practising as part of an MDT, highest qualification attained or time since graduation.

Table 4-3 Pearson's chi square analysis of factors and importance placed on attaining a leadership position

Factor (n=number of responses in analysis)	**Importance placed on attaining leadership position**		
	Chi Square	**Degrees of freedom**	**p-value**
Gender (n=513)	1.052	2	0.591
Workplace (n=512)			
Private practice	2.327	2	0.312
Public hospital	1.137	2	0.566
Private hospital	2.681	2	0.262
Primary care	4.369	2	0.113
Education	3.040	2	0.219
Supervisory status (n=510)	1.273	2	0.529
Working in MDT (n=505)	0.596	2	0.742
Highest qualification (n=510)	12.031	8	0.150
Time since graduation (n=509)	15.751	10	0.107
Any leadership training (n=509)	19.199	2	<0.001
Formal leadership training (n=511)	11.868	2	0.003
Informal leadership training (n=507)	26.543	2	<0.001

4.3.3. Objective 3 - Leadership training

The most commonly cited types of formal and informal leadership training are displayed in Table 4.4.

Table 4-4 Frequency distribution of formal and informal leadership training examples most frequently cited by respondents

Formal Leadership Training	**Number of respondents (% of total who had completed formal training)**
Diploma or certificate in management or leadership	24 (18.6%)
Health Service Executive (HSE) funded leadership and management courses	19 (14.7%)
Masters courses in management or leadership	17 (13.2%)
Leadership courses through work	11 (8.5%)
Informal Leadership Training	**Number of respondents (% of total who had completed informal training)**
Mentoring	58 (34.1%)
Experiential learning at work	20 (11.8%)
Experience as clinical supervisor of junior staff or students	15 (8.8%)
Independent reading/learning	12 (7.1%)
Role-modelling/observing others	10 (5.9%)
Peer review/supervision	10 (5.9%)

Overall 41.5% (n=216) had had some form of leadership training, 24.7% had completed formal training and 32.8% had completed informal training. A significant association ($p<0.001$) was found between leadership training (both formal and informal) and self-declaration as a leader (refer to Table 4.2). A greater number of respondents who had completed leadership development training (observed n=194) perceived themselves to be a leader than was expected (n=159.8), and a smaller number of those who had not

completed leadership development training (observed n=190) perceived themselves to be a leader than was expected (n=224.2).

A significant association ($p<0.001$) was found between leadership training and the importance placed on attaining a leadership position (refer to Table 4.3). The number of respondents who rated attaining a leadership position as 'very important' (observed n=97) or 'extremely important' (observed n=39) was higher than expected for those who had undertaken leadership training (expected n=80.9 and 30.9 respectively). The number of physiotherapists who rated attaining a leadership position as 'Not important or neutral' (observed n= 164) was higher than expected for physiotherapists who had not undertaken leadership development training (expected n=139.8). This pattern was the same for formal training and informal training.

4.3.4. Objective 4 - Ratings of leadership capabilities

Table 4.5 displays the ratings of the leadership capabilities in the workplace, the healthcare system and society.

Mann Whitney U tests found that each capability was more highly rated as important in the workplace than in society and this difference was significant ($p<0.001$ for all capabilities). Most capabilities were rated as significantly more important in the workplace than in the healthcare system. However, there was no significant difference between the ratings of the importance of professionalism, adaptability, active management and social dominance in the workplace and in the healthcare system. In contrast, ratings of business acumen and vision were rated more highly in the healthcare system than in the workplace. Results of the Mann Whitney U test of the capabilities are displayed in Table 4.6.

Table 4-5 Order of capabilities rated as extremely important by physiotherapists across the three settings

Workplace		Healthcare System		Society	
Capability	**Percentage (%) of respondents rated as extremely important**	**Capability**	**Percentage (%) of respondents rated as extremely important**	**Capability**	**Percentage (%) of respondents rated as extremely important**
Communication	79.0	Communication	71.0	Communication	58.1
Professionalism	67.4	Professionalism	66.2	Professionalism	49.2
Motivating	66.7	Active management	56.6	Empathy	44.6
Credibility	64.5	Adaptability	56.4	Social skills	40.6
Active management	61.8	Vision	53.5	Motivating	39.2
Adaptability	60.7	Motivating	53.2	Adaptability	37.1
Delegation	58.9	Credibility	52.1	Active management	34.6
Empathy	57.8	Delegation	50.4	Credibility	34.2
Social skills	55.6	Empathy	44.3	Self-regulation	30.8
Self-regulation	46.8	Business acumen	43.7	Vision	30.4
Vision	43.1	Social skills	39.4	Delegation	28.4
Extroversion	39.7	Self-regulation	38.6	Extroversion	25.9
Business acumen	34.7	Extroversion	33.0	Self-awareness	24.9
Self-awareness	33.1	Self-awareness	28.3	Business acumen	21.2
Social dominance	27.0	Social dominance	27.0	Social dominance	18.4

Table 4-6 Ratings of leadership capabilities across the different settings and comparison between settings using Mann Whitney U test

Leadership capability	Setting (% of respondents rated as extremely important)			Comparison workplace and the healthcare system (p value)	Comparison workplace and society (p value)
	Workplace	Healthcare System	Society		
Credibility	64.5	52.1	34.2	<0.001	<0.001
Motivating	66.7	53.2	39.2	<0.001	<0.001
Communication	79.0	71.0	58.1	0.002	<0.001
Professionalism	67.4	66.2	49.2	0.554	<0.001
Business Acumen	34.7	43.7	21.2	0.023	<0.001
Delegation	58.9	50.4	28.4	0.001	<0.001
Vision	43.1	53.5	30.4	0.006	<0.001
Adaptability	60.7	56.4	37.1	0.066	<0.001
Extroversion	39.7	33.0	25.9	0.004	<0.001
Active Management	61.8	56.6	34.6	0.051	<0.001
Social Dominance	27.0	27.0	18.4	0.550	<0.001
Empathy	57.8	44.3	44.6	<0.001	<0.001
Social Skills	55.6	39.4	40.6	<0.001	<0.001
Self-awareness	33.1	28.3	24.9	0.005	<0.001
Self-regulation	46.8	38.6	30.8	<0.001	<0.001

4.3.5. Objective 5 - Leadership and Physiotherapists who practice in private practice

A significant association was found between physiotherapists who responded that they work in private practice (n=194, 37.0% of respondents) and rating of business acumen in the workplace (X^2=18.971, *df*=2, p<0.001) and in society (X^2=7.650, *df*=2, p=0.022). There was no significant association between working in private practice and rating of business acumen in the healthcare system (X^2=0.868, *df*=2, p=0.648). A greater number of physiotherapists working in private practice rated business acumen as 'extremely important' in the workplace (observed n=90) than expected (n=67.4), and a smaller number of physiotherapists working in private practice (observed=24) rated business acumen as 'not important or neutral' in the workplace than expected (n=32.6). Similarly, a greater number of physiotherapists working in private practice rated business acumen

as ‘extremely important’ in society (observed n=53) than expected (n=41), and a smaller number of physiotherapists working in private practice (observed=68) rated business acumen as ‘not important or neutral’ in society than expected (n=78).

4.3.6. Objective 6 - Thematic Analysis Results

Comments were left in the open comment box on leadership and leadership development by 153 respondents. The demographic details of these respondents are displayed in Table 4.7.

Table 4-7 Demographic details of respondents to open comment box

Demographic (n=responses to question)	**Number (percentage)**
Gender n=153	Male – 24 (15.7%) Female – 129 (84.3%)
Degree n=152	Diploma – 22 (14.5%) Bachelor – 64 (42.1%) Masters (taught) – 46 (30.3%) Masters (research) – 16 (10.5%) Doctoral – 4 (2.6%)
Time since graduation n=151	<2 years – 2 (1.3%) 2-5 years – 22 (14.6%) 6-10 years – 16 (10.6%) 11-15 years – 27 (17.9%) 16-20 years – 25 (16.6%) >20 years – 59 (39.1%)
Workplace n=152	Public hospital – 55 (36.2%) Private hospital – 9 (5.9%) Primary Care – 23 (15.1%) Private Practice – 55 (36.2%) Education - 12 (7.9%) Other – 24 (15.8%)

Seven themes were identified and are presented along with their associated subthemes in Table 4.8. Each theme and corresponding subthemes will be described below and pertinent examples given to illustrate them.

Table 4-8 Themes and subthemes

Themes	Subthemes
Leadership is important	• Leadership is a key competence in physiotherapy • Leadership is key to future developments in physiotherapy
Education	• Leadership development - Individual development - Would like training - Undergraduate (pre-registration) • Opportunities within career structure • Role-modelling • Mentoring
Leadership qualities	
Leadership versus management	• Don't have to be a manager to be a leader
Organisational Culture	• Lack of training opportunities • Criticism of current leaders • Barriers to leadership - Emphasis on clinical skills - Poor career structure
Role of the ISCP	• Should offer courses/skill development
Reflections on the physiotherapy profession	

4.3.6.1. Leadership is important

A prominent concept throughout the responses was that 'leadership is important'. Leadership was viewed as important both for individual physiotherapists and for the profession of physiotherapy. Reasons given for the importance of leadership included:

'To ensure we regain our professional status in terms of earning capacity and don't fall behind the larger healthcare professions' TCD1

‘*Personal and professional development’* TCD17, TCD153

‘To equip physiotherapists to respond to and assist peers in adapting to a changing environment’ TCD18

‘to promote the role and extensive competencies of the physiotherapy profession’ TCD35

Within the theme ‘leadership is important’ two subthemes were identified. The first of these was *leadership is a key competence in physiotherapy*. The comments in this subtheme demonstrated how respondents perceive leadership to be a core skill that physiotherapists need in their day-to-day work.

‘*Any good 'learning' I've had on this area has been hugely helpfully in my own day to day practice’*, TCD23

‘I think the idea of leadership development training is essential so that all staff have a basic knowledge of team work and management skills’. TCD94

There were also comments about the need for all physiotherapists to demonstrate leadership.

‘It is important that all physiotherapists see themselves as leaders in some respects’ TCD57

‘*Leadership skills should be nurtured at all levels of the profession.’* TCD142

There were also references made to the importance of leadership to the future of physiotherapy and hence a second subtheme was *leadership is key to future developments in physiotherapy*.

‘*This is a very important skill to develop for the future of physiotherapists in Ireland and to promote to the wider public and to our medical colleagues our valuable diagnostic and skill abilities’* TCD26

‘*Leadership development is critical to the future of our profession as we make our voice heard in the wider healthcare setting’* TCD147

4.3.6.2. Education

The second theme covered the opinions expressed on developing leadership skills and capabilities. Several subthemes were identified within this broad theme; *leadership development, opportunities within career structure, mentoring* and *role-modelling*.

The first subtheme, *leadership development*, encompassed the need for physiotherapists to develop leadership skills, respondents' expressions of wanting to complete leadership development, leadership development at an undergraduate level, and continuous professional development.

There were comments on the need for physiotherapists to complete leadership training and develop leadership skills.

> *'I feel all health professionals should take accountability in improving their knowledge in this area to ensure they are doing the best that they can do'.* TCD17
>
> *'I believe development is a very important part of leadership as people who may not have realised they would make good leaders are enabled to tap into the skills required. Furthermore, people who are currently in leadership roles can also improve their skills and therefore everyone would benefit from this'* TCD129

Many respondents expressed a desire to complete leadership development training or stated a belief that leadership training should be available to physiotherapists.

> '*Would welcome formal training on leadership, as a topic in its own right'* TCD7
>
> *'I think training in this area is vital to allow people to have the confidence to take on tasks and develop their roles in their jobs.'* TCD51
>
> '*Formal development programmes would be very beneficial as a recognised part of our career pathway.'* TCD118

This subtheme also included leadership training at pre-registration level. The undergraduate degree programme was seen as an opportune time to introduce leadership training to student physiotherapists by some respondents. However, there were also comments that this opportunity was being missed.

> *'Some leadership training should be considered at under graduate level.'* TCD3
>
> '*Our undergraduate & postgraduate training does little to develop leadership abilities or qualities in a student. It is an area worth developing further.*' TCD21

While many respondents spoke of developing leadership skills through formal training or development programmes others recognised that leadership techniques can be developed through experiential learning. For example, through increased responsibility and diverse learning opportunities in the workplace.

> '*Often physiotherapists develop these skills as a response to the role they find themselves in rather than as part of specific training programmes.'* TCD7

'*As a physiotherapist, like many others, who teaches an exercise class - I feel leadership is established and naturally improved as a result of teaching.'* TCD128

With regards to specific methods to improve leadership skills two approaches referred to by respondents were mentoring and role-modelling.

'The greatest learning and development is to expose yourself to good leaders.' TCD24

'Some essential components of leadership may be better developed through formal mentoring/coaching processes.' TCD135

4.3.6.3. Leadership Qualities

Many respondents wrote about leadership capabilities that were not included in the survey or offered further opinions on those that were.

'Self-awareness and emotional intelligence are essential. Understanding motivation, power and control from an individual level to organisational and society.' TCD47

'*I consider that a good leader develops the team, as well as leads the team by example. A good leader self-regulates him/herself and has sufficient insight into his/her own character to be aware of his/her own leadership style. A good leader delegates, and also audits the performance of the team.*' TCD72

The importance of approachability and friendliness in leaders was cited by several respondents.

'*In the healthcare system those in leader roles should be appropriately chosen for both their decision making but also empathy and overall abilities. Team leaders should be approachable by all staff no matter the difference in hierarchy*.' TCD44

'*It's extremely important for a leader to be respected but yet accessible and approachable and never to be feared by staff.*' TCD129

4.3.6.4. Leadership and Management

'Leadership and management' was another theme. Within this theme, respondents commented on these concepts and demonstrated that they appreciated the differences between these two roles.

'*Being a senior physiotherapist or a physiotherapy manager does not necessarily mean one is a leader'* TCD76

'*It's vital to distinguish leadership from management. Both concepts are constantly confused.'* TCD131

There was criticism of some managers for not being leaders, and for managers not having appropriate training to be effective leaders.

'Some managers are in roles as they are good managers but not necessarily good leaders' TCD133

'In physiotherapy departments the manager or leader rarely has any formal training and is not necessarily the dominant force in the department. I have seen many instances where the manager is a paper pusher and this leaves a void for members of staff to take the role.' TCD122

Some of the respondents highlighted that you did not need to be a manager or in a formal senior position to be a leader and these responses formed the subtheme; *don't have to be a manager to be a leader*. There was a call for more physiotherapists not in formal leadership roles to demonstrate leadership.

'*It is important that all physiotherapists see themselves as leaders in some respects - not everyone can be the manager/CEO etc, but everyone should want to pave the way for those therapists coming behind us and continue to promote our role to society.'* TCD57

'*There are many clinical and academic leaders, just because you aren't in a management role doesn't mean you can't lead.*' TCD22

4.3.6.5. Organisational Culture

Perhaps the most wide-ranging theme was that of 'organisational culture'. Several subthemes were identified in this theme: *lack of training opportunities, criticism of current leaders* and *barriers to leadership.* This theme encompassed the context of leadership in physiotherapy in Ireland. It included the respondents' views of the healthcare system and their current work environment. There was dissatisfaction expressed with the state of the present working situation for physiotherapists in Ireland and its subsequent impact on leadership.

'I do the work of a senior physiotherapist even though I am still work as a basic grade position and I find that very frustrating' TCD82

'Working in the public health system cancels any motivational or leadership skills! It's so frustrating!' TCD77

'There are so many layers in the health system it is now extremely difficult to 'lead' because of constraints from higher levels'. TCD106

Respondents perceived there to be a lack of training opportunities within their workplaces. Some respondents commented that physiotherapists were unable to do leadership training courses before attaining a formal leadership role and thus were unprepared when that role was finally achieved.

'*Some of my younger colleagues indicate that they may like a leadership role but don't get an opportunity to develop these skills'* TCD113

'Many physios arrive within a leadership role without any formal or informal training and find it difficult to get that training'. TCD133

There were also many comments (n=14) criticising the current leaders or managers in physiotherapy in Ireland.

'*There are individuals in leadership roles who should not be there. It is very difficult to work in a situation where the leader is intimidating and bullying their staff'* TCD13

'*People who don't necessarily possess leadership qualities are in positions of leadership'* TCD87

'*The danger that I perceive and have experienced is the abuse of leadership positions when natural bullies fall into leadership roles'* TCD114

A prominent subtheme identified within the 'Organisational culture' theme was the perceived barriers to pursuing leadership positions in the Irish health care system and barriers to developing leadership skills. These barriers included: misconceptions about leadership, the emphasis on clinical skills, workload pressures, lack of support or recognition, poor career structure and a lack of leadership positions.

Several respondents recognised that an emphasis on learning clinical skills, low priority placed on leadership and pressures from clinical caseloads precluded spending time developing non-clinical skills such as leadership.

'I think in the current circumstances of staff shortages and increasing workload with expectations of providing a flawless service, I think development of leadership skills is the last thing on anyone`s agenda on a day to day basis.' TCD50

'*It's not an area that I think a lot of physios do training in - we concentrate on our clinical stuff.'* TCD79

The career structure and a lack of leadership positions or opportunities within physiotherapy in Ireland was also commented on.

'There seems to be a lack of structure within the profession from basic grade up. For most, you can get a basic grade position, get on a senior panel and then through that a senior position. From there, where do you go? Clinical specialist posts and managerial post are very limited, with clinical specialist posts being confined to the big hospitals. Once you reach the top of your pay scale as a senior there is no other natural progression.' TCD20

'I think that developing leadership within the physiotherapy field is severely limited by the structure of positions within the health service. Progression is limited and gaining experience in non-clinical skills is not a priority.' TCD48

4.3.6.6. The role of the ISCP

Another theme was 'The role of the ISCP'. There were comments that the ISCP needed to demonstrate leadership on issues like protection of the professional title and unemployment in new graduates.

'The leadership of the ISCP would want to sort out the protection of title and regulation of "Physical Therapists" in Ireland. It has reduced the credibility of Irish Qualified Physiotherapists.' TCD49

Several respondents indicated that they would like the professional organisation to provide leadership development opportunities.

'*I think it would be helpful for the ISCP to offer some kind of professional development in this area'* TCD16

'*I think it would be great if ISCP facilitated more formal leadership courses for managers or future managers*.' TCD67

4.3.6.7. Reflections on the physiotherapy profession

The final theme covered the reflections of respondents on physiotherapists and the physiotherapy profession in Ireland. While there were a few positive comments made about the physiotherapy profession these were greatly outweighed by negative reflections on the profession. Respondents were critical of physiotherapists' unwillingness and ability to lead

Many responses in this theme were critical of the physiotherapy profession.

> '*There is not enough trust, autonomy, flexibility, diversity or adaptability in our profession despite the highly qualified and generally smart people who are physios.'* TCD100
>
> *'we are often overshadowed by other professions, or undersell ourselves, because we don't have the leadership skills necessary to ensure our voice is heard, whether it be in the workplace or at the societal level.'* TCD132

There was criticism of the leadership capabilities of physiotherapists and comments about there being a lack of leadership in the profession.

> '*Poor belief/vision amongst physiotherapist in seeing themselves as leaders outside of our profession'* TCD27
>
> *'Physiotherapists are blatantly absent or scarce in many positions of influence and authority'* TCD76

Also within this theme were comments about the need for physiotherapists to better promote the profession.

> '*This is a very important skill to develop for the future of physiotherapists in Ireland and to promote to the wider public and to our medical colleagues our valuable diagnostic and skill abilities.*' TCD26
>
> *'I feel it is very important for us to be seen as leaders within the team/working environment, to promote the role and extensive competencies of the physiotherapy profession. If we don't promote ourselves no-one else will!'* TCD35

4.4. Discussion

The response rate of 22% was low, but not unexpected for this type of survey (Evans and Mathur, 2005), and was in line with other physiotherapy literature where online surveys were conducted with physiotherapy populations or members of professional bodies (McMahon and Connolly, 2013, Connell et al., 2014). Efforts were made to increase responses through reminder emails and the use of the professional organisation for distribution to provide credibility. Another limitation of the study to be considered was the potential for bias. The survey was sent to members of the ISCP rather than to all physiotherapists in Ireland. It would, however, have been impossible to contact physiotherapists via email who are not members of the ISCP. The procedure used in this study allowed for a self-selection bias where physiotherapists with personal interest in leadership may be over-represented in the study findings, as opposed to those who were indifferent to the subject and thus less likely to respond (Eysenbach and Wyatt, 2002). As well as this, the social desirability associated with being a leader may have led to a response bias where respondents were more likely to perceive themselves as a leader in this survey than would actually consider themselves to be a leader in their daily practice. It is important to be mindful of these limitations when interpreting the results of the study.

4.4.1. Self-declaration as a leader

In this study 74.0% of respondents believed themselves to be a leader. This was slightly less than the 79.6% of respondents in the Canadian study (Desveaux et al., 2012a), but is still a positive finding. It is important that all physiotherapists see themselves as leaders so that they feel confident and empowered to drive continual change and improvement in the service that they provide. Self-awareness of leadership capabilities is an essential step that will allow physiotherapists to pursue leadership roles in the health care system (Damp-Lowery, 2012). However, this finding may have been biased by the fact that the respondents were a self-selected cohort. People who respond to a survey about leadership may be more likely to be interested in leadership in general and thus more likely to perceive themselves to be leaders.

Factors found to be associated with self-declaration as a leader were highest qualification attained, time since graduation and leadership development training. Pearson's chi square analysis demonstrated that physiotherapists with Masters or doctoral degrees were more likely to perceive themselves to be leaders than

physiotherapists without these additional qualifications. This may reflect that those who have higher levels of education may feel that they have more to teach others and thus may be more likely to consider themselves to be a leader. It may also be that physiotherapists with higher levels of education may be more likely to be practising in more senior or management positions and therefore may have responsibility in supervising and managing other members of the team. Wylie and Gallagher (2009) found that health professionals practising at higher staff levels reported higher transformational leadership scores than those practising at lower levels in a survey-based investigation of transformational leadership in health professionals.

Chi square analysis also demonstrated that there was an association between being qualified for longer and self-declaration as a leader. Just as with 'the highest degree attained' this may have been because physiotherapists who have been qualified for longer may be more likely to be in senior or management positions. They may also feel more secure and confident about their status in their workplace, or in the profession, and thus empowered to advocate and strive for the things that they are passionate about. The significant associations between self-declaration as a leader and highest qualification attained and self-declaration as a leader and time since graduation also reflect findings of Chan et al. (2015). Chan et al. (2015) compared the strengths of physiotherapy leaders and physiotherapists without leadership positions or awards. The physiotherapists in the 'leader' group were found to have more years of experience and to have attained a higher level of education.

The finding that leadership development training was associated with self-declaration as a leader could be interpreted in two ways. It may indicate that the leadership development training contributed to these professionals perceiving themselves to be leaders. It may also reflect that physiotherapists who perceive themselves as leaders may be more likely to participate in and complete leadership development training. This finding concurs with that of Wylie and Gallagher (2009) whose results indicated that allied health professionals who had completed leadership training reported significantly higher aggregated leadership scores on the Multifactorial Leadership Questionnaire ($p<0.001$).

4.4.2. Importance of attaining a leadership position

When asked to rate how important attaining a leadership position was to their sense of overall career achievement, 53.0% rated achieving a leadership position as very

important or extremely important. In contrast to Rozier et al. (1998) who found that 'appointment or election to a leadership position in a professional organisation' was not deemed important to overall career success, the majority of respondents here indicated that this was important to their career success. This finding also contrasted with research findings in the nursing profession. Sherman (2005) reported growing concern among nurse leaders about nurses' lack of desire to advance to leadership positions. Issues such as pay equity, decision-making power in the role, and negative feedback about the role from current nurse leaders were found to influence the perceptions of the younger nurses who participated in the focus groups. In a survey of nurses and midwives in Scotland, Wise (2007) found that moving into their line manager's role was a career aspiration of only 10% of survey respondents, and Bulmer (2013) reported that levels of leadership aspiration were low in a survey of registered nurses in Pennsylvania.

The finding that the majority of respondents rated attaining a leadership position as 'very important' or 'extremely important' was reflected by the theme 'leadership is important' in the comments to the open comment box. The importance of leadership in healthcare (Collins-Nakai, 2006, Millward and Bryan, 2005, Kumar, 2013, West et al., 2015), and in physiotherapy more specifically (Desveaux et al., 2012a, Desveaux and Verrier, 2014, Chan et al., 2015), has been cited in numerous papers (see section 3.2.2). Gilmartin and D'Aunno (2007) reported that leadership was significantly and positively associated with turnover, performance and individual work satisfaction in their review of 60 studies in healthcare leadership. The subtheme *leadership is a key competence in physiotherapy* reflects the WCPT Description of Physical Therapy policy statement which stated that the scope of physiotherapy practice is not limited to direct patient care but also includes leading, managing, advocating for patients/clients, research and public health strategies (WCPT, 2011a). The Health and Care Professionals Council in the UK recommends that physiotherapists 'understand the concept of leadership and its application to practice' in its document, 'Standards of Proficiency – Physiotherapists' (HPC, 2013). Within Ireland, the Physiotherapy Competency Framework of the HSE details 'leadership and service development' as a competency expected of physiotherapists at senior and clinical specialist level (HSE, 2008).

4.4.3. Leadership development training

When looking at the demographics of respondents who rated attaining a leadership position as 'very important' or 'extremely important' an association was found with having

completed leadership development training (P<0.001). This result may simply reflect that those who believe achieving a leadership position is important would be more likely to participate in leadership development training. However, it could also be argued that people were more likely to understand the importance of leadership to practice as a physiotherapist once they had undertaken leadership development training.

Results showed that 24.7% had participated in formal leadership training and 32.8% had participated in informal leadership training. 'Education' was also a theme in the responses in the open comment box. This theme encompassed comments about the need for physiotherapists to develop leadership skills, statements about wanting to complete training in this area, and different ways of developing leadership skills. A wide range of sources and types of training were reported by respondents. The most frequently cited form of leadership development was mentoring (n=58). Mentoring was also suggested as a development strategy in the open comment responses. Mentorship has been described as a supportive and nurturing relationship focused on the sharing of knowledge and experience between experienced mentors and an aspiring learner (Owens et al., 1998). The role of mentoring in leadership development in healthcare organisations has been recognised (McAlearney, 2005). In a qualitative study of physiotherapists in Canada, Ezzat and Maly (2012) found that mentoring relationships enabled physiotherapists to adapt to change, advance practice, and develop the profession.

Within the 'Education' theme there was also recognition of the need for *Leadership training at pre-registration level.* Comments calling for leadership training activities to be commenced during the entry level degree echoed a taskforce convened by the Health Policy and Administration (HPA) section of the APTA in 1999 which recommended that leadership and management skills should be developed in all phases of student preparation (Kovacek et al., 1999). Some respondents recognised that experiential learning activities were a possible way to develop leadership skills and reported opportunities to develop leadership skills in their workplaces. Experiential learning programmes for physiotherapy students have been investigated. Wilson and Collins (2006) evaluated the development of students in the USA involved in an educational module involving an experiential learning opportunity where they assumed dual roles as both managers and clinicians in not-for-profit physiotherapy clinics. The most frequently reported improvements when answering open-ended questions about their learning from the experience were in relation to leadership skills; how to become one, how to get the best out of group members and how to adapt leadership skills depending on the team

(Wilson and Collins, 2006). The importance of engaging physiotherapy students to develop knowledge and skills in leadership was advocated by (Dean and Duncan, 2016) in an article describing the Doctor of Physical Therapy programme at Macquarie University in Sydney, Australia. The Macquarie programme has been strategically developed to prepare innovative leaders and includes a Leadership, Policy and Advocacy course in the final year (Dean and Duncan, 2016).

The theme, 'The role of the ISCP', was also related to leadership development and training. Several respondents indicated that they would like the professional organisation to offer leadership development courses. At present the ISCP does not have a special interest group which focuses on leadership, neither does it provide leadership development programmes. It is important to take into consideration that the respondents to this survey were all members of the ISCP and so their feelings of the importance, duties and responsibilities of the professional group may not be the same as physiotherapists who are not members of the ISCP.

4.4.4. Leadership capabilities

Communication and professionalism were the most highly rated leadership capabilities across all three settings. These capabilities were also the two most highly rated capabilities in the Canadian study (Desveaux et al., 2012a). The importance of effective communication to leadership has been widely reported (De Vries et al., 2010, Hicks, 2011, Gaiter, 2013). With respect to physiotherapy, effective communication is a core standard (WCPT, 2011c, HPC, 2013). It has been shown to be valued by patients attending physiotherapists (Cooper et al., 2008, Kidd et al., 2011) and is essential in demonstrating effective practice (Reynolds, 2005). In a Delphi study investigating the LAMP skills needed by physiotherapy graduates, the physiotherapy managers who participated in the surveys rated communication most highly (Lopopolo et al., 2004). Physiotherapists rely on effective communication (both verbal and nonverbal) between themselves and their clients, their colleagues, and other health and social care workers (Parry and Brown, 2009). Similarly, a high degree of professionalism—described by Wilkinson et al. (2009) as incorporating adherence to ethical practice principles, effective interactions with people working within the health system, effective interactions with patients and their families, reliability, and commitment to autonomous maintenance or improvement of competence in oneself, others, and systems – helps to build trust with patients and has been found to be beneficial to both individuals and organisations

(Brennan and Monson, 2014). Professionalism is one of five competency domains that the Healthcare Leadership Alliance (HLA) found were universal to all practising healthcare managers (Stefl, 2008). The HLA was a consortium of six major healthcare professional groups in the USA. The consortium used research from their individualised credentialing processes to propose competency domains common to all healthcare managers. The importance placed on communication and professionalism across all three settings suggests that development of skills in these areas should be a core component of leadership training for physiotherapists.

Respondents rated motivating as the third most important leadership capability in the workplace, which may reflect that these respondents view the ability to inspire and encourage others as an important leadership role in the workplace and is consistent with a transformational leadership style (Bass and Avolio, 1994). Transformational leaders motivate others to achieve goals and the shared vision by providing meaning and challenge to their work (Bass and Avolio, 1994).

The third most highly rated capability for a physiotherapist to demonstrate in the health care system was active management. Active management was defined as ‘‘actively monitor[ing] situations and mak[ing] corrective interventions before situations become problematic” (Desveaux et al., 2012a). This finding suggests that these respondents recognize the importance of being cognisant of potential problems in the health care system and of being assertive when intervening to address them. As detailed by the Chartered Society of Physiotherapists (CSP, 2012a) in the United Kingdom, physiotherapy leaders must take a central role in the redesign, delivery, and sustainability of key patient services and pathways.

Empathy was the third most important leadership capability in society. The importance placed on empathy in society may demonstrate that respondents want the physiotherapy profession to be perceived as caring and understanding by the general public. Bayliss and Strunk (2015) spoke of the need to foster empathy in physiotherapy students; describing empathy as a vital component of therapeutic communication that is valued by patients and shown to enhance both patient outcomes and compliance. Within the leadership literature empathy has been associated with transformational leadership (Skinner and Spurgeon, 2005, Barbuto and Burbach, 2006). Skinner and Spurgeon (2005) found significant correlations between concepts of empathy (empathetic concern, perspective taking and empathetic match) and transformational leadership.

‘Leadership qualities’ was also a theme in the responses in the open comment box. This theme covered the capabilities and qualities which respondents perceived to be important to leadership. Additional comments were given on the capabilities rated in the survey and there were also suggestions of capabilities important to leadership that were not included in the survey. There were comments about the importance of a leader being approachable, friendly or personable. These capabilities are related to the concept of communication and may reflect the importance physiotherapists place on being able to communicate ideas and problems to their leaders.

Social dominance was the lowest rated capability across all three settings. Social dominance was defined as ‘gain respect and attention of others, appear competent and have a strong influence over others’. The lower importance placed on social dominance may give some information about the leadership style adopted by physiotherapists in Ireland. A reluctance to appear dominant or to have a strong influence over others is suggestive of a more transformational or servant leadership style. Transformational leadership involves empowering others to achieve the shared vision (Robbins and Davidhizar, 2007). Servant leaders do not use their power to get things done but instead try to persuade and convince their team (Greenleaf). Servant leadership changes the focus from influence to service in the leader-follower relationship (Van Dierendonck, 2011).

4.4.5. Rating of leadership capabilities across settings

Respondents rated each capability more highly in the workplace than in society. This finding was consistent with that of Desveaux and Verrier (2014) who hypothesised that the decrease in perceived importance of leadership capabilities at the societal level may reflect that physiotherapists are more focused on leadership in their immediate work environment than in wider society. The importance of leadership may be more readily apparent in the workplace than in society, where the concept of leadership may seem more abstract. Working at the point of care with patients across the health care system, from home to community to hospital services, physiotherapists are ideally positioned to identify areas for improvement and lead efforts to bring change and innovation (CSP, 2012a). Their long contact time with patients enables them to develop trusting relationships and thus to respond effectively to patients’ needs and concerns. Recognizing the opportunities for physiotherapists to use their leadership skills in the wider societal context may be less obvious, however. The physiotherapy profession

needs to promote physiotherapy services through modern marketing strategies to improve public awareness of and confidence in physiotherapy (Webster et al., 2008) which will require leadership at the societal level. Desveaux and Verrier (2014) concluded that physiotherapists need to recognise leadership roles and opportunities beyond their own workplace if physiotherapy is to grow as a profession and increase its profile. The need for the physiotherapy profession in Ireland to better promote itself was also commented on by several respondents to the open comment box within the theme 'reflections on the physiotherapy profession'. Opportunities for physiotherapists in Ireland to demonstrate leadership in society may include health promotion initiatives, education of the public on the prevention of injury and programmes to enable people to become more physically active. Several such promotional campaigns are currently being run by physiotherapy professional groups around the world; National Physiotherapy Month in Canada (CPA, 2015b) aims to raise awareness of the physiotherapy profession in Canada and its many benefits for patients by engaging CPA members, patients, and the public in events and activities. In Australia, the ''I ♥ my Physio'' campaign (APA, 2015a) invites members of the public to share stories of how their lives have improved with support from a physiotherapist. The CSP Council in the United Kingdom supports Physiotherapy Works, a 3-year program aimed at increasing demand for physiotherapy services by promoting how physiotherapy can help people live better and longer and improving public awareness of the benefits of physiotherapy (CSP, 2016d).

4.4.6. Business acumen

Physiotherapists who work in private practice were more likely to rate business acumen as 'extremely important' in the workplace and in society than those who do not work in private practice. Desveaux et al. (2012a) also found that there was an association between working in private practice and ratings of business acumen in the workplace in their Canadian study. In both physiotherapy, and healthcare more generally, business planning is often seen as the domain of those practising in the private sector, rather than those practising in other practice settings, or in education (Wassinger and Baxter, 2011). However, a business approach is also important in the public and non-profit sectors. As noted by Collins-Nakai (2006) in the medical profession, increasing pressure to improve efficiency and operate in a cost-effective manner has created a growing demand for leaders with business acumen. In a study investigating the skills that managers feel are important for employment success, Pescatello et al. (2000) found that healthcare managers differed from non-healthcare managers in the importance they placed on

business skills. While 66.7% of non-healthcare managers perceived possession of business skills to be critical for career success, only 22.1% of healthcare managers believed they were an important quality for a staff level physiotherapist to demonstrate, and this difference was statistically significant (p=0.001). Physiotherapists who practice directly considering the financial and business aspects of their service may be more aware of their significance in day to day practice than physiotherapists who are more removed from these aspects. However, physiotherapists who practice in the public sector or in education also need to appreciate that money and financial matters drive most of the decisions regarding their service and status within an organisation or the healthcare system. The principles of developing business plans have relevance beyond the start-up and running of private practices, including but not limited to, activities such as: starting a new service or facility within a hospital department, organisation of a scientific or professional conference, expansion of a community-based service or planning the development of a new academic course module (Wassinger and Baxter, 2011). Perceptions of business skills are an important consideration as these opportunities may be lost if physiotherapists do not possess these critical nonclinical skills.

4.4.7. Organisational culture

Another theme in the responses to the open comment box was 'organisational culture'. This theme encompassed the context of leadership in physiotherapy in Ireland and included views on barriers to leadership, the healthcare system, current physiotherapy leaders and the organisational culture of the workplaces of physiotherapists. Robbins and Coulter (2002) define organisational culture as the common perceptions, values and beliefs held by organisational members that determine to a large degree how they act and behave towards each other and outsiders. Many comments in this theme were critical about the HSE or their workplaces. There is a negative public perception of health care services in Ireland (Burke, 2009) and trust in the health service is low due to the many scandals in relation to standards of care that have come to light in recent years (Brady and O'Donnell, 2010). This general dissatisfaction must be taken into account when physiotherapists give their opinions on the system within which they work. However, the dissatisfaction expressed suggests a need for leadership in the physiotherapy profession to drive change and encourage physiotherapists to work to improve the situation both in their immediate work environment and the larger healthcare system.

As well as negative comments about the health care system in general there were also comments which were critical of the current leaders in physiotherapy in Ireland (n=14). Respondents commented that there were people inappropriately appointed to leadership positions who did not have the required skills, or that people were promoted to these roles without sufficient training. There was recognition of the separate concepts of leadership and management and several respondents were critical of managers who did not demonstrate effective leadership. However, the relatively small number of comments in comparison to the overall number of respondents and the potential for bias must be taken into account here. Physiotherapists who were dissatisfied with their manager, colleagues or the profession may have been more likely to comment on them than physiotherapists who were content with their current situation. At present, there is very limited literature on the leadership capabilities or performance of physiotherapy managers or physiotherapists in other leadership roles (Chan et al., 2015). Research is needed in this area to investigate current practices and identify areas requiring improvement. Of concern, when discussing physiotherapy leaders in Ireland, were the references (n=4) to bullying. The issue of bullying in the NHS (Quine, 1999, Carter et al., 2013), and more specifically of physiotherapy students, has been researched in the UK (Whiteside et al., 2014). Quine (1999) found that 37% of the therapists (including physiotherapists) who responded to a survey in an NHS Trust in the South East of England reported that they had been a victim of bullying. In a mixed methods study of seven NHS trusts in the North East of England, Carter et al. (2013) found that exposure to bullying, as a target or witness, was associated with negative outcomes (lower job satisfaction, poorer psychological health and increased intentions to leave) and that managers were the most common source of bullying. A report commissioned to inform the decision making of NHS management which summarised the prevalence, causes and consequences of workplace bullying recommended that preventative measures are focused on leaders and managers as they have the power to prevent and manage bullying and to influence the culture of workplaces (Illing et al., 2013).

4.4.8. Career structure

The current career structure for physiotherapists in Ireland was viewed as a barrier to leadership by several respondents. Within the Health Service Executive in Ireland there are three competency levels for physiotherapists; entry level, senior and clinical specialist (HSE, 2008). The benefits of physiotherapists extending their role and replacing non-consultant hospital doctors in fracture clinics have been recognised

(Moloney et al., 2009) and the appointment of clinical specialist musculoskeletal physiotherapists to work alongside consultants and triage patients on outpatient waiting lists has been a step forward (RCPI, 2014). However, in other countries there has been greater differentiation of physiotherapy levels. For example, in the UK the role of consultant physiotherapist has been established for physiotherapists who demonstrate expert attributes in clinical expertise, professional leadership and consultancy, education and development, and practice and service development (Stevenson, 2011). The ENRiP report which explored new roles in healthcare practice in the UK (including physiotherapy clinical specialists) found that professionals in these innovative roles were concerned about their future career pathway and what their next career move would be (Read et al., 2001).

4.4.9. The physiotherapy profession

The final theme was 'reflections on the physiotherapy profession'. This theme covered opinions of the physiotherapy profession in Ireland and the idea of physiotherapists as leaders. While there were a few comments noting that there were some good leaders, that the profession was improving in terms of leadership and that there was scope for it to grow into new areas, in general the comments about the profession were negative. There were several comments about a lack of leaders or leadership in the profession and criticisms that physiotherapists in Ireland were unable or unwilling to lead. Evidence of a reluctance to lead was highlighted by the HRB (2010) report into the research priorities of physiotherapists in Ireland. Physiotherapists were found to be primarily concerned with investigating the effectiveness of treatment approaches most often used in practice rather than exploring innovative techniques. However, again the relatively low number of comments compared to the overall number of respondents and risk of bias must be taken into account. Further research is needed to investigate and evaluate the leadership styles and practices of those who could be considered leaders in the physiotherapy position.

4.4.10. Implications for practice

Results from this study are encouraging as almost three quarters of respondents perceive themselves as leaders. However, caution must be exercised when interpreting this result due to the low response rate and potential self-selection bias of the survey.

Further research is warranted to investigate how physiotherapists in Ireland demonstrate leadership and the leadership styles they employ.

This study provides information of the leadership capabilities which physiotherapists in Ireland perceive as important. Research is needed to investigate how physiotherapists believe these capabilities should be enacted in the workplace, the healthcare system and in society.

Leadership development may enable physiotherapists to perceive themselves as leaders. For this reason, leadership development opportunities should be made available to physiotherapists in Ireland. However, more research is needed as to the optimal mode of delivery and content of these development activities.

4.4.11. Limitations

As described above limitations of this study included the low response rate and the potential for bias among the respondents. Another potential limitation when conducting surveys is misunderstanding of the wording of questions. When using a survey there is a risk that some of the terms are unclear or that there could be differences in interpretation (Desveaux and Verrier, 2014). To mitigate for this the survey was piloted to ensure readability and clarity, and amended based on this feedback. Additionally, working definitions of the terms used were provided and remained visible to respondents throughout the survey.

4.5. Conclusion

This initial, exploratory study provides information on the perceptions of leadership of physiotherapists in Ireland. The majority of respondents perceived themselves to be leaders and rated attainment of a leadership position as important to their overall sense of career success. Recognition of the importance of leadership and leadership development to the profession of physiotherapy were also found to be key themes in respondents' comments, however, concerns were also voiced about the leadership in the physiotherapy profession at present. There was also a level of dissatisfaction expressed with the current structure of the physiotherapy profession in Ireland and with the culture of the healthcare system. Respondents to this survey consider

communication and professionalism to be the most important leadership capabilities. Development of skills related to communication and professionalism should be considered when designing leadership training programmes for physiotherapists in Ireland. Respondents who had completed leadership development training were more likely to perceive themselves to be leaders. Leadership development training may support physiotherapists to assume leadership roles both clinically and non-clinically. Further research is warranted to investigate how physiotherapists in Ireland demonstrate leadership and the leadership styles that they use.

5. Chapter 5 – Leadership capabilities of physiotherapy managers: Phase I

The aim of this chapter is to describe the methodology and results of the first phase of Study II. Study II was a mixed methods study consisting of a quantitative survey (phase 1) and interviews with physiotherapy managers (phase 2). Chapter 1 of this thesis highlighted the challenges facing the physiotherapy profession in Ireland and the need for leadership to address these. The literature review in Chapter 3 demonstrated that the importance of leadership is increasingly being recognised by the physiotherapy profession with leadership development opportunities being offered by many professional bodies. However, investigation of the leadership capabilities of physiotherapists is needed to enable better understanding of current leadership practice and to enable appropriate training programmes to be developed (Desveaux et al., 2016).

Study I provided information on physiotherapists' perceptions of the importance of leadership capabilities. To follow this study, the next step was to investigate the leadership capabilities demonstrated by physiotherapy leaders. Different types of leadership were found in the physiotherapy literature in Chapter 3: formal, informal, managerial, clinical and academic. This was in keeping with the Warwick 6 C Leadership Framework discussed in Chapter 2 (see Section 2.12), which recognises different leadership characteristics: formal, informal, direct, indirect and based on different sources of legitimacy (Hartley and Benington, 2010). As described in Section 3.2.9, there is no physiotherapy leadership specialist interest group in Ireland. In place of this the Irish Society of Chartered Physiotherapists (ISCP) has an employment group, Chartered Physiotherapists in Management (CPM), for those in leadership or management roles. The CPM has recently incorporated leadership issues into their Constitution (CPM, 2015). Members of this group could be said to be some of the leaders of the physiotherapy profession given their formal positions of authority and the leadership component of their role. As a starting point in exploring the perceptions of physiotherapy leaders in Ireland of their leadership capabilities, physiotherapy managers were surveyed using Bolman and Deal's Leadership Orientations Instrument. The rationale for using this analytic framework to assess the leadership has been described in Chapter 2 (see Section 2.13). In terms of the leadership characteristics of physiotherapy managers; they are direct leaders (in that work in contact with their team), they have formal positions of authority and they may have clinical or non-clinical roles. The results of this study have been published (McGowan et al.) and are contained in appendix I.

5.1. Phase 1 – Introduction

As described in Chapter 1, the Irish health system is undergoing significant reform with efforts to modernise and improve services and a shift towards primary care as the central focus for the delivery of healthcare (Carney, 2010, DOH, 2012). The ongoing changes in the health service have and will continue to demand changing work practices for physiotherapists (McMahon et al., 2014). Other challenges faced by health care professionals in the Irish health system include long waiting lists, greater demands on healthcare budgets, the introduction of information technology innovations, growth in the incidence of chronic disease and the ageing population (Carney, 2010, DOH, 2012). Physiotherapy managers hold leadership roles within the physiotherapy profession (Desveaux et al., 2016) and as such have an important role in guiding and enabling physiotherapists through this period of change in Ireland. Being a leader has been rated as one of the most important work categories for physiotherapy managers (Schafer, 2002).

As physiotherapy practice evolves, the skills of physiotherapy managers must keep pace (Schafer, 2002). To ensure that staff feel empowered and supported in their work during this period of change healthcare managers must understand the importance of delivering an emotionally and behaviourally intelligent style of leadership (Delmatoff and Lazarus, 2014). In today's change-oriented healthcare environment, leaders need to understand the effect of their internal emotion and external behaviour on what people see, hear, and respond to (Delmatoff and Lazarus, 2014).

In the 1980s, Bolman and Deal used existing theories of organisations and leadership to develop an organisational typology to aid the study and understanding of leadership (Bolman and Deal, 2008). Their theoretical model is based upon the premise that leaders view organisational experiences according to pre-conditioned lenses or frames (Bolman and Deal, 1991). The four frames of leadership in this model are structural, human resource, political and symbolic as described in Section 2.13. Bolman and Deal's framework is constructed on the assumption that an individual's behaviour mirrors their internal cause maps or theories for action (Bolman and Deal, 1991), and thus an individual's behaviour and the capabilities they demonstrate depend on the frames that they employ. Each frame enables a leader to see a given situation from a different perspective (Bolman and Deal, 2008). Frames facilitate people to identify problems, diagnose their causes, understand and place meaning on experiences, and develop

solutions (Entman, 1993). All four frames are important because each offers a unique perspective on organisational reality (Bolman and Deal, 1992b).

Bolman and Deal contend that the ability to use more than one frame should improve an individual's ability to act effectively and make clear judgements (Bolman and Deal, 1992a, 1992b). Managers who are able to co-ordinate multiple logics, and thus have more choices available, will be more effective than those with a narrow perspective in defining and dealing with problems. The ability to use multiple frames is advantageous because while each frame can be coherent and powerful, the collection can be more comprehensive than any single frame and multiple frames enable leaders to reframe situations (Bolman and Deal, 1992b). Reframing is a conscious effort to understand a situation using multiple lenses.

The Bolman and Deal leadership theory has been used to examine the leadership styles of occupational therapy programme directors, nursing chairpersons, radiation therapy programme directors and medical residency programme directors (Miller, 1998, Mosser and Walls, 2002, Turley, 2002, Sharpe, 2005, Sasnett and Clay, 2008). Bolman and Deal's model allows assessment of leadership capabilities by identifying usage of the four frames, enables comparisons to be made among professionals, leadership gaps to be identified (e.g. the use of no frames or only one frame), and facilitates organisations to plan appropriate development programmes to expand existing leadership skills (Sasnett and Clay, 2008). While there is a good evidence base for a link between leadership and organisational outcomes in the general literature, and a growing base in healthcare literature (West et al., 2015), to date there have been no studies exploring the leadership capabilities of physiotherapists. An understanding of the leadership of physiotherapists in leadership roles is needed to promote professional growth, aid self-awareness and enable the design of effective leadership development programmes (Chan et al., 2015).

Hence, the objectives for this study were namely:
(1) To explore the leadership capabilities of physiotherapy managers by ascertaining which of Bolman and Deal's (1991, 2008) four frames these leaders use and prefer.
(2) To measure how physiotherapy managers rate their effectiveness as managers and as leaders.
(3) To explore which factors are associated with self-perceived ratings of effectiveness as a manager and as a leader.

5.2. Methods

5.2.1. Study design

A quantitative, internet-based survey was administered via email to a purposive sample of physiotherapy managers in Ireland. Ethical approval was granted by Trinity College Faculty of Health Sciences Ethics Committee (see Appendix II – pg 416).

5.2.2. Respondent recruitment

Permission to survey members of the ISCP was obtained from the ISCP Board. Once this permission had been obtained the survey link was circulated by an administrator from the ISCP to members of the Chartered Physiotherapists in Management (CPM) group of the ISCP (n=73). To become a member of the CPM group a physiotherapist must be employed in a recognised health or education sector management role and be a member of the ISCP. An administrator from the ISCP acted as a gatekeeper and forwarded information about the study and the survey link to CPM members on the group mailing list. The communication contained a short description of the project and an embedded link to the survey. The first page of the survey provided details of the study and informed respondents that by clicking the link to begin the survey they were giving informed consent.

A reminder email was sent to CPM members three weeks after the initial email to encourage participation in the study. To further encourage participation in the study, the CPM Chairperson also made the study information and a hardcopy of the survey available to CPM members attending a CPM meeting. Participants who chose to complete the written version of the survey returned their completed surveys to an envelope which the CPM Chairperson later collected and then forwarded to the PhD candidate.

5.2.3. Survey instrument

The survey instrument was the Bolman and Deal Leadership Orientation Survey (LOI) (Bolman and Deal, 1990). Permission to use the LOI was obtained from the authors. There are two forms of this survey; LOI (Self), which this study used (Appendix V, pg 443-452), where respondents rate their own leadership skills, and LOI (Other), where

colleagues rate the leadership skills of their leaders. The LOI provides information on the number of leadership frames used, and which predominates. It is made up of four sections.

Section 1 of the survey, “Behaviours”, determines leadership frame usage. It consists of 32 items which describe specific behaviours indicative of the four leadership frames. Respondents use a five-point Likert-type scale to rate how often each item was true for them (1 – never, 5 – always). Responses from items 1, 5, 9, 13, 17, 21, 25 and 29 are totalled to give the frame response for the structural frame, responses from items 2, 6, 10, 14, 18, 22, 26 and 30 are totalled to give the frame response for the human resource frame, responses from items 3, 7, 11, 15, 19, 23, 27 and 31 are totalled to give the frame response for the political frame, and responses from items 4, 8, 12, 16, 20, 24, 28 and 32 are totalled to give the frame response for the symbolic frame. The internal consistency of Section 1 of the survey has been reported to be very high; alpha coefficients for the frame measures range between 0.91 and 0.93 (Bolman and Deal, 1991, 2010).

The categorisation scheme of scoring 32 or more out of a possible 40 on a frame (a mean score of 4 or more) in section one was used in this study. This operational definition of frame usage was based on previous studies that have used the LOI (Mosser and Walls, 2002, Bowen, 2004, Sasnett and Ross, 2007). Respondents’ scores for the eight items were totalled (as described above) to give a score out of 40 for each frame. If a respondent had a score of 32 or more for a frame (a mean frame score of 4 or more) then they were deemed to use that frame. Therefore, a respondent who had no frame response of 32 or more was classified as using no frames, a respondent who had one frame response of 32 or more was classified as using a single frame, a respondent who had two frame responses of 32 or more was classified as using paired frames, a respondent who had three or four responses of 32 or more was said to used three or four multiple frames (Phillips and Baron, 2013).

Section 2 of the survey, “Leadership Style”, asks respondents to describe their leadership style using questions related to the four leadership frames (Bolman and Deal, 1990, 1992a). This section consists of six questions which ask the respondent to rank four items from the item that best describes them to the item that least describes them. The four items in each of the six questions in section 2 are arranged so that option “a” relates to the structural frame, option “b” the human resources frame, option “c” the political frame, and option “d” for the symbolic frame. This means that the respondents

essentially rate themselves in terms of the four leadership orientations. The responses for each “a” option were totalled to give the frame response for the structural frame, the responses for each “b” option were totalled to give the frame response for the human resource frame, the responses for each “c” option were totalled to give the frame response for the political frame and the responses for each “d” option were totalled to give the frame response for the symbolic frame. Section 2 of the LOI has high internal consistency with alpha coefficients for the frames ranging between 0.79 and 0.84 (Bolman and Deal, 2010).

Bolman and Deal (1992a) stated that because Sections 1 and 2 have different measuring scales the two sections together produce a more comprehensive picture of leadership orientation. In Section 1 the rating scale measures effectiveness in each frame, whereas the forced-choice scale used in Section 2 “...produces sharper differentiation among the frames because it does not permit rating high on everything”.

In section 3, respondents are asked to compare themselves to other managers they have known with comparable levels of experience. Respondents could select from five responses (1-5) when rating themselves as a manager and as a leader. A response of “5” indicated that the respondents rated themselves in the top 20% of physiotherapy managers, a “3” indicated they were in the middle 20%, and a “1” placed them in the bottom 20%.

Section 4 consisted of questions about selected demographic variables including gender, the length of time they had been in their current role and their total years of experience as a manager. Additional questions were formulated and included in section 4 to identify additional organisation and personal demographic variables of the respondents. These questions asked respondents if they had completed any leadership development training (either formal or informal), what setting they work in (e.g. private practice, public hospital etc), and how many physiotherapists they manage.

The survey was piloted on three postgraduate physiotherapy students to ensure readability and clarity. Following feedback from this pilot a small change was made to Section 2 of the survey. In the original survey respondents are asked to ‘give the number "4" to the phrase that best describes you, "3" to the item that is next best, and on down to "1" for the item that is least like you’. Due to the visual layout of questions on Survey Monkey when ranking items this was changed so that respondents were asked to give a “1” to the item that best described them, a “2” to the item that is next best, and on down

to “4” for the item that was least like them. When the results were recorded on the Excel spreadsheet this was then changed back so that items that were scored “1” were changed to a “4”, items scored “2” were changed to a “3” etc.

5.2.4. Statistical analysis

The data were downloaded from Survey Monkey and copied into a spreadsheet (Microsoft Office Excel). The data was analysed using the SPSS version 21 (IBM Corp., Armonk, NY). The results of the four written surveys were added to the spread sheet. Non-parametric statistical tests were used because the data consisted of a combination of ordinal and raw data, some of which distributed skew in distribution (e.g. number of physiotherapists managed).

To compare the managers’ scores across the four leadership frames, median scores for each frame were calculated for the group based on the respondents’ frame responses for section one, section two and for the survey total. As described above frame responses for the four frames (structural, human resource, political and symbolic) were calculated for each respondent in sections one and two of the survey. To calculate each respondent’s total survey score for each frame, their frame response in section one was added to the corresponding frame response in section two. For example, if a respondent had a frame response of 32 for the structural frame in section one and a frame response of 18 for the structural frame in section two then these results would have been summed to give a total survey score of 50 for the structural frame. The median score for each frame was calculated based on all the respondents’ results for each frame in section one, section two and for the survey total.

Each respondent’s preferred frame was determined for section one, section two and for the survey total. For each respondent, the frame with the highest frame response indicated their preferred leadership frame. Frequencies and percentages were then calculated for the preferred frames in section one, section two and for the overall survey.

To investigate the physiotherapy managers’ use of the four leadership frames the number of frames a respondent uses were calculated using their frame response scores in section one. As described above, the categorisation scheme of scoring 32 or more on a frame was used to determine frame use. The frequencies and percentages of frames used by the managers were calculated. To establish if there is a relationship between

the number of leadership frames used by the managers and selected organisational and personal demographics the Jonckheere-Terpstra test for trend, which takes into account the ordinal nature of the response, was performed. The significance level was set at $p<0.05$. The demographic details investigated were: experience working as a manager (years), time working in current role (years), and number of physiotherapists managed.

Frequencies and percentages were calculated for the ratings of managerial and leadership effectiveness. To investigate whether there was a difference between the respondents' self-ratings of effectiveness as a manager compared to effectiveness as a leader the Wilcoxon Signed Ranks test was performed. The Jonckheere-Terpstra test for trend was performed to investigate if there was a statistically significant trend between the number of frames that a respondent uses and their self-rating as a manager and/or leader. The Jonckheere-Terpstra test for trend was also performed to determine if there was a statistically significant trend between demographic factors and self-ratings as a manager and/or leader. The significance level was set at $p<0.05$.

5.3. Results

Forty-five physiotherapy managers responded to the invitation to complete the survey to give a response rate of 62% (45/73). Four respondents completed the written survey, while the rest completed the survey online. Three respondents did not complete the survey entirely; two of these had not completed a sufficient amount of the survey (section 1) and so were not included in the analysis of the results. The demographic details of the respondents are presented in Table 5.1. The reported percentages were calculated based on the total responses to each question and do not include respondents who skipped that question. Of note, only a small proportion of respondents were male (9.8%) which precluded comparison of results by gender. This proportion was in keeping with the CPM population (9.6% of members are male). The majority of respondents had undertaken some form of leadership development training; only 4 respondents (9.8%) had not completed any leadership training. This meant that comparison between physiotherapy managers who had completed leadership training and those who had not was also precluded.

Table 5-1 Demographic details of respondents

	Frequency[a]	Percentage
Gender		
Male	4	9.8%
Female	37	90.2%
Time in current position (years)		
0-5	10	23.8%
5.5-10	17	40.5%
10.5-15	11	26.2%
>15	4	9.5%
Experience working as a manager (years)		
0-5	4	9.5%
5.5-10	16	38.1%
10.5-15	15	35.7%
>15	7	16.7%
Workplace		
Public hospital	25	61.0%
Primary care	7	17.1%
Public hospital/primary care	6	14.6%
Voluntary organisation	1	2.4%
Voluntary organisation/private practice	1	2.4%
Private hospital/private practice	1	2.4%
Number of physiotherapists managed		
1-10	8	19.5%
11-20	17	41.5%
21-30	7	17.1%
>30	9	22.0%
Formal leadership development training		
Yes	37	90.2%
No	4	9.8%
Informal leadership development training		
Yes	18	47.4%
No	20	52.6%

[a]Frequency totals do not total n=43 due to some not completing certain questions.

Table 5.2 displays the number and frequency of respondents using each frame as calculated from the responses to section one using the categorisation scheme of scoring 32 or more on a frame. The most frequently used frame was the human resource frame, followed by the structural frame and then the symbolic frame. The political frame was least often used; only four respondents were found to use this frame.

The median scores for each of the frames in section one, section two and for the total survey are also displayed in Table 5.2. In section one the human resource frame had the highest median score, followed by the structural frame, then the symbolic frame and lastly the political frame. This pattern was also the same for the survey total, however in section two while the human resource frame still had the highest median followed by the structural frame, the political and symbolic frames had the same median score.

Table 5.2 also displays the respondents' preferred frames. The pattern of frame preference was the same in section one, section two and for the survey total. The human resource frame was most frequently the preferred frame, followed by the structural frame, and then the symbolic frame. The political frame was least often recorded as being a respondents' preferred frame.

Table 5-2 Results table showing the median score for each frame, the number of respondents using each frame and respondents' preferences for frame usage

	Structural	Human Resource	Political	Symbolic
	Section 1 (n=43 responses)			
Median Score	31	33	26	27
Respondents using this frame n (%)	20 (46.5%)	26 (60.5%)	4 (9.3%)	8 (18.6%)
Preferred frame[a] n (%)	11 (25.6%)	28 (65.1%)	0 (0%)	2 (4.7%)
	Section 2 (n=42 responses)			
	Structural	**Human Resource**	**Political**	**Symbolic**
Median Score	18	20	11	11
Preferred frame[b] n (%)	14 (33.3%)	23 (54.8%)	1 (2.4%)	2 (4.8%)
	Survey Total (n=42 responses)			
	Structural	**Human Resource**	**Political**	**Symbolic**
Median Score	49	53	38.5	39
Preferred frame[b] n (%)	13 (31.0%)	22 (52.4%)	1 (2.4%)	2 (4.8%)

[a]Frequency total does not equal n=43 due to some respondents having tied frame preferences
[b]Frequency total does not equal n=42 due to some respondents having tied frame preferences

The pattern of frame usage based on the results from section one is displayed in Table 5.3. The results of seven survey respondents indicated that they did not consistently use any frame. The highest proportion of respondents were found to use one frame (n=21). Ten respondents were found to use paired frames and only five to use multiple frames. Of the respondents who used a single frame, nine used the structural frame and twelve used the human resource frame. None of the respondents singularly used the political or symbolic frames. The most frequently cited pair of frames used was also the structural-human resource frames (n=5). Two respondents used the human resource and political frames and two used the human resource and symbolic frames. One respondent was

found to use structural and symbolic frames. Three respondents were found to use three frames and all three used the same combination of frames: the structural, human resource and symbolic frames. Only two respondents were found to use all four frames.

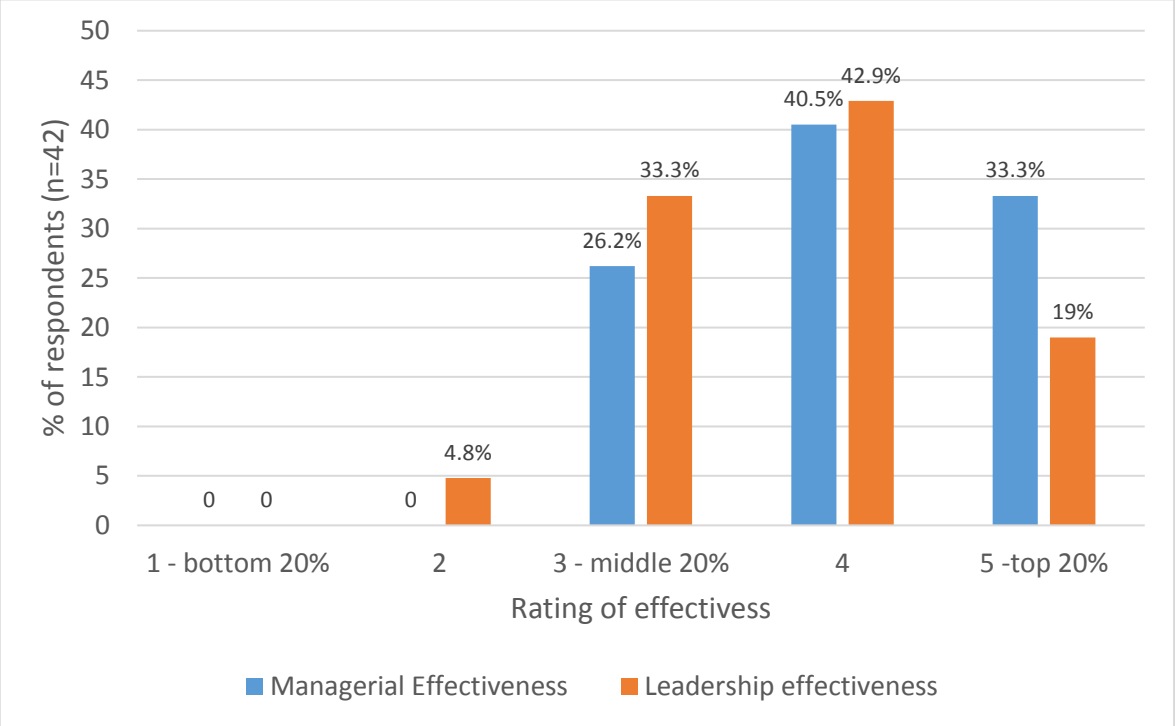
Table 5-3 Frequency distribution of type of frame used by participants (number of frames employed calculated using rule of 32)

Frames Used	**N**	**%**
No Frame	7	16.3%
Single Frame		
Structural	9	20.9%
Human Resource	12	27.9%
Political	0	0%
Symbolic	0	0%
Total single frame	21	48.8%
Paired frames		
Structural-Human resource	5	11.6%
Structural-Political	0	0
Structural-Symbolic	1	2.3%
Human resource-Political	2	4.7%
Human resource-Symbolic	2	4.7%
Political- Symbolic	0	0%
Paired frames total	10	23.3%
Multi-frame		
Structural-HR-Political	0	0%
Structural-HR-Symbolic	3	7.0%
Structural-Political-Symbolic	0	0%
HR-Political-Symbolic	0	0%
Four frame	2	4.7%
Total multiframe	5	11.6%
Total	43	100%

The Jonckheere-Terpstra test for trend demonstrated that there was no statistically significant trend between the number of leadership frames used and number of years in their current role, T_{JT}=270.5, z=-0.700, *p*=0.484, the number of years of experience as a manager, T_{JT}=310.5, z=0.233, *p*=0.816, or the number in the team, T_{JT}=221.5, z=-1.491, *p*=0.136.

Figure 5.1 displays the results of Section 3 which asked respondents to rate their effectiveness as a manager and as a leader compared to their peers. Fourteen respondents (33.3%) rated themselves as being in the top 20% of managers in terms of managerial effectiveness, whereas eight respondents (19.0%) rated themselves as being in the top 20% of managers in terms of leadership effectiveness. Wilcoxon Signed Ranks test revealed that there was a statistically significant difference in the scores of effectiveness as a manager and effectiveness as a leader Z=-2.837 *p*=0.005. Respondents tended to rate their managerial effectiveness more highly than their leadership effectiveness and this difference was statistically significant.

Figure 5-1 Respondents' perceptions of their effectiveness as a manager and as a leader



A statistically significant trend was found between the number of leadership frames used and self-rating as a manager, T_{JT}=380, z=1.975, *p*=0.048, and as a leader, T_{JT}=431, z=3.245, *p*=0.001. There was no statistically significant trend between self-rated managerial effectiveness and the number of physiotherapists managed, T_{JT}=289.5, z=0.300, *p*=0.764, or the length of time in their current role, T_{JT}=329.5, z=0.931, *p*=0.352. However, there was a statistically significant trend of greater experience as a manager with higher rating of managerial effectiveness, T_{JT}=429, z=3.246, p=0.001.

There was no statistically significant trend between ratings of leadership effectiveness and length of time in their current role, T_{JT}=291.5, z=-0.058, *p*=0.954, experience as a manager T_{JT}=360.5, z=1.548, *p*=0.122, or size of team managed, T_{JT}=287, z=0.169, *p*=0.866.

5.4. Discussion

This aim of this study was to investigate the leadership capabilities of physiotherapy managers by ascertaining which of Bolman and Deal's four frames these leaders use and whether they are able to vary their leadership behaviour. The pattern of frame usage in this study was similar to findings of previous studies which have investigated the leadership frames of healthcare professionals working in education (Mosser and Walls, 2002, Turley, 2002, Sasnett and Clay, 2008, Sharpe, 2005). The high scores recorded for the human resource frame indicate that the physiotherapy managers in this study consider themselves to be people-oriented leaders who advocate openness, caring, and participation, use emotional intelligence to motivate and empower, and who communicate their faith and confidence in people (Bolman and Deal, 2008). Physiotherapy managers will often have experience and expertise in team building and group management, and thus may find the human resource frame most compatible with their training. This leadership style is consistent with the prevailing culture in healthcare; a culture of respect for the individual, fairness in the delivery of care, and advocacy for patients (Sasnett and Clay, 2008). The frequent use of the structural frame indicates the importance the respondents place on rules, policy, procedures, and efficiency. Given the prevalence of clinical guidelines and protocols in the healthcare system today (Woolf et al., 1999) it is unsurprising that the managers reported practising in this frame.

The frame least often used by the respondents was the political frame. This may reflect that the physiotherapy managers in this study perceive conflict and politics in their organisations to be incongruent with the people-centred nature of their work, although this hypothesis needs further exploration. Whatever the reason, politics in organisations are inevitable because scarcity, power relations and interdependence will unfailingly produce political activity (Bolman and Deal, 2008). Organisational politics require leaders to protect themselves, as well as promote their interests and the interests of their team (Speedy and Jackson, 2013). While the idea of politics in healthcare may have a negative connotation (McKenna, 2010), avoiding political activity may reduce effectiveness and the ability to pursue goals for change (Bolman and Deal, 2008). Managers who ignore

the political frame risk putting their own interests in jeopardy. Unlike the structural frame which assumes that power and control follow an explicit and formal pattern of authority, the political frame acknowledges that leadership can flow from many informal and less apparent directions (Fleming-May and Douglass, 2014). As healthcare organisations continue to experience economic constraints their leaders will need to have the power to influence decisions about the allocation and prioritisation of scarce resources. Economic issues are important considerations in clinical and policy decision making for health-related interventions (Woolf et al., 2012). Physiotherapists must be able to demonstrate their value and cost-effectiveness in today's challenging healthcare environment (Jewell et al., 2013).

The symbolic frame was also only used by a small number of respondents. The symbolic frame is concerned with an organisation's culture, values, purpose and vision. Symbolic leaders feel their own work is significant and thus are able to help their team find meaning at work (Bolman and Deal, 2008). Kinjerski and Skrypnek (2006) have described how inspiring leadership leads to increased 'spirit at work'- a distinct state that involves a sense of common purpose, a belief one's work makes a difference and a connection to something larger than self. The passion and vision of symbolic leaders is needed to develop and sustain ongoing change (Sasnett and Clay, 2008). Underuse of the symbolic leadership frame may cause difficulties in this period of healthcare transformation. As the physiotherapy profession in Ireland addresses the many challenges it is facing, including physiotherapy graduate unemployment, staff shortages in the health care system and impending physiotherapy registration (see Section 1.2), inspirational leaders who can motivate and mobilise others will be needed.

In their research, Bolman and Deal (1991, 1992a, 1992b) indicated that the patterns of thinking that can lead to success as a manager are not the same as those contributing to effective leadership. Managerial effectiveness is associated with the structural frame whereas leadership effectiveness is associated with operating within the political and symbolic frames. This may explain the finding in this study that respondents rated themselves more highly as managers than as leaders. The physiotherapy managers relied on the structural and human resource leadership frames rather than the political and symbolic frames. To be effective as both managers and leaders, physiotherapy managers need to be able to employ all four frames as appropriate (Bolman and Deal, 1991, 1992b, 2008). Bolman and Deal (1992b) theorised that because practising managers so often think only in terms of management (relying on the structural and

human resource frames and underusing the political and symbolic frames), and not leadership, it is no surprise that many teams are over managed and under led.

To try to alter the heavy reliance on the human resource frame and encourage multiple frame usage, physiotherapy managers may benefit from specific leadership development and training. These leadership programmes will need to be sufficiently comprehensive to respond to existing cultural biases and to allow the acquisition of new leadership skills (Sasnett and Clay, 2008). Given the large proportion of respondents who reported having completed leadership development activities it can be reasonably concluded that these physiotherapy managers believe that development of leadership skills is important. However, the details of the informal development activities, and learning objectives and curricula of the training courses completed by the managers are not known. The results of this study suggest that the managers should engage in leadership development activities that will develop their ability to use the political and symbolic frames rather than just continuing to strengthen their employment of the structural and human resources frames. At present there is limited evidence for leadership development in physiotherapy and more research is necessary to identify the most appropriate and effective approach to develop leadership in physiotherapists (see Section 3.2.9).

The majority of respondents perceived themselves to be in the top 40% of both leaders and managers. This demonstrates the confidence that the physiotherapy managers had in their managerial and leadership abilities. In the leadership literature numerous studies have concluded that self-rating may not be a good measure of overall leadership (Harris and Schaubroeck, 1988, Yammarino and Atwater, 1997, Fleenor et al., 2010). Therefore, the self-rating scales used in this study may be better described as measuring a manager's self-confidence in their managerial and leadership skills than their effectiveness as a leader in practice. Self-confidence has been listed as an essential characteristic for effective leadership in the leadership literature (Kirkpatrick and Locke, 1991, Yukl, 2010, Northouse, 2013). In a theoretical explanation of the relationship between a leader's self-confidence and successful leadership (McCormick, 2001) theorised that leader self-efficacy is critical because it affects the goals a leader pursues, development of functional leadership strategies, and the skilful execution of those strategies.

In this study an association was found between the number of leadership frames that a physiotherapy manager uses and their perceived effectiveness as a manager and as a

leader. This finding was in keeping with Bolman and Deal's theory that managers who can draw upon multiple frames, and thus have more options available, are more effective than managers who adopt a narrow view when approaching and dealing with organisational challenges (Bolman and Deal, 1991, 1992a, 2008). The ability to have multiple perspectives or views may contribute to a broader understanding of the problems and difficulties faced in complex organisations (Thompson et al., 2008) and thus create greater confidence in their ability to fulfil their leadership role.

An association was found between self-perceived rating of managerial effectiveness and years of experience as a manager. No association was found, however, between the years of experience that a manager had and their self-perceived rating as a leader. This suggests that managers continue to develop confidence in their managerial skills during their day-to-day work but that this does not necessarily improve confidence in their abilities as a leader. Specific leadership development training may be needed to enable managers to use more leadership frames and thus improve their confidence in their leadership skills.

5.4.1. Limitations

This phase of the study was limited by the fact that the leadership capabilities of the physiotherapy managers were measured solely by their self-perceptions. The limitations of self-ratings of leadership and risk of social desirability bias have been noted in the literature (Atwater and Yammarino, 1992). Thus, the study is limited by the accuracy and reliability of those self-perceptions. The responses were upwardly biased as evidenced by the 62% of respondents who rated themselves in the top 40% of leaders. The study was conducted only with physiotherapy managers who were members of the CPM and therefore the results may not be generalised to physiotherapy managers who choose not to be a member of this group. Although the response rate is comparable with other surveys of physiotherapists (French, 2007, Bishop et al., 2016) there may have been a non-response bias. It is possible that physiotherapy managers with an interest in leadership self-selected to respond to this survey causing some self-selection bias within the survey estimates. Self-selection bias can occur because people are more likely to respond to surveys if the topic is of interest to them (Eysenbach and Wyatt, 2002). For these reasons interpretation of these results should be treated with caution and this research viewed as initial exploratory research and a stimulus for further study into the perceptions and practice of leadership of physiotherapists.

5.5. Conclusion from Phase 1

The physiotherapy managers in this study demonstrated reliance on the human resource and structural leadership frames. The political and symbolic frames were underused by this cohort. The majority of respondents to the survey reported using only one or no leadership frames which may impact on their ability to address complex challenges in the most effective and comprehensive way. The use of leadership frames was associated with self-perceived rating as a manager and a leader. Physiotherapy managers may be able to enhance their leadership skill set and become more confident of their leadership abilities through development of their political and symbolic frames. Specially designed programmes may be necessary to target development of skills in these areas.

6. Chapter 6 – Leadership capabilities of physiotherapy managers: Phase II

6.1. Introduction

The aim of this chapter is to present the methodology and results of the semi-structured interviews that were conducted with physiotherapy managers as the second phase of Study II. The results from the Leadership Orientations Survey (LOI) in Study II phase I indicated that physiotherapy managers work predominantly through the human resource and structural frames and suggested that physiotherapy managers do not use multiple frames. However, due to the complex nature of leadership skills and behaviour, the LOI is able to measure only a small number of the potential aspects of leadership and thus does not provide a comprehensive measurement of leadership (Bowen, 2004). Adding an interview process to this study allowed more information to be garnered regarding how managers use leadership frames and why they prefer one frame to another. Qualitative methods can uncover the subtleties of how leaders think and how they frame experience (Bolman and Deal, 1992a). By obtaining evidence from practising managers on what physiotherapy managers actually do researchers will be better able to develop relevant measures of managers' competence (Schafer, 2002). Therefore, to expand on the results from the survey, and investigate the leadership frames used by physiotherapy managers in more detail, interviews with physiotherapy managers were conducted.

Phase 1 of this study demonstrated that there was no statistically significant trend between the participants' years of experience as a manager, the years spent in their current role or the size of their team, and the number of leadership frames that they use. However, this survey did not permit investigation of the differences in leadership capabilities between physiotherapy managers who work in solely managerial positions and those who also have clinical roles. In a survey of physiotherapy professional programme faculty members and clinical physiotherapy managers, Schafer (2002) found that work setting (hospital, private practice, higher education) appeared to have an effect on the degree of importance placed on physiotherapy managerial work categories. Schafer advised that future research should account for work setting when studying the work of physiotherapy managers. The physiotherapy managers who responded to the survey in phase 1 of this study were predominantly working in public hospitals and primary care. Further exploration of the leadership capabilities of physiotherapy managers from different backgrounds and working in different situations was therefore indicated.

Conducting interviews with physiotherapy managers also allowed another component of the Warwick 6 C's Leadership Framework, Challenges, to be explored. Hartley and Benington (2010) purport that by identifying the challenges to be addressed the purposes of leadership can be clarified. In the leadership literature it is increasingly being recognised that the type of leadership required may vary according to the challenge to be addressed, and that a key role of leaders is to identify, frame and analyse what the problems are that need to be addressed (Hartley and Benington, 2011). Identifying leadership challenges is also important for the design of appropriate leadership development strategies. Turnball James (2011) advocated that leadership development should be deeply embedded and driven out of the context and challenges that leaders face.

Therefore, the objectives of this phase of the study were to:
(1) Explore the perceived leadership capabilities of physiotherapy managers in Ireland using the four frames of the Bolman and Deal leadership model.
(2) Investigate the experiences of physiotherapy managers in Ireland of working in formal leadership positions and the challenges they face.

These objectives and the results from Phase 1 of this study led to the following research questions being formulated:

- Do physiotherapy managers work predominantly through the human resource and structural frames?
- Do the leadership capabilities of physiotherapy managers vary according to their workplace?
- What leadership challenges do physiotherapy managers perceive themselves and/or the physiotherapy profession to be facing?

6.2. Methodology

Semi-structured interviews were conducted with a purposive sample of physiotherapy managers in Ireland. Interviews were chosen as the research method to elucidate more in-depth data about the experiences and perspectives of physiotherapy managers as they allow participants to elaborate on each question. A qualitative descriptive approach was taken in this study. According to Sandelowski (2000), qualitative descriptive studies focus on generating a comprehensive summary of practices and events as they occur in

people's everyday contexts; it is the method of choice when straight descriptions of phenomena are the study goal. The aim of this study is to describe the physiotherapy managers' perceptions of their leadership capabilities and so qualitative description was chosen as the most appropriate approach. Qualitative description has also been suggested as a relevant approach in health services research and to be particularly useful for mixed methods studies (Neergaard et al., 2009).

6.2.1. Participant Recruitment

Ethical approval was granted by the Trinity College Dublin Faculty of Health Sciences Ethics Committee (Appendix II – pg 417). Members of the Chartered Physiotherapists in Management (CPM) group were informed of the study in their weekly ezine which they receive via email. The ezine advertisement included a link to the study information leaflet (appendix VI – pg 461). Interested members were asked to contact the PhD candidate by email to set up a time for the interviews.

Due to a low response rate to the ezine advertisement, letters containing the study information leaflet were subsequently sent to physiotherapy managers' workplaces (n=30) requesting their participation in the study. The letters outlined the purposes of this research project and invited interested participants to put themselves forward for the interview. Managers who were interested in participating in an interview were asked to contact the PhD candidate (EM) by email to ask any further questions they had and to arrange a time for the interview. Interested participants were sent a copy of the consent form (appendix VI – pg 460) for the study by email before their interview. A maximum variation sampling approach was taken as suggested for qualitative descriptive methodologies (Sandelowski, 2000). To ensure that physiotherapy managers from a range of backgrounds were included a sampling matrix was used. Factors in this sampling matrix included - workplace (public hospital, private hospital, private practice, primary care, other), gender, location (Dublin, outside Dublin), team size, experience, and clinical caseload.

Eligibility criteria for participation in the interviews were:

- Physiotherapist by background
- In a named managerial role, e.g. manager/director/founder
- Manage at least two physiotherapists

Potential participants were identified by conducting an internet search based on the sampling matrix and the eligibility criteria. Where the physiotherapy manager was not named on a website the hospital or clinic was phoned to find out the manager's name so that a letter could be addressed to them.

6.2.2. Participants

The demographic details of the participants are displayed in Table 6.1. To maintain the confidentiality of the participants the specific demographic details of the participants have been generalised into categories. Level of experience was categorised into low (0-5 years), medium (6-15 years) and high (16+ years). Team size was categorised into small (0-10), medium (11-20) and large (21+). The participants were also asked whether they had a clinical caseload or whether they worked in a purely managerial position. Physiotherapy managers who worked in a voluntary hospital or a HSE hospital were categorised as working in a public hospital. Physiotherapy managers who managed physiotherapists working in primary care and/or community services were categorised as working in primary care.

Table 6-1 Participant demographics

Participant	Gender	Workplace	Level of experience	Team size	Clinical role
PTM001	Female	Public Hospital	Low	Medium	No
PTM002	Female	Public Hospital	Low	Small	Yes
PTM003	Female	Specialist service	Medium	Small	Yes
PTM004	Female	Primary care	Low	Large	No
PTM005	Female	Public Hospital	Medium	Medium	No
PTM006	Female	Private Practice	High	Small	Yes
PTM007	Female	Primary care/ Public hospital	Medium	Large	No
PTM008	Female	Primary care/ Public hospital	Medium	Large	No
PTM009	Female	Public hospital	High	Medium	No
PTM010	Female	Private practice	High	Medium	Yes
PTM011	Male	Private practice	High	Small	Yes
PTM012	Male	Private practice	Low	Small	Yes
PTM013	Female	Public Hospital	Medium	Large	No
PTM014	Female	Public Hospital	Low	Large	No
PTM015	Male	Public Hospital	High	Medium	No
PTM016	Female	Private Hospital	Medium	Medium	Yes
PTM017	Female	Primary care	Medium	Medium	No
PTM018	Male	Private practice	Medium	Small	Yes

6.2.3. Development of an interview schedule

The interview schedule consisted of six sections (appendix IX, pg 469-470). As advised by Britten (1995) the first section consisted of demographic questions that were easy for the participants to answer before proceeding to the more challenging questions e.g. 'How many physiotherapists are there on your team?' 'How long have been a manager?' The next four sections were based on the Bolman and Deal Four Frame Model. This framework has previously been used to guide the development of an interview schedule (Schneiderman, 2005) and for coding frame responses in qualitative analysis (Bolman and Deal, 1992a). Questions in the structural section asked about the use of policy and procedure and the organisation's hierarchy. Questions in the human resource section asked about motivating others and the leadership development. Questions in the political frame asked about effecting change and conflict management. Lastly, questions in the symbolic frame asked about team bonding, mentoring and their core values. The final section consisted of more general questions to allow the managers to speak of their leadership experiences in a less structured way. The managers were asked about leadership challenges and barriers in physiotherapy, what advice they would give to an aspiring physiotherapy leader and to give an example of a time when they had demonstrated effective leadership.

6.2.4. Interview procedure

Interviews were conducted in person, audiotaped and additional notes were made by the PhD candidate. The interviews took place at the participant's workplace (n=15), the Trinity Centre for Health Sciences at St James's Hospital (n=2), or in a coffee shop (n=1), depending on the preference of the participant. The interview procedure was explained before the interview commenced and participants were given the opportunity to ask any questions they had before being asked to sign the consent form for the study. The interviews consisted of semi-structured, open-ended questions. Follow-up probes focusing on the managers' experiences were used to prompt the managers to expand on interesting points or to ask additional questions when appropriate. Participants were encouraged to give as much detail and as many examples as they wished. The interviews lasted for a mean time of 42 minutes and ranged from 21 to 70 minutes in length.

6.2.5. Data Analysis

Participants were given codes to allow their identity remain confidential. Any identifiable details, e.g. workplace names, were removed to ensure confidentiality. After each interview the PhD candidate wrote a short reflective piece on the interview detailing the main points, any unusual or new findings, and any adjustments that were made to the interview schedule. This reflective process led to additional questions being added to the interview schedule. These included, 'Can you describe the skills that feel are most important in leading your team?', 'Are there goals/targets/KPIs that your team aim to achieve?', 'What advice would you give to an aspiring physiotherapy leader?', 'Can you tell me about an occasion when you demonstrated effective leadership?', and 'Do you perceive there to be any barriers to physiotherapy managers demonstrating leadership?'

The reflective notes written after each interview also included a summary of how the participant used each of the four frames. By summarising each participant's report of the leadership capabilities that they demonstrate, an initial analysis of the leadership capabilities of the managers was performed. The reflective notes for each interview were also re-read before coding to remind the PhD candidate of the context of the interview before the analysis was performed.

The interviews were transcribed verbatim. Transcribing the interviews allows the researcher to become very familiar with the data (Gale et al., 2013). In order to minimise errors in this process, recordings were listened back for accuracy, and transcripts were corrected as appropriate. Before the data-set was finalised member checking was conducted; participants reviewed their transcript and were offered the opportunity to make amendments. This also allowed participants to confirm that they were satisfied with the blinding of their transcript.

Before embarking on the analysis of the qualitative data the PhD candidate and PhD supervisor actively reflected on and made explicit their biases as suggested by Sandelowski (2010). A qualitative descriptive approach using template analysis was taken in the analysis of the interview data. Template analysis is a form of thematic analysis that balances a high degree of structure in the process of analysing qualitative data with the flexibility to adapt it to the specific needs of an individual study (King, 2012). This method provides a systematic technique to categorise qualitative data thematically (McCluskey et al., 2011), and has been previously used in healthcare (King et al., 2002, McCluskey et al., 2011). Template analysis can be positioned in the middle ground

between deductive and inductive styles of analysis (King, 2012). It was chosen as the analysis approach for this study because it allows *a priori* themes to be used to develop the initial version of the coding template (McCluskey et al., 2011) – in this case, the four frames of the Bolman and Deal Framework, and also for further themes to emerge and be coded as analysis proceeds (Gollop et al., 2004). As described by King (2012), themes were defined as the recurrent and distinctive features or patterns in the participants' interviews that characterise perceptions and/or experiences and that are relevant to the research question. Themes were identified in the data by their prevalence, both in terms of references within each interview and across the entire data set (Braun and Clarke, 2006). As the analysis proceeded, refinement of the template resulted in themes and related subthemes within themes.

Coding is the process of attaching a label (code) to a piece of text to indicate that it relates to a theme (King, 2012). A key feature of template analysis is the hierarchical organisation of codes. Groups of similar codes are clustered together to produce more general higher order codes (King, 2012). Thus, in this project a first level theme such as 'Structural frame' encompassed more specific second level subthemes such as '*Operations'* and '*Strategic planning and alignment'*. Hierarchical coding allows texts to be analysed at varying levels of specificity (King, 2012).

6.2.6. Development of the template

The development of the thematic coding template followed the six stages described by King (2012, 2016). The six stages were:

1. Define *a priori* themes - Four *a priori* themes were defined. These were based on the Bolman and Deal Framework and were structural, human resource, political and symbolic.
2. Interview transcription – Interviews were transcribed verbatim and transcripts were carefully read to check for accuracy and allow familiarisation with the data.
3. Initial coding of the data - Parts of the transcript relevant to the research question(s) were identified. Preliminary codes were assigned wherever any section of the transcript appeared to relate to the study question(s). Where sections could be encapsulated by one of the *a priori* themes they were 'attached'

to the appropriate theme or if there was no relevant theme, an existing theme was modified or a new one devised.

4. Produce the initial template – The initial template was developed after a subset of transcripts had been coded. Preliminary codes were clustered together to bring them into meaningful groups so that there were a smaller number of higher-order codes describing the broader themes in the data.

5. Develop the template – The initial template was applied to the full data set. The template was modified in careful consideration of each transcript. Whenever a relevant piece of text did not fit comfortably in an existing theme or subtheme, a change to the template was made. Through these changes the template developed into its final form.

6. Interpretation and write-up – The final template was used to aid interpretation and write up of findings.

The initial coding of the data was conducted manually. Once the initial template had been applied to all transcripts a second round of coding was conducted using Nvivo 11 for Windows software (QSR International Pty Ltd). Throughout this coding, the initial template was amended through a process of constant revision in response to pertinent findings in the data. This constant revision included refining definitions, adding new codes whenever significant statements could not be classified, removing redundant codes, promoting more significant themes to higher level codes and reducing less significant themes to lower level codes. This process continued until no new codes were uncovered from the data. Relatively few alterations were made to the template after ten interviews had been coded. Saturation was reached when 15 interviews were analysed in full, the analysis of the remaining three interviews resulting in no further changes to the codebook (Guest et al., 2006).

As well as the six stages described above, King (2012, 2016) recommends that quality and reflexivity checks should be carried out at one or more of the coding stages to ensure that analysis is not being systematically distorted by the researcher's own preconceptions and assumptions. To increase the validity of the analysis, the PhD candidate conducted a peer debriefing with the other member of the research team, the PhD supervisor, who is an experienced qualitative researcher. In this meeting, the codebook and the categorisation of the statements, including definitions used, were discussed. A team approach to qualitative research increases rigour and improves the

quality of analysis (Barry et al., 1999, Neergaard et al., 2009). Following this meeting, the PhD supervisor independently coded six transcripts to check the validity and utility of the codebook. The PhD supervisor is familiar with the Bolman and Deal Framework and therefor was able to assess whether the codebook was appropriately aligned with the four frames model. The codebook was revised following feedback from the PhD supervisor. The revisions included forming new subthemes, promoting certain codes to higher levels, reducing other codes to subcodes and merging subcodes to form higher level codes.

To further improve the validity and reliability of the analysis an external, independent advisor (NE) was invited to give an unbiased view on the coding and codebook. NE is a nurse by background and an experienced qualitative researcher. The PhD candidate conducted a peer debriefing with NE to explain the study objectives and the Bolman and Deal framework. NE then independently coded six transcripts using the revised coding template. The PhD candidate met with NE to discuss the coding and the validity of the codebook. The coding of the transcripts was compared and differences in the coding were discussed to clarify different interpretations of the data. NE was satisfied that the codebook was comprehensive. Minor amendments to the codebook were suggested by NE, these were discussed and where appropriate were applied to give the final version the codebook.

The steps involved in producing the final version of the thematic coding template for this study, including the quality checks, are summarised in Figure 6.1.

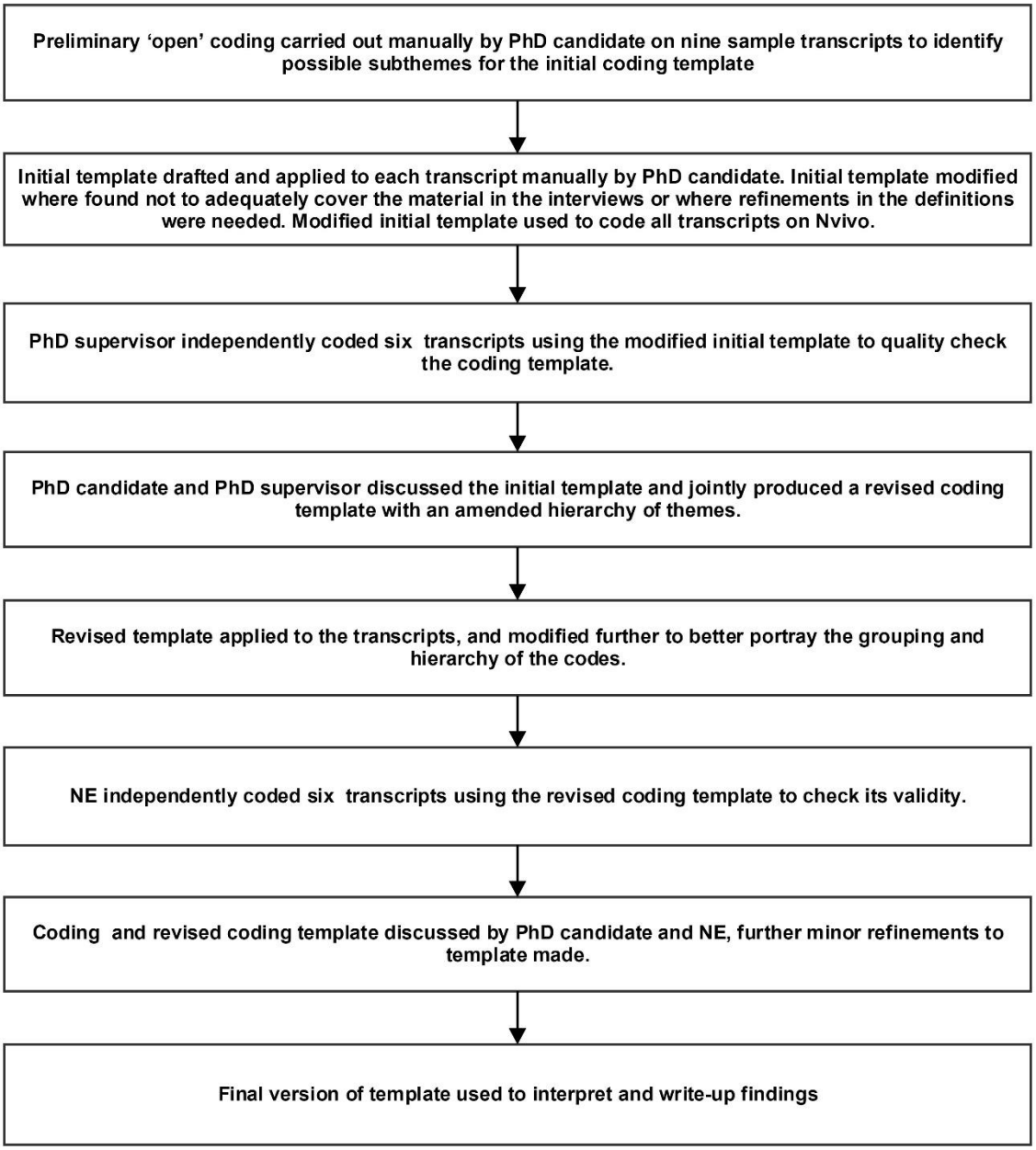


Figure 6-1 Process used to develop coding template in Study II

6.2.7. Quality Checks

To enhance the quality of the data analysis several strategies were employed as suggested by King (2012). As previously described, independent coding and critical comparison among researchers was used. An independent advisor external to the research team coded a selection of transcripts and gave feedback on the validity of the codebook. Respondent feedback and the provision of audit trails were also employed. Member checking was conducted by sending each participant the transcript of their

interview. The participants were able to clarify statements or to make any other amendments they felt were appropriate. To enhance transparency and ensure logical consistency in the decisions and interpretations made, an audit trail was recorded throughout the analysis of the data. In qualitative research an audit trail is a record of the steps the researcher has completed in carrying out the analysis and a record of the way his or her thinking has developed (King, 2012).

6.2.8. The Final Coding Template

The final coding template comprised five first level themes. These themes and their subthemes are outlined and used to structure the results section below. Extracts from the interview data are presented to illustrate the themes and subthemes and pseudonyms have been used throughout. The selected quotes are particularly pertinent illustrations of the points made. As well as analysing across participants to elicit shared themes, differing perspectives are also highlighted.

As described by McDowall and Saunders (2010), the focus of the analysis was on meaningful coding and interpreting the themes across the participants, rather than reducing the data to frequencies. The final version of the template allowed patterns of experiences to be identified across cases and between different demographic groups (e.g. workplace, gender, clinical role). The coding template and the definitions used for each code are displayed in appendix IX (pg 471-476).

6.3. Results

The principal themes were ‘Structural’, ‘Human resource’, ‘Political’, ‘Symbolic’ and ‘Challenges’. Three other themes were found in the data but these were less prevalent than the principal themes: ‘Workplace’, ‘Physiotherapy profession’ and ‘Clinical role’. The principal themes and their primary subthemes are summarised in a simplified template in Table 6.2.

Table 6-2 The principal themes and their primary subthemes

Principal Theme	Primary subtheme
Structural	• Operations • Strategic planning and alignment
Human Resource	• Professional development • Qualities • Communication
Political	• Organisational citizenship behaviour • Engagement • Organisational interpersonal dynamics
Symbolic	• Organisational culture • Professional identity • Attributes-behaviours
Challenges	• Lack of resources • Time restraints • Other professions • Changing structure

Each theme and associated subthemes will be presented and illustrated with supporting extracts of data. Differences noted between managers from different workplaces are highlighted.

6.3.1. Structural

The primary, secondary and tertiary subthemes associated with the structural theme are displayed in Table 6.3.

Table 6-3 Structural theme

Theme	**Structural Frame**		
Primary Subtheme	**Operations**		
Secondary Subtheme	People Management	Accountability	Co-ordinating Service
Tertiary Subtheme	• *Recruitment*	• *Reporting Relationship* • *Performance Review* • *Documentation*	• *Delegation* • *Budget/Funding* • *Meetings* • *Time Management* • *Human resource/admin support*
Primary Subtheme	**Strategic Planning and Alignment**		
Secondary Subtheme	Planning	Policy and Procedure	
Tertiary Subtheme	• *Planning* • *Goals/Key Performance Indicators*	• *Positive and negative statements about policy and procedure* • *Rules/guidelines* • *Bureaucracy*	

The 'Structural' theme is made up of references to and examples of the physiotherapy managers working through the structural frame. This theme also included the managers' experiences and views of tasks and strategies associated with the structural frame. As displayed in Table 6.3, the physiotherapy managers reported working through the structural frame in two main approaches: *operations* and *strategic planning and alignment*. As well as this, there were more general comments about how they liked to take a structural approach to their work.

"I guess I like structure, having clear structure and ways for doing things, and putting structured systems in place. So that it's not just on the whim of how you feel that day as to what decision you make. And I think I'm possibly good at organising and structure and that." PTM007 Primary care/public Hospital

6.3.1.1. Operations

Within the subtheme *operations* the managers spoke about the day-to-day running of their team and workplace, the administrative tasks associated with their role and the strategies they used to organise processes.

Co-ordinating Service

The subtheme *co-ordinating service* encompassed tasks such as delegation, budget and funding, meetings, time management, and human resource/administration support. This subtheme described the everyday tasks that they completed and strategies employed to ensure the smooth running of their practice/department.

"*I get work based upon whether it is part of the everyday operational running of the department. So whether I have to approve stock, whether I have to sign salary returns, whether I have to work with ICT in relation to updating a piece of equipment or something like that. So the work is based upon what needs to happen in our department for our department to function."* PTM001 Public hospital

Time management was discussed by most of the managers. Three managers spoke of the importance of having good time management skills.

"*I would be a real organiser and time-management would be my key strengths, time-management and organising, I'd be a list person*." PTM009 Voluntary hospital

Time management strategies included prioritisation of the tasks that needed to be completed, sharing tasks with others, setting deadlines and putting processes in place to improve efficiency. However, one manager spoke of having to manage her time on a reactionary basis because of the huge demands on her time.

"*the workload demands are much, much greater than the time that's available everything I'm doing is mostly reactionary because of the demands so it just depends on what shouts the loudest and where the highest priorities are as to what I do on any particular day or morning*" PTM007 Primary care/public hospital

Four of the physiotherapy managers reported assisting their team to manage their time, by giving advice, reducing clinical demands on them when necessary or by ensuring they had sufficient time to do administration.

> "*staff come back to me to say if they can actually meet the requirements of the caseload, if they're finding it difficult within their time, have they got enough time for admin and all the other things, can they manage within the time allocated to them*," PTM003 Specialist service

Similarly, half of the managers reported being involved in monitoring the clinical caseloads of their team members. Clinical caseload management involved ensuring that team members were getting a range of clinical experience, that all high priority patients were seen and that each member of their team was able to manage their caseload.

The majority of the physiotherapy managers discussed the role of meetings in co-ordinating their services. Meetings were used for monitoring change, evaluating achievement in quality projects, discussing the work of the department, updating higher level managers on how the physiotherapy team is performing, implementing service improvement, and communicating and sharing issues with others.

> "*I think we're fortunate here that we meet with colleagues, the other discipline managers, and our services manager and that has been a good forum for implementing, just implementing change and service improvement*" PTM003 Specialist service

However, two of the managers reported that they did not have meetings with their staff as often as they would like.

> "*There's a huge difficulty in that dissemination because we only meet up officially once a month, it's a really packed agenda as you might imagine, it's like "don't even breathe" because you might miss something."* PTM004 Primary care

In terms of administrative support the managers reported having varying levels of support available to them. Private practice and private hospital managers placed most significance on their administration and secretarial staff. They praised how good they were and how important they were to the running of the clinic.

> "*We have very good reception staff in the clinic and we put a lot of our resources and money here into reception cover*" PTM010 Private practice

One private practice manager reported paying his accountant to do administrative tasks because he does not like to complete that type of work. While another private practice manager spoke of planning to pay a company to look after their HR policies. Three public hospital and primary care managers, in contrast, reported that they did not have human

resource support or administration staff.

> "*I suppose local to here we have an issue in that we have no HR department. HR was very much decentralised. And in decentralising it nobody now owns it, so therefore as a physio manager I feel as if I do an awful lot of HR stuff that I shouldn't have to do*." PTM001 Public hospital

Also within co-ordinating service was recognition of the role of delegation. Within this subtheme, the managers spoke of delegating to their senior physiotherapists, and also of delegating tasks to other managers. Delegation was used by one manager to divide out tasks when people did not volunteer for additional projects. While another manager viewed delegation as a way to allow their team members to gain more experience and develop their skills.

> "*I think delegation is important both to allow me focus on the higher priority issues and also again I think when you start micromanaging departments it doesn't make for good succession planning or happy staff*." PTM014 Public hospital

Managing the team finances was also an aspect of the operational running of the department, however it was only discussed by four of the managers. References were made to managing the funding of courses and other educational courses or study leave.

> "*They're well supported in terms of funding for training and that kind of thing, we're pretty good at sending people, like when other institutions would have just stopped the training budgets, stopped giving people any time off during the week, we've continued with that. So we continue to have the same budget*." PTM015 Public hospital

<u>Accountability</u>

The secondary subtheme *accountability* encompassed the ways in which the physiotherapy managers held their team members accountable for their actions and results. The managers spoke of having to account for their own results, as well as giving others responsibility for things and monitoring their outcomes.

> "*we've got it to a stage now where we do have a senior in charge in each network and being responsible for what's happening in their network which is new to them."* PTM007 Primary care/public hospital

This subtheme encompassed performance reviews, documentation and the reporting relationships and hierarchies within their organisations. The physiotherapy managers

spoke about the reporting relationships in their own team and the physiotherapists, physiotherapy assistants and administrative assistants who report to them. They described who they were responsible to and in turn who their manager reported to.

> "*I'm the line manager for all of the staff which are as I said clinical specialists, seniors, basic grades. The seniors would have responsibility day-to-day to do with the basic grades but ultimately I suppose I'm their line manager for anything formal"* PTM008 Primary care/public hospital

For private practice managers, in contrast, there was much less emphasis on reporting relationships and hierarchy.

> *"There's no hierarchy*" PTM006 Private practice

Several of the physiotherapy managers reported conducting performance reviews with their team. Performance reviews were seen as a useful way to monitor how their team members were performing, to acknowledge skill gaps and guide CPD, to ensure compliance with department rules and procedures, and to discuss key performance indicators or targets.

> "*performance review is useful, it gives you a bit of time with people to sit down. You know my performance reviews take longer than they used to because you've more of an in depth chat with them, and I really try and protect it and make sure it's not cut short, and try and link in with them maybe a few months later and just see how they're doing*." PTM016 Private hospital

For private practice managers in particular, performance review was used to track the performance of individual team members with regards to statistics and performance indicators.

> "*We have reviews and we have a performance sheet and we have a ratio for the performance of the physiotherapist and they're aware of it. We had a meeting with them, a staff meeting, only two weeks ago with everybody where we look at the number of new patients that came into the clinic and look at the number of patients that came into the clinic monthly*." PTM010 Private practice

Two managers spoke of how accountability can be more difficult in the primary care setting where it can be more difficult to closely monitor the work of individuals.

> "*if you did have somebody that you would have concerns about you can't just drop in to try and do an unannounced visit which is what really tells you an awful lot of information because if they're not there they can give you a very plausible, 'Oh well I was doing a home visit'. So it does make it much harder*" PTM007 Primary care/public hospital

Documentation was a common subtheme across the different workplaces. Accurate documentation served a number of functions: production of an annual report for the physiotherapy team, putting together coherent and evidence-based documents, recording minutes in meetings, documenting consent and writing research reports with appropriate layout and structure. There was also an emphasis placed on ensuring documentation practices adhere to professional and organisational requirements.

Another type of documentation was the recording of statistics and data. Overall, the physiotherapy managers spoke positively about collecting data and perceived it to be an important thing to do.

> "*Some of the data that we collect for [IT system name] I certainly find helpful to look at from a trend perspective.....We would look at some of that data around how physiotherapy is performing, things like our percentage DNAs and cancellations, the number of new and return patients, compliance with mandatory training."* PTM014 Public hospital

The reported ways that statistics and data were used by the managers included:

- Evaluating performance levels of the team and individuals
- Monitoring change over time
- As evidence to strengthen their application for more resources
- To guide the development of service plans
- Holding staff members accountable for their performance statistics
- Collecting satisfaction surveys from patients
- As a measure of success as a leader (private practice manager)

Another method used by some of the managers to monitor the work of their team and guide necessary change was audit. Audits were performed to check compliance with documentation standards and with policy. Audit was also used in the clinical setting to assess current practice and then to guide the implementation of procedures to improve it.

> "*When the agencies produced the guideline on [specific condition] that then changed the way it ran, we did an audit, we looked at where we failed and we put procedures in place to set the standards*." PTM002 public hospital

People Management

The *people management* subtheme covered the recruitment of new staff, retaining current staff, balancing levels of experience within the team and moving people between roles depending on the needs of the service.

> "*There's a lot of juggling around on a day-to-day basis in the hospital depending on who's in who's out, or with maternity leave and things. So people would cross cover quite a bit, there's quite a lot of juggling from that point of view*." PTM008 Primary care/public hospital

Four of the physiotherapy managers who worked in the public hospitals reported difficulties with the recruitment process and with filling vacancies, particularly maternity leaves. These managers reported that the recruitment process was complicated and constraining, and that they were expected to meet the increasing demands without being granted additional staff.

> *"I've the challenge within the organisation of additional full wards opening without additional staffing*" PTM013 Public hospital

Recruitment processes were quite different for physiotherapy managers who worked in private practice. Two of the private practice managers reported that they had to ensure that they had an appropriate number of staff to ensure that patients didn't have to wait to be seen by a physiotherapist, but also to ensure that the physiotherapists had a sufficient number of patients to see.

> *"we would expect that if our staffing numbers are right that we have an appropriate number of gaps in the diary that are filled but that there aren't so many gaps that a therapist is disgruntled with the number of gaps in her diary."* PTM010 Private practice

6.3.1.2. Strategic Planning and Alignment

The *strategic planning and alignment* subtheme encompassed goal setting, planning for their department or practice, the use of policy and procedure, and alignment with rules and guidelines (both organisational and professional).

Planning

Planning was a prevalent subtheme for public hospital managers and primary care managers. Within this subtheme, the managers discussed strategic plans, department plans, organising a planning day, planning for specific projects, and for quality improvement. Four of the managers spoke of planning in collaboration with other members of their team or with other managers. For some managers, service plans were developed annually in conjunction with the annual report while others described planning for smaller projects and tasks on a more regular basis.

> "*Every Friday I review what I haven't done and plan the week. So it means on a Monday morning you're very focused*." PTM017 Primary care

There was recognition of the importance of ensuring that the physiotherapy team's plans are aligned to the strategic plans of the hospital or to the HSE.

> "*I put together a fairly comprehensive plan, a fairly comprehensive presentation for the department, for that meeting and I coupled that with HSE service plans and HSE initiatives in the area to look at for this year"* PTM004 primary care

Goal setting was a prevalent behaviour for physiotherapy managers from across the range of workplaces. This subtheme also included references to targets and key performance indicators.

> "*You set goals, you set agreed goals and you set them so that they're achievable. They're challenging enough that you need to stretch for them but they're not so challenging that you can't achieve them, and you feedback whether you've met those goals or not*." PTM009 Public hospital

Managers set goals in many different areas: patient waiting times, Did not attend (DNA) rates, number of new patients seen, number of appointments, rate of re-referrals and HSE priorities. There were references from primary care and public hospital physiotherapy managers about the importance of achieving goals that are important to the HSE, for example waiting lists. One public hospital manager spoke of aiming to meet nationally set targets regarding the first assessment of patients who have had a stroke or hip fracture and of initiating quality improvement projects to try to achieve these goals. For private practice physiotherapy managers, goal setting was more concerned with the individual patient and with specific targets for each physiotherapist on the team:

> *"every new patient that comes in we set goals and targets for each new patient and then it's up to the whole team, all the physios in the practice to try and help the patient achieve those goals."* PTM012 Private practice

Policy and Procedure

In general, the physiotherapy managers had a positive attitude towards policy and procedure. The majority of the managers reported finding policy and procedure useful. Examples of how policy and procedure was helpful included providing clarity for staff, ensuring that matters are conducted fairly, and providing consistency and order.

> "*Well they are essential to the smooth running of any service. We actually spend a lot of time in terms of induction and annual review that all staff are utterly aware of their policies and procedures*." PTM017 Primary care

Policy and procedure was a prevalent subtheme for the public hospital physiotherapy managers. They spoke of the benefit of having them for reference when unsure of something, the importance of protocols for clinical issues, and of how helpful they are when setting up new services. The physiotherapy managers also gave examples of policies and procedures being actively used, implemented and updated.

> "*they're not sitting on a shelf, the policies are quite active and they're reviewed, we would review them at a team meeting. Every few meetings we'll pull a policy and we'll review it at the meeting with the team so that they're kept live and people tend to be aware of them you know*." PTM003 Specialist service

However, there were also some negative comments on policy and procedure. These included that policies and procedures are time consuming, and that they have difficulty in developing and writing policies and procedures.

> "*I find actually doing up policies and procedures difficult as the wording and templates we have to use can be confusing and I suppose it is something that we don't tend to get training on but learn on the job*." PTM005 Public hospital

Managers in primary care spoke about having difficulty applying some policies and procedures in practice because they were not always relevant to the day-to-day realities of their work and because they change regularly. There were also some complaints about administrative procedures being bureaucratic.

> "*it's just the way the HSE is now getting increasingly bureaucratic and in the past while they always had rules you could sub vent a lot of the rules especially when you knew it made sense and was the right thing to do but now the systems are in place to prevent you from doing that*." PTM007 Primary care/public hospital

The use of policies and procedures was also discussed by the private practice managers. Three of these managers spoke of the actively using policy and procedure in their practices. They described implementing policy and procedure in the daily running of their clinics, for human resource issues, health and safety, monitoring equipment and specific clinical procedures.

> "*I devise them all. They're constantly appraised and evaluated by the other physiotherapists in the practice. And if they find something in their daily practice that isn't covered by the policies and procedures we update the policies and procedures again so they're constantly being updated*." PTM012 Private practice

Whereas for one private practice manager it was apparent that there was less emphasis placed on policy and procedure.

> "*I'm never sure what policies and procedures mean, the criteria for running the clinic would be that we have the place as spotlessly clean as possible. So that it's a nice environment for people to come into, that it's welcoming*" PTM006 Private practice

As well as policy and procedure, rules and clinical guidelines were referred to by some of the managers. The managers spoke of developing and using clinical protocols to guide procedures in their workplaces.

> "*I've been writing guidelines, clinical guidelines and changed practice that way, run workshops, staff education and the final thing we did was looking at changing practice and policy in [specific aspect of clinical area], and they're now rewriting their policy on that."* PTM002 Public Hospital

Guidelines from external agencies, e.g. HIQA Standards, ISCP guidelines, were also discussed by four of the managers.

> "*The physiotherapy practice has to follow the guidelines of the Society of Chartered Physiotherapists in Ireland. And I'm very rigid on that, there's no room for manoeuvre outside of that*" PTM011 Private Practice

6.3.2. Human Resource

The primary, secondary and tertiary subthemes associated with the 'Human resource' theme are displayed in Table 6.4. The physiotherapy managers indicated that they worked through the human resource frame through their awareness of the needs of their team members and their aim to keep members of their team happy.

> "*I think people being happy at work is very important. More so in the last two years than I would have ever thought*." PTM016 Private hospital

Table 6-4 Human resource theme

Theme	**Human Resource Frame**		
Primary Subtheme	Professional Development		
Secondary Subtheme	Development/ training	Encouragement/ motivation	Support
Tertiary Subtheme	• *Leadership training*		• *Assisting others* • *Empowering*
Primary Subthemes	Qualities	Communication	
Secondary Subtheme	Qualities	Communication	
Tertiary Subtheme	• *Empathy* • *Fairness* • *Respect* • *Self-awareness* • *Teamwork* • *Social interaction*	• *Staff preference* • *Open to ideas* • *Feedback*	

6.3.2.1. Professional Development

The subtheme *professional development* covered the support that the physiotherapy managers give to the physiotherapists in their team, the encouragement and motivation strategies that they employ and the development and training opportunities that they afford their staff and engage in themselves.

Development and Training

The *development/training* subtheme was very prevalent in the interviews. This subtheme covered the different types of training that their team members engaged in, the different ways that the managers enabled their team to develop as professionals and clinicians, and the managers' role in ensuring the development of their team members. The majority of the managers viewed facilitating the development of their team as an important aspect of their role.

"*I think if you take the time out to understand what's going on for them personally at the moment, where they want to be and help them see if they can progress their career, I think if they feel more fulfilled they're happier in their role and they normally, I feel it comes back from an output perspective; if they're happier you normally get more work from them*." PTM014 Public hospital

Managers in public hospitals used personal development plans (PDPs) to facilitate the development of their team. By developing PDPs with their team members, the managers became aware of the interests and development needs of their team and so were able to identify appropriate opportunities for them.

"*If I hear that there's an opportunity within that area, either within the ISCP, or within the hospital, that's going to tick the box for something that they wanted to do, then I'd channel them in to make sure that that happens for them*." PTM001 Public hospital

Two of the managers who work in primary care placed an emphasis on ensuring that the team members get to meet so that they can learn from each other.

"*I've started a seniors group meeting and again that's to facilitate learning that they have across the different sites and to use one site's learning and initiative at one site at another site so that that cross learning and cross communication happens*." PTM004 Primary care

Across the different workplaces, the managers reported facilitating in-house training or in-service training. Private practice managers in particular spoke of taking an active role in teaching their team members.

"*I'm providing a lot of training for them so it's a very positive place to be because of the amount of training that I am providing for them so and that's all. So it's all regular, it's all ongoing and they're all learning a huge amount so that's all very positive."* PTM010 Private practice

The funding for courses and training showed some variation across the different workplaces. In-house training was available in hospitals, primary care and private practices. To receive funding to do courses outside of the workplace the process differed. A manager in a voluntary hospital spoke of being able to reassure her staff that there was money available for courses, while a manager in a different voluntary hospital spoke of being able to contribute towards the cost of development activities but not necessarily cover the entire cost. Funding for courses varied across private practice managers, some

did not pay for courses at all (but did still encourage staff to engage in training activities) while others would pay for courses if they felt it would benefit the clinic.

> "*People are very self-motivated in that they take courses, everybody is taking courses and doing all the up-to-date, dry-needling and whatever, and I would encourage people to take the time, I don't pay for them because they are self-employed so that's an expense*." PTM006 Private practice

A specific component within the development and training subtheme was leadership training. This component covered the different types of leadership training that the managers had participated in as well as their opinions of leadership development. There were numerous different types of leadership training course cited. These included: in-house leadership courses, a HSE Health and Social Care Professions leadership course, LEAN training, communication study days, Masters degrees, Raising Performance training and training through the CPM. There were also courses cited which would have been aimed more towards management skills but would have included leadership concepts and so were viewed as leadership training by the managers – FETAC Qualification in People Management, Diploma in Healthcare Management, and the HSE First Time Management course.

Two public hospital managers had organised their own in-house leadership development training courses.

> *"It's a leadership development course, so I'd finished my own and it was four modules. I thought I'd do PDPs with staff, I was doing it with my senior staff grades. I find a lot of my senior staff grades can't get senior jobs, none of us are moving on, including me, so again I was doing a personal development plan and it just became apparent - why don't I run one in-house?"* PTM013 Public hospital

Unlike the other managers private practice managers had not completed specific leadership development training. One private practice manager believed that leadership training may be beneficial:

> "*nobody would find themselves in a leadership position without doing some sort of leadership training. So would I? Will I? I don't know if I will. But would it benefit me? There's absolutely no doubt about it, surely it would.*" PTM010 private practice

However, another manager did not feel that there was any need to do leadership training but that gaining experience would be more beneficial.

> "*No I think if I'd more experience I'd enjoy it more. I don't think it's the preparation, it's the experience I need rather than preparation*." PTM012 Private practice

Other managers also expressed the opinion that experience was important for leadership development. While speaking of the benefit of completing leadership training five managers noted that you also need to gain experience on the job.

> "*I still feel that in all of them there's kind of something missing that you'll only learn on the job, or things that you'd like to go back and do*." PTM005 Public hospital

Support

Many of the mangers spoke of wanting to provide support to people on their team and some gave specific examples of times when they supported members of their team through difficulties. Eight managers spoke of the importance of acknowledging the various challenges that their team members faced and of providing support where they were able.

> "*People are under huge pressure, we've had a very tough time in Ireland and the staff hear very sad and dreadful stories, that we listen to them as well and that they can debrief, and that they have a social outlet*." PTM017 Primary care

Similar to *support* was the subtheme of *assisting others*. Examples of when the physiotherapy managers assisted others included helping with the clinical caseload when they were very busy, advocating on behalf of their team members, helping team members to progress in their careers, and guiding a team member through a difficult clinical problem.

> "*I guided the physiotherapist through the position so that they could maintain both professional and personal integrity and completed the task with both their profession and their personality intact and [they] have gone on to do very well out of it*." PTM012 Private practice

A specific approach to professional development used by seven of the physiotherapy managers was to empower their team members in their work.

> "*I feel that I would lead very much by passionately empowering them to be the best they could rather than telling them. To bring them with me and so that they want to be as good as they can be*." PTM002 Public hospital

The physiotherapy managers spoke of giving others autonomy in their work and the responsibility to try new projects or ways of doing things. One manager reported that it was important to show their staff that they trust them to do things without constant supervision and micromanagement.

"*So I think the more you can let staff run with things once they know that there is support there if needed. I think we've a department full of capable people so it's nice to let them fulfil their capabilities and have almost their examples of stuff that they have led*." PTM014 Public hospital

Encouragement and motivation

Also within the *professional development* subtheme was encouragement and motivation. The managers gave examples of the ways that they keep their staff motivated including: developing PDPs, organising team-based activities and projects, giving feedback, encouraging new ideas and supporting individual's interests.

"*So by investing in them I hope I motivate them. And by finding something a little bit extra or a challenge that both they and I want I think it's a motivating thing*." PTM001 Public hospital

6.3.2.2. Qualities

The managers discussed the different qualities that they believed they demonstrated or that they perceived to be important for a leader to demonstrate. Many of these were related to the human resource theme and so are presented here. The most prevalent of these qualities were teamwork, social skills, self-awareness, respect, fairness and empathy.

The managers discussed teamwork and how they facilitated and encouraged this. There were comments about how their team works well together and how team-members support each other. There was also recognition of the importance of team based activities and being able to ensure effective teamwork.

"*another skill that I think is very important is to be a, develop skills to be a team worker, team player, good communicator, because those will stand to you all the time*." PTM004 Primary care

Similar to skills in managing a team were social skills. The physiotherapy managers spoke of how they enjoyed the social aspect of their role, interacting with others, and working with people. The managers described the informal chatting and other social activities that they did with their team. There were examples given of why social skills

were important and of times when the managers facilitated the social interaction of their team.

"*You've to get on with people, you've to get on with people that you don't like, and you've to get on with people that you mightn't at all click with but you're all in the same boat"* PTM016 Private hospital

Some of the physiotherapy managers demonstrated self-awareness by recognising their own strengths and weaknesses, and by appreciating the importance of this awareness. Two of the managers spoke about how being aware of your weaknesses can help you to address them.

"*And my one big weakness was procrastination, and not dealing with things immediately. And that was probably about 20 years ago, that was really good for me to have done that because that was my weakness, I really didn't want to deal with problems if they came. So it made me very proactive in recognising that and hopefully in dealing with them as best I could*." PTM006 Private practice

Showing respect for their colleagues and ensuring fairness were also reported to be important.

"*And also in a professional world I feel, when you're dealing with other professionals I think you have to treat them as such, not treat them as juniors or as inferiors or as subjects or as I've seen in hospital departments that I worked in, as junior school kids being looked after by a prefect*." PTM011 Private Practice

Empathy was not as prevalent as some of the other leadership qualities but some of the managers did speak of the importance of empathy and being able to understand things from their team's point of view.

"*need to have a humanity and an empathy*" PTM006 Private practice

6.3.2.3. Communication

The importance of effective communication was a very prevalent subtheme amongst the managers. This subtheme encompassed the subthemes of *feedback*, *open to ideas and opinions*, and *staff preference*.

"*Well I suppose it's probably one of the jobs where you need a range of skills but communication I think is probably one of the bigger ones."* PTM014 Public hospital

The physiotherapy managers cited communication as important when dealing with problems that arise within the team or organisation and also in conflict management situations. Many of the physiotherapy managers spoke of the importance of listening to their staff.

> "*Listening, I think it's very important to be a good listener, to listen and hear people out.*" PTM003 specialist service

Communication was also viewed as an important strategy when dealing with projects or challenges outside of the physiotherapy team.

The majority of the managers were open to and actively encouraged the members of their team to express their opinions about the service or about decisions that are being made, and also to voice their own ideas.

> "*I certainly have an openness to staff coming in with ideas and solutions of how they see things could work better and I'm very much open to trying things*." PTM014 Public hospital

Several of the managers spoke of taking a team approach to making decisions or plans for the department, or for coming up with strategies to deal with specific problems.

> "*We'd have a meeting, we'd brainstorm everybody and see what people thought and then we'd come to some kind of arrangement or compromise to see if it was for the common good and that the majority of people agreed with it*." PTM006 Private practice

As well as listening to the ideas and opinions of their team the physiotherapy managers also spoke of taking the preferences of their team members into account when making decisions about things like rotations, projects and tasks.

> "*Looking and listening to them as well in terms of what they like to do and what they don't like to do, so I try not to put people in place just for the sake of maintaining a rotation and get feedback from them about what areas they want to progress in within reason*." PTM008 Primary care/public hospital

This subtheme (staff preference) was not expressed by the private practice managers. This may have been because their staff do not do rotations and often only work in one area of physiotherapy.

The *feedback* subtheme covered both the feedback that the managers gave to their team and their willingness to receive feedback from their manager(s) and their subordinates. Generally, the managers were very open to receiving feedback but some found that this could be difficult to get.

"*I do ask for, when I have one-to-one sessions with people, I do ask for feedback on myself. That isn't often forthcoming but I would also have different meetings with seniors and with staff grades where we discuss issues, or they give feedback in relation to different initiatives within the department"* PTM004 Primary care

The managers appreciated the importance of giving feedback to their team and how motivating it can be for staff to have their hard work acknowledged.

"*I think through positive feedback as well. I think you always have to acknowledge the good work that people are doing*" PTM009 Public hospital

6.3.3. Political

The primary, secondary and tertiary subthemes associated with the 'Political' theme are displayed in Table 6.5. The physiotherapy managers demonstrated their use of the political frame when they spoke of competing for scarce resources, managing conflict and having influence over decisions.

Table 6-5 The Political Theme

Theme	**Political Frame**		
Primary subtheme	Organisational Citizenship Behaviour	Engagement	
Secondary subthemes	Organisational Citizenship Behaviour	Collaboration	Career progression
Tertiary subthemes	• *Committee membership* • *Promoting the profession* • *Looking for opportunities* • *Research involvement*	• *Networking* • *Liaise with managers* • *Liaise with consultants*	• *Into managerial role* • *Beyond managerial role*
Primary subtheme	Organisational Interpersonal Dynamics		
Secondary subthemes	Influence	Effecting Change	Conflict management
Tertiary subthemes	• *Autonomy* • *Powerless* • *Power structure*	• *Accessing resources* • *Business case/proposal* • *Campaign/lobby* • *Tactical approach* • *Negotiation*	• *Conflict management* • *Inter-profession rivalry*

The ‘Political’ theme comprised three main subthemes: *organisational citizenship behaviour, engagement* and *organisational interpersonal dynamics*.

6.3.3.1. Organisational citizenship behaviour

The *organisational citizenship behaviour* subtheme described the various activities that the physiotherapy managers chose to do which lay beyond their contractual obligations; it was the additional activities that the physiotherapy did to benefit themselves, their team, their profession and their organisation. Comments under this theme came under four main subthemes: *research involvement, promotion of the profession, committee membership* and *looking for opportunities*.

Five of the managers reported that physiotherapists in their team were involved in research. These managers worked in public hospitals and primary care.

> “*we try and support and encourage things like audits, research, all that kind of stuff in the department*.” PTM014 Public hospital

The importance of promoting the physiotherapy profession was recognised by seven of the physiotherapy managers. They spoke of being visible, improving their profile, making links and developing professional relationships with people of influence. Two private practice physiotherapy managers spoke of the importance of promoting the physiotherapy profession to the public.

> “*as a whole I think public awareness is one of the biggest things and to run campaigns and to make the public as aware as possible that this is the discipline for you to go to for this problem*.” PTM018 Private practice

However, other managers expressed concern that physiotherapists were missing opportunities due to failure to promote the physiotherapy profession effectively.

> *“What we can say though is that we need to shout louder that actually this is what we do and I think we just haven't in the past. As a profession, we tend to be the workers, heads down working, working, working, and not stepping back and making our voice heard.”* PTM009 Public hospital

Looking for opportunities to develop the physiotherapy service, or as an individual, was reported by seven of the physiotherapy managers. Some gave specific examples of when they had sought out opportunities.

"*a lot of it's to do with putting your hand up and stepping forwards so when there's an opportunity you say, 'Yes, I'll do that'*." PTM015 Public hospital

They also spoke of encouraging their team members to look for opportunities and to demonstrate leadership.

"*what I'm trying to get them to think of, particularly once they've been a couple of years qualified, is to start thinking broader in the hospital for the profession, you know can they do something with the ISCP? Is there something bigger picture that they can start to look at? So to try and find those opportunities*" PTM014 Public hospital

Six of the managers from HSE services and voluntary hospitals reported the various committees that they were members of including a senior management committee, health and safety committee, infection control and hygiene committee, professional body committee, steering committee for accreditation, and the community physiotherapy group. The committees were seen as opportunities to meet with professions from other departments, to demonstrate the effectiveness of physiotherapy, to gain information about what is going on in the hospital and as a way to develop new skills.

6.3.3.2. Engagement

The *engagement* subtheme was defined as 'actively working to advance themselves and/or their team within their organisation or the health care system.' It covered two main subthemes collaboration and career progression.

<u>Collaboration</u>

The collaboration subtheme covered the different ways in which the physiotherapy managers worked with others to achieve things. Broadly this included collaborating, networking and liaising with medical consultants and other managers. The importance of collaborating with others was recognised by several of the physiotherapy managers.

"*I think physios are brilliant MSK practitioners, and that is our strength, and the more we link in with the other disciplines, the more that will rise*." PTM016 Private hospital

Some of the physiotherapy managers reported liaising with other managers to get advice and guidance on issues. They collaborated with other physiotherapy managers and with

managers from other disciplines or more general managers. Three physiotherapy managers spoke of liaising with their own manager when they wanted to influence something within their organisation.

> "*if I need approval from say the general manager, I would need to collaborate with all the people who potentially will be involved in it to get agreement. That could be different care group mangers, different discipline managers, it could be different agencies*." PTM004 Primary care

Another group that some of the physiotherapy managers spoke of liaising with were the medical consultants. Seven of the physiotherapy managers recognised the importance of getting consultant buy-in when trying to introduce new physiotherapy services into the hospital or maintaining current services. There was a perception that by liaising with consultants the physiotherapy team may be able to have more impact and more influence over the things of interest to them.

> "*recognising the role of the consultants as well, if you hit a brick wall then the consultants are your allies*." PTM015 Public hospital

Networking was another strategy to make connections and try to progress their interests. Networking was mentioned by six of the managers, however there were not many examples given of how they networked. These managers spoke of the importance of networking for getting to know people with influence and for getting support and help from others.

> "*it's the networking side of things getting to know people around and about who have similar problems or issues as you have*." PTM008 Primary care/public hospital.

<u>Career Advancement</u>

Also within the *engagement* subtheme was the concept of career advancement. Four managers spoke of their transition into managerial positions. They described what it was like to move up to a managerial role.

> "*I leapt from a senior II position in [country name] straight into a manager role here in Ireland. So I had, I can say it now, I had zilch management experience. I really didn't know where to start*" PTM009 Public hospital

One manager spoke of how she had been motivated to become a manager because her sphere of influence had been small in her previous role and she wanted to have an impact on more than just her clinical patients. In contrast, another manger spoke of how he had never set out to become a manager.

Progressing beyond the level of discipline manager was discussed by five of the physiotherapy managers. There was recognition that some physiotherapy managers were progressing to more influential positions.

> "*There's a lot of movement at the moment even just in our CPM meeting there of people who were physio managers and are now something bigger and better*" PTM008 Primary care/public hospital

However, there were also comments about a lack of physiotherapists progressing to higher levels. As well as this some of the physiotherapy managers said that they did not want to progress in their career at present.

6.3.3.3. Organisational Interpersonal Dynamics

The subtheme *organisational interpersonal dynamics* was the largest and most wide-ranging in the political theme. This subtheme included the managers' perceptions of their influence, the strategies the managers use to effect change and the techniques they employ to manage conflict.

Influence

The subtheme *influence* covered the managers' perceptions of their influence within their organisation and also reflections on the importance of having influence. There was recognition of the need for the physiotherapy team to have influence in the organisation.

> "*And if you had every physiotherapist trying to do the elevator pitch, proving their benefits, you would see a mindset change, they're all great clinicians but they need to be influencing a bit more*." PTM013 Public hospital

Demonstrating influence was identified by a physiotherapy manager as being one of the challenges facing physiotherapy leaders.

> "*There's a big disconnect between the administration of the HSE and frontline services. And the challenge is how do we influence that and affect change positively for our clients. And I think that area of resilience and very structured politically focused attention on how we achieve it is really important now, which I hadn't appreciated years ago*." PTM017 Primary care

Related to influence were comments in the powerless subtheme. Ten managers described not feeling that they had power or influence over some decisions or processes in their workplace. There was a belief among physiotherapy managers in public hospitals

that the physiotherapy team did not have the power to make or influence decisions that it should have.

> "*I recognise that as a physiotherapy manager you don't have a huge amount of leverage. If you say, 'We'll close the service.' They're not going to see the sky falling in, that's the reality*." PTM015 Public hospital

Five managers voiced frustrations about not having autonomy in their work.

> "*middle management can be a very frustrating place to be. Because we don't have the autonomy to make the decisions"* PTM003 Specialist service

However, six of the managers were more positive about having autonomy to make decisions and changes.

> "*If I'm making a change that's more process related, that's internal within the house here we certainly wouldn't need to ask for permission for that, that's something that would be under the remit of the department here*." PTM014 Public hospital

There was frustration with the lack of physiotherapy representation at the higher levels within the health service. Managers in voluntary and HSE services cited recent changes in structure as the reason for physiotherapy managers not having power in their decision making. Some of these managers perceived their power to have lessened in recent years and there were frustrations expressed regarding a lack of power to make some clinical decisions.

> "*I just see power as lessening and lessening over the last few years, you know even a year ago there would have been things that I could do as physio manager that I cannot do now and I've to go and ask permission for.*" PTM007 Primary care/public hospital

Also related to power and influence, was the subtheme *power structure*. Here the physiotherapy managers discussed the power structure of their workplaces and where they felt they were situated within that. In speaking about who had the most power in the organisation the managers answered:

- Public hospital – General manager, CEO, finance department, senior executive team, Director of Nursing, Chairman of the Board, consultants.
- Specialist service – the Director
- Primary care - General manager, nurses, Director of Nursing
- Primary care/public hospital – Consultants, nursing, Integrated Service Area (ISA) manger in the community
- Private hospital – CEO, Director of Nursing, Management team, consultants

The private practice managers viewed power differently to the other physiotherapy managers and did not speak about influence. These managers spoke of a lack of a power structure in their practices or recognised that they had the most power.

> "*Well I suppose the hierarchy would be I am the person who set up this practice so I would be the elder lemon in terms of I would be the longest here. Having said that I have two equal partners so there are three of us who are equal partners in the practice. But I probably would have just a little bit more clout because I'm here the longest in that regard but we are equal partners*" PTM010 Private practice

Effecting Change

Another subtheme within *organisational interpersonal dynamics* was effecting change. Here the managers spoke about their successes and difficulties in effecting change within their organisations and the strategies they used to try to achieve this. These strategies were divided into the subthemes: *tactical approach, negotiating, campaign or lobby, business case*, and *accessing resources*.

Within the subtheme of *effecting change*, one of the most commonly cited changes that the managers were trying to effect was to acquire resources. The resources that the managers were looking for included: equipment, clinical space, a new building, money for training, cover for staff on leave and new posts.

> "*So that's impacting on, so basically the issue there is to try and persuade, make sure we get our, there'll be an envelope of money, and everybody will be looking for that money and we'll be trying to make sure that physio is part of that*." PTM015 Public hospital

One of the ways in which the managers effected change was by using a tactical approach. This meant tailoring the methods they used to best suit the situation and to have the most effect on the person that they were trying to influence.

> "*you need to look at your key stake-holders and your key influencers and then you've got to let them know what you're doing and why. Spot the people that you've got on board right from the word go, they're the easy ones. You can use them to help you to champion your change process."* PTM009 Public hospital

One manager spoke of being aware of the bigger system that they were trying to influence and another reported that they felt they were able to drive change within their own department but that it was harder to influence change beyond this.

"*Change locally is easy and this I can do, and we're very good within physiotherapy department here at changing. Where it has proved very difficult is to implement change throughout even my allied health colleagues at times because of different pressures*" PTM013 Public hospital

Five of the physiotherapy managers described how they used negotiation as a strategy when trying to effect change or when dealing with problems within their team. One physiotherapy manager perceived negotiation to be a core component of their role.

"*Well when I think about negotiating you're nearly negotiating all the time… I could be negotiating with staff around encouraging them to take on something, maybe a project. I could be negotiating with my boss, my manager, to implement some actions that I feel to be important*." PTM003 Specialist Service

Another strategy to effect change was to campaign or lobby for change. Six of the managers spoke about lobbying for the things that they had campaigned for and the strategies that they used as part of these campaigns.

"*We campaigned since I came here to have some sort of area over in the new part of the hospital allocated where physios can do rehab.....So after a long time campaigning we actually got an area allocated to be a rehab area."* PTM001 Public hospital

However, a manager working in a public hospital reported unsuccessfully campaigning to get a Health and Social Care Representative on the Board of the hospital.

"We pushed very hard for many of the years that I was there for some sort of a health and social care rep at management team level and actually at Board level.....there was no health and social care person on that so that was the position that we were really pushing for but we never got it." PTM009 Public hospital

Compiling a business case or submitting a proposal was the most commonly cited strategy among the physiotherapy managers when they were trying to effect a change.

"*I will then need to kind of put my feedback together from HR and from finance, and bring that, write it as a proposal and bring that to the general manager, with the proposal having gone in I'd have a meeting about it and put my case forwards*." PTM004 Primary care

Business cases were particularly prevalent among the public hospital managers where the managers used business cases to apply for additional staff or resources. One of the physiotherapy managers spoke of getting their team involved in writing a business case

and how this had been a successful strategy. However, another physiotherapy manager reported that submitting business cases was generally not an effective strategy for her.

> "*That is an interesting one, you just put in the business cases, I've done in my career about 300, I've rarely gotten any. So how you probably do it, as someone said, 'if you have to put in a business case then you don't have the post'*." PTM013 public hospital

Conflict Management

The final subtheme under *organisational interpersonal dynamics* was *conflict management*. The physiotherapy managers were asked how they manage conflict situations and so they all addressed the concept of conflict in their workplace. There was recognition of the importance of effectively managing conflict.

> "*I suppose managing conflict is hugely important, not allowing conflict to get out of hand….So it's important to keep whatever conflict is there, is to manage it so it doesn't get, so that you genuinely don't have people seriously falling out with each other*." PTM015 Public hospital

The most commonly cited strategies for dealing with conflict were to facilitate good communication with the individuals involved and to encourage the staff to resolve the conflict themselves. With the communication approach the managers appreciated the importance of addressing problems openly and honestly, and of getting both sides of the story.

> "*We have open discussion, again we have meetings if not two weekly. We encourage any issues there are to be brought forward and openly and honestly discussed. And again I suppose that solves 99.9% of the problems*." PTM012 Private Practice

The other approach was to try to empower their team to resolve the issue amongst themselves. The managers reported helping their team to avert a problem escalating into a conflict and of preventing a conflict reaching management level by facilitating the people involved to manage the problem themselves.

> "*The first thing I do is try to get everybody's side of the story to see if I can find where the source of the difficulty is and based upon that I make a decision whether it needs my involvement or not; how big an issue is it?"* PTM001 Public Hospital

While most of the managers spoke of how they dealt with conflict, four commented that there was little conflict within their team.

> "*Yes within our own team I can't think of any major instances, touch wood, or much conflict. But externally to the physiotherapy team within the multi-disciplinary team here yes definitely we have plenty of conflict, it goes through phases.*" PTM005 Public hospital

Many of the managers were able to give examples of having dealt successfully with conflict or of the different strategies that they used, however, five managers were less comfortable with conflict or reported difficulties addressing conflict in the past.

> "*I suppose I'm uncomfortable with conflict. I think I tend not to cause too much conflict I'm kind of quite a pliable kind of person within work…. I try not to get involved in he said/she said stuff but it's very difficult. So it's a work in progress I think, how I deal with conflict."* PTM008 Primary care/public hospital

A particular form of conflict management was competition and rivalry between the physiotherapy managers and different professions. This subtheme was more prevalent among the managers who worked in primary care or a public hospital. There were comparisons made between themselves and managers in other healthcare professions. In particular, there were many comments demonstrating a rivalry with the nursing profession.

> "*there were five health and social care profession managers who all felt that we were no longer involved in the decision-making process within the hospital and that it was very much nursing controlled, even the medics, medical board were slightly separate. It was very much a nurse driven hospital.*" PTM009 Public hospital

One manager spoke of the negative effect inter-professional rivalry was having on the work environment.

> "*there's a lot of distrust and tension, and a lot of inter-professional rivalry and it stems from different opinions of how you best manage your service..... And I'm sure we're probably contributing to it as well in some shape or form but it's come to a point where everybody is quite unhappy*." PTM008 Primary care/public hospital

Comparisons were also made between physiotherapy and other healthcare professions. There was recognition of a lack of physiotherapists in positions of power and influence compared to other health care professionals.One physiotherapy manager perceived physiotherapists to have less leverage in the hospital compared to other professions within the hospital.

"*If on the other hand the head of the radiography services says, 'This is not safe, I'm going to close the CT service', that immediately has a massive knock-on on a number, so she's huge leverage. I don't have that. The service mightn't be quite as good but if I was to say, 'Well we're not going to provide services to orthopaedics,' the service mightn't be as good but the clinics with 60 or 70 patients on a Monday afternoon would continue on*." PTM015 Public hospital

6.3.4. Symbolic Frame

The primary, secondary and tertiary subthemes associated with the 'Symbolic' theme are displayed in Table 6.6. The physiotherapy managers indicated working through the symbolic frame when they spoke of the culture and ethos of their workplace, their values and attributes, and the meaning of their role.

"*And it's also because I as the owner of the clinic, empty the bins and clean up and I don't expect anybody to do anything that I wouldn't do. I change the toilet rolls if they need to be done*." PTM006 Private Practice

Table 6-6 Symbolic theme

Theme	**Symbolic frame**		
Primary subthemes	Organisational Culture	Attributes-behaviours	
Secondary subthemes	• *Atmosphere/ambience* • *Open-door policy* • *Time with staff socialising* • *Celebrations* • *Values*	• *Passion* • *Big picture* • *Future oriented*	
Primary subthemes	Professional Identity		
Secondary subthemes	Perceptions of physiotherapy/reputation	Identity as a physiotherapist	Mentor/coach
Tertiary subthemes	• *Value of physiotherapy*	• *Clinical role*	• *Role-model*

The symbolic frame comprised three main subthemes: *organisational culture, attributes-behaviours* and *professional Identity.*

6.3.4.1. Organisational Culture

In this study, organisational culture was defined as the culture of the workplace; the common perceptions, values and beliefs held by organisational members that determine to a large degree how they act and behave towards each other and outsiders (Robbins and Coulter, 2002). This theme encompassed the managers' approach to spending time with their team socially and to celebrations, their awareness of the atmosphere or ambience of the workplace, their leadership values and a specific leadership strategy of symbolic importance, an open-door policy.

Some of the managers spoke of wanting to facilitate a particular type of culture in their workplace. Examples of these included:

- Culture of continuous improvement [PTM003]
- A no-blame culture [PTM005, PTM013]
- Culture of learning, research and development [PTM013]
- One where people feel valued and welcomed [PTM013]
- One where people are open to feedback [PTM014]

Seven of the managers spoke of the importance of trying to facilitate a positive culture within their workplace. One private practice manager recognised the impact that this may have on their patients.

> "*I'm seeing that as even more important as years go on because the feeling within the staff in the clinic is very, very important as to how we are perceived by patients, and people coming in and out. If we're seen to be getting on and all in good form well then it brushes off. And people I suppose work harder when they are in better form*" PTM018 Private practice

One strategy that the managers used to facilitate a positive culture in their workplace was to spend time socialising with their staff. Spending time socialising with the team was seen as way to encourage bonding within the team and a team spirit. Many of the physiotherapy managers felt that it was important to engage in social activities with their staff.

> "*I like going out and having a cup of tea with the staff for 20 minutes, not because I like to have a cup of tea but because I feel it's important to hear whose boyfriend is doing this and whose kids are doing that and all the rest of it. I feel that's an important investment*." PTM001 Public Hospital

The types of social events and socialising that the managers organised were Christmas parties, Birthday events, coffee mornings, team building exercises, lunches, walks, nights out and BBQs. A strategy used by some of the managers was to build a social aspect into work activities that they were doing as a group.

> "*And team wise it's a bit similar, we'd have team days and if we have a team planning day I'd usually say we'll go for lunch or we'll get pizzas in, kind of build in a social side of it as well."* PTM003 Specialist service

Four of the managers felt that it was important for their staff to have a social outlet. One private practice manager spoke of using social activities to try to improve the atmosphere of the clinic and to improve engagement of the staff.

> "*So trying to do some fun stuff together. Going out in the evening, having a drink together and trying to share some of the social stuff together*" PTM010 Private practice

However, five of the managers did not feel that facilitating social engagement was an important aspect of their role or did not promote this with their team.

> "*I think the staff sometimes go out, they'd go out for a meal, if things are tough they might go out, everyone go out and go for a meal and stuff like that. But I certainly wouldn't be the one instigating it. I wouldn't be bringing them to paint ball or walk up the side of a mountain with them or anything like that."* PTM015 Public hospital

A particular form of social activity that the managers spoke of engaging in were celebrations. Generally, the celebrations were linked to the social lives of the team e.g. weddings, engagements and children. Six of the managers spoke of celebrating their staff members' birthdays.

> "*We did the birthday club. We've given money and whenever it's anyone's birthday it is put up on the board there with the banner. When I'm passing it then I know whose birthday it is. Now when I see that staff member I can say, 'Oh Happy Birthday'. And it's the little things like that they feel valued that I notice that."* PTM013 Public Hospital

One manager spoke of celebrating the opening of a new physiotherapy rehabilitation space, and another spoke of celebrating World Physiotherapy Day with her team.

Four of the managers spoke of having an open-door policy where they actively encouraged members of their team to approach them when they had questions or issues that they wished to raise with them.

> "*And if people have problems I literally have an open-door policy, people just come in and, 'Do you have five minutes?' And invariably that's the way it works*." PTM015 Public hospital

Within the concept of organisational culture is the idea of cultivating a particular atmosphere or ambience in the workplace. Six of the managers demonstrated an awareness of the atmosphere of their workplace. Most of these managers spoke of the

good atmosphere in their workplaces and of wanting to ensure that patients were coming into a positive environment.

> "*The criteria for running the clinic would be that we have the place as spotlessly clean as possible. So that it's a nice environment for people to come into, that it's welcoming, that the people at reception make each patient feel like they're the most important person that came in*." PTM006 Private practice

However, not all the managers reported that the atmosphere of their workplaces was positive.

> "*I've one group of staff at the moment who are in a team that is, I can only call it toxic, and I don't know what the reasons are but there's a lot if distrust and tension"* PTM008 Primary care/public hospital

The physiotherapy managers were asked about their leadership core values and there were a range of answers. The most common answer to this question was related to patient centred care and ensuring that patients were treated to a high standard.

> "*The primary core value is treating the patient ethically, morally, correctly. And making sure that my colleagues do the same thing*." PTM011 Private practice

Respect was also commonly cited by the managers. This encompassed both demonstrating respect for their staff and for patients. Honesty, integrity and fairness were also commonly cited by the managers as values that they hoped to demonstrate.

> "*I think you have to respect everybody regardless of whether you're upset with them or not you have to respect the role and what they're trying to do*." PTM009 public hospital

Less prevalent but cited by three managers was the concept of being caring and demonstrating kindness.

> "*I suppose, I can't think of another word except for kindness, but you know that people just give each other support*." PTM008 Primary care/public hospital

Developing the skills and abilities of their team was also viewed as an important value by three of the managers.

> "*The main thing I want is creating brilliant physios so that any physio that comes and works in the practice will leave with a skill set that allows them to stand up on their own two feet and a skill set that will allow them to have a career for the rest of their lives, that would be my core value*." PTM012 Private practice

6.3.4.2. Leadership attributes or behaviours

This subtheme covered the leadership attributes that were considered to fall within the symbolic frame. This included being future oriented, seeing the big picture and being passionate.

Passion was a specific leadership attribute demonstrated by some of the managers in their interviews. Seven managers spoke of their passion for their own role or for the physiotherapy profession.

> "*I'm very passionate clinically about what I do and I feel very strongly that we make a big difference*." PTM002 Public hospital

The importance of having vision or of working for the future and growth of their department or the profession was recognised by some of the managers. Six managers spoke of the importance of having vision or of keeping focused on the future; anticipating what was ahead and what they wanted to achieve. There was also an emphasis placed on being able to clearly communicate your vision to your staff.

> "*I think you have to have your vision and then be very clear with your team and keeping them briefed and keep reviewing where you're at, what you can and can't do and what we can do well and what we can't do well, and the risks."* PTM017 Primary care

As well as being aware of the future, five of the physiotherapy managers spoke of the importance of having an awareness of the big picture.

> "*I think when you come out of college we're almost indoctrinated to focus in on the pathology, the fractured elbow or the total hip replacement and forget about the bigger picture. So I think it's really important to always keep the bigger picture in mind and in leadership you have to look at the bigger picture*" PTM003 Specialist service

6.3.4.3. Professional Identity

The final subtheme under the 'Symbolic' theme was *professional identity*. This subtheme covered the social identity of being a physiotherapist, receiving guidance from other physiotherapists, and awareness of attitudes towards and perceptions of the physiotherapy profession.

Perceptions of physiotherapy/reputation

The reputation, or perceptions of, their physiotherapy team or the physiotherapy profession was discussed by nine of the physiotherapy managers. They gave examples of actively trying to project a positive reputation their physiotherapy team and of trying to ensure that physiotherapy was valued by others. The physiotherapy managers also voiced their opinions on whether they perceived the physiotherapy profession to be viewed positively by other healthcare professionals or the general public.

Hospital-based physiotherapy managers spoke of working to ensure that others view the physiotherapy department favourably. They spoke of aiming to have the value of physiotherapy recognised by others and of facilitating members of their team to promote the physiotherapy team profile.

> "*Now I waited two years before I did that because I wanted to build the reputation and the influence of the department first, before I made a case that we are actually valuable, you need us*." PTM002 Public hospital

Some of the managers expressed a belief that physiotherapists are viewed positively. However, in contrast, one manager did not feel that the physiotherapy profession was viewed positively.

> "*I think the way the profession is being viewed by the general public and by the Department of Health is a problem."* PTM011 Private practice

One manager expressed a belief that the public do not understand what physiotherapists do or that they were confused about the physiotherapy profession because of the competing physical therapy profession.

> "*there were people who were members of the public who had no idea what a physio did, what this all meant*" PTM009 Public hospital

There was also a perception that other professionals working in the health care system do not understand what physiotherapists do.

Mentoring

A prevalent subtheme within professional identity was mentoring. The managers spoke of their experiences of having a mentor or coach and whether they felt that was a

worthwhile experience. Many managers spoke positively of having a mentor and reported that it was something that they would recommend to others.

> "*I had when I started, he's since retired, excellent idea for a person who's new to the service alright. He was excellent, everything was very confidential, you could bounce anything off him, I felt safe talking to him and especially I didn't know anything here at all. And he let me form my own ideas and opinions but yeah excellent idea*." PTM016 Private hospital

Other managers spoke of their intention to get a mentor, however two managers expressed concerns about looking for and finding an appropriate mentor. Only three of the managers spoke of being a mentor to others.

> *"People come to me and ask me things and I'm always helpful to them and I give them plenty of chat and information, so people use me but I have never gone to anybody else*." PTM010 private practice

Four managers reported having an informal mentor rather than a formalised relationship and seven of the managers reported that they did not have a mentor.

> "*In this profession? No. Nobody I would say I followed or looked up to*." PTM011 private practice

Similar to a mentor, three managers spoke of having a coach and of finding this to have been helpful.

Related to the subtheme mentor was the concept of role-models. There was recognition that it can be a positive influence to have a role model. The managers gave examples of the role models that they had had in their careers and leaders who had inspired them. Six of the managers spoke of trying to be good role models themselves.

> "*Lead by example is always a good one. Certainly the people who inspired me in my early career were the people who I'll always look back and go, 'They did that really well'*" PTM014 Public hospital

<u>Identity as a physiotherapist</u>

The final subtheme was 'Identity as a physiotherapist'. There were fewer comments within this subtheme. One manager spoke of trying to maintain the physiotherapy identity of their team, while another expressed a belief that the best physiotherapy leaders embraced their physiotherapy identity.

"*But I think the really good physiotherapy leaders are physiotherapists first and foremost and they see what the role of a physiotherapy leader is in terms of our professional background*." PTM008 Primary care/public hospital

The symbolic significance of maintaining a clinical role as a physiotherapist or of helping the team when they were very busy was expressed by a few of the managers. Four managers spoke of the importance of keeping in touch with the service and understanding what their team members were experiencing.

> "*I found all these things now on twitter, a good leader a day a month goes up and becomes a healthcare assistant. Over the last while there have been opportunities that if we are down staff or something happens, that I actually step in. I am trying to be a good role model, that you're involved, that you understand the stress*." PTM013 Public hospital

6.3.5. Other Themes

Additional themes and subthemes in the data that were not accounted for in Bolman and Deal's (1991, 2008) framework are displayed in Table 6.7. As discussed above, 'Challenges' was a principle theme and 'Workplace', 'Physiotherapy profession' and 'Clinical role' were less significant themes.

Table 6-7 Additional themes

Theme	**Subthemes**
Challenges	• Time constraints • Lack of resources • Other professions • Changing structure
Workplace	• Voluntary hospital • Primary care/community • Private practice • HSE
Physiotherapy Profession	• ISCP • CPM
Clinical role	• Clinical focus • Evidence Based Practice • Patient centred care • Health promotion

6.3.6. Challenges

The theme 'Challenges' encompassed the challenges that the physiotherapy managers perceived themselves to be facing in their role as physiotherapy leaders and the challenges facing the physiotherapy profession. The most prevalent of these formed the subthemes within this theme: *time constraints, other professions, lack of resources* and *changing structure*. Other challenges reported by the managers included that physiotherapy is still developing as a profession, registration and protection of the professional title, influencing others, the structure of hospital physiotherapy departments, the standard of physiotherapy graduates and the unwillingness of physiotherapists to demonstrate leadership.

6.3.6.1. Time Constraints

Time constraints and having too much work to do in the allotted time were reported by several of the managers.

> *"I became so busy that I literally was in here not being able to do that. I very much have an open door policy, it's always open. It was getting closed more and more because I just physically couldn't do the work and have the staff coming in at the same time."* PTM001 Public hospital

Three managers reported that their heavy workloads meant that it was difficult for them to do leadership activities additional to their day-to-day administrative tasks.

> "*A barrier for me would be the volume of work that I have like it's huge, it's just phenomenal actually.....I find that the volume of work that I have really conflicts with taking on all that extra work*." PTM004 Primary care

The heavy workload demands and time constraints experienced by their team members were also highlighted by three of the managers.

> "*we're looking at trends and we're saying well the activity is still the same but certainly on the ground the staff would feel that they don't have the same amount of quality treatment time with patients*" PTM014 Public hospital

The time constraints subtheme was more prevalent among the physiotherapy managers who worked in hospitals and primary care. However, there was one private practice manager who also reported difficulties with having too much work and not enough time due to the size of her practice.

> "*I think I do too much of it, I think it becomes too much, I think it's very hard to*

control how much it becomes. I think physiotherapy, once you're a physiotherapist it becomes very dominant in your life and I think that that is too much." PTM010 private practice

6.3.6.2. Other professions

The physiotherapy managers also discussed the difficulties and challenges associated with working with other professions. This subtheme was particularly prevalent among the physiotherapy managers who worked in public hospitals. There were complaints that colleagues from other professions did not heed advice from a physiotherapy manager or were resistant to their requests.

"*It's difficult because you are co-ordinating people who aren't in your discipline but you aren't their line manager so they're not accountable to you as such. So sometimes I've had difficulties around maybe staff not really responding to team co-ordinator requests but if it was coming from their manager they would do it a little more promptly.'* PTM003 Public hospital

Four of the managers expressed a belief that the physiotherapy profession was not as influential or powerful as other healthcare professions. There were comments made about the nursing profession and about the positions that they held within hospitals.

"*I think they are quite a powerful group, probably because physios are in a minority that we wouldn't have as much strength or probably wouldn't be recognised as much for those kinds of roles*." PTM005 Public hospital

Another area where physiotherapists faced a challenge from other professions was in terms of competition for patients and for business. Three managers (from a public hospital, private hospital and private practice) spoke of this challenge.

"*I really think that's the biggest challenge to us, there are so many other people that are saying, 'We do this, we do this, we do this, we do this'. And almost encroaching on what would be a physiotherapy scope of practice, and we can't blame them. What we can say though is that we need to shout louder that actually this is what we do and I think we just haven't in the past*." PTM009 Public hospital

6.3.6.3. Lack of resources

Lack of resources was another challenge faced by the physiotherapy managers. Within this subtheme, the managers spoke of financial restraints and insufficient staffing levels. One manager reported that the recession and budget cuts were his biggest challenge while another spoke of the effect of the recession on her business

> "*I think it's the money..... I think there's been a lot of lack of money over the last few years, there hasn't been money*." PTM013 Public hospital

Financial constraints meant that one manager's clinic was unable to pay her for the administrative tasks that she had to do.

> *"But the reason I'm not doing it is because financially we're not set up to be able to do that, so our clinic cannot afford to pay me to do the two days at the moment that it would cost the clinic to pay me to run it"* PTM010 Private practice

The other limited resource was staffing; three managers spoke of the challenge of ensuring they have sufficient staff members to meet the demand.

> "*I always got a challenge out of lateral thinking and finding new ways of managing services with limited resources but it's become so challenging in the last three years, four years, with huge numbers increasing in middle management and numbers decreasing on the frontline*." PTM017 Primary care

The physiotherapy managers recognised that this lack of staff members put their team members under pressure and saw it as a source of discontent within the wider multi-disciplinary team.

> "*So five maternity leaves, we might get about one and a half in cover. So that leaves a massive hole. And say you have someone on sick leave as well, suddenly people are seriously challenged*." PTM015 Public hospital

6.3.6.4. Changing Structure

The most prevalent subtheme under 'Challenges' was that of *changing structure*. There were many references to change in structure: change in the structure of their immediate workplaces, change in the structure of the hospital that they work in, change in primary care structure, change in personnel, and change in the health care system generally.

This subtheme was particularly prevalent among the managers who work in primary care and the changes in primary care were even noted by managers working in other areas.

"*there was a proposal that the actual line managing structure will be taken away, which is actually a concern because the numbers that are currently in the department is, you know, is barely manageable with one person, and then with that gone I think there would be huge concern for the profession but also for the service as well*" PTM004 Primary Care

One participant who worked as manager of a physiotherapy team working in both a public hospital and primary care spoke extensively on this subtheme and how challenging she found the current changes.

"*I suppose change is unsettling and we've been talking about change for quite a while and they bring in change and then they change again and they change again so they're not allowing anything to bed down so that makes it very unsettling."* PTM007 Primary care/public hospital

Other managers also spoke of how they found the constant change to be a challenge and of how this change impacted different areas of their work and their teams.

"*I think another challenge is the ever changing structure of the health service in Ireland….and it's just changing all the time and it's trying to navigate the system, I think, and make sure that we're best using our resources. So you know even things like how we've traditionally done work is not necessarily the best way of going forward*" PTM014 Public hospital

There was also acknowledgement of the physiotherapy managers' lack of control regarding the changes, and lack of knowledge regarding further changes that may occur.

"I think the clinical directorate structural changing and our input into that now is that we probably haven't had very much as allied health" PTM013 Public hospital

In contrast to this, one private practice manager spoke of changes to the structure of her business that she and her fellow managers had implemented. Despite being in control of the change this manager still spoke of finding the change to be challenging.

6.3.7. Clinical Role

Another theme that did not fall within the Bolman and Deal Framework was 'Clinical role'. The physiotherapy managers spoke about whether they still had a clinical role or not. Eight of the physiotherapy managers reported that they had a clinical caseload and the physiotherapy managers who worked in private practice all had full-time clinical workloads.

The private practice/private hospital physiotherapy managers spoke of enjoying the clinical aspect of their role. For some they much preferred their clinical role to their managerial role.

> "*Yeah I love the physio side of things and I probably hate the managerial side of things.*" PTM018 Private practice

However, another private practice manager spoke of the difficulty of being a leader when you are working as a clinical physiotherapist.

> "*I'm a full-time clinical physio and I'm trying to be a leader within that, I think that is too hard. I think as we've established there, that it's much more enjoyable to be a leader if you're trained to be a leader. And I think to be mainly clinical and then to be doing the leader thing is just very hard*." PTM010 Private practice

Two of the managers spoke of feeling out of touch because they only had a small clinical caseload now or didn't work clinically at all anymore.

> "*I don't really have enough to really get good experience, I suppose sometimes I feel I do an assessment but I haven't done one for a long time so your skills tend to need brushing up on, you know, it's difficult to keep up to date*." PTM003 Specialist service

A recurring perception was that physiotherapists were too focused on their clinical role. Some of the managers were critical that physiotherapists did not recognise that there was more to their role than their clinical caseload or that they were reluctant to work beyond their clinical role at times.

> "*a lot of the staff are really clinically focused, they really, really want to do their job, they want their job to be about them and the patient and maybe the multi-disciplinary team that surrounds that patient but they don't really want to push beyond that and expect you to do all of that for them.*" PTM008 Primary care/public hospital

Two of the managers spoke of recent graduates and undergraduate students in particular being too clinically focused and not looking at the bigger picture of their role.

Another subtheme within 'Clinical role' was the concept of patient centred care. The majority of the managers spoke of the importance that they and their staff placed on delivering high-quality care for patients. The managers gave examples of the approaches they took to improve the quality of care they provided for patients and also the ways in which they ensured that the needs of the patient were met.

> "*encourage them to be aware of the quality of their treatments. I suppose I try to lead by example and promote patient centred care*." PTM005 Public hospital

Other subthemes within clinical focus were health promotion and evidence-based practice. The physiotherapy managers who worked in primary care were particularly aware of physiotherapy's role in health promotion and there were comments that this was a missed opportunity that physiotherapists should be leading on.

> "*more emphasis on self-management and health promotion from a self-management way. That's a huge thing that we're trying to promote now*." PTM007 Primary care/public hospital

Evidence-based practice was a less prevalent subtheme but it was discussed by a three of the managers.

6.3.8. Physiotherapy Profession

This theme covered the managers' thoughts and views of being a physiotherapist and of the physiotherapy profession.

> "*I think we're in a lot of unchartered water, I think physiotherapy is a new profession and there's no or very few templates to follow. I think we're developing our own templates, I think in 20 years time it'll be easier for other physiotherapists coming along"* PTM012 Private Practice

There were both positive and negative comments about physiotherapists as professionals. The positive comments described physiotherapists' ability as musculoskeletal practitioners, their leadership skills, their hardworking nature and their drive and ambition to succeed.

> "*Well first of all physios are self-starters, they're generally very intelligent people, and most physios are finishers; they like to get a job done and done well*." PTM017 Primary Care

However, there were also negative comments about physiotherapists. One physiotherapy manager criticised physiotherapists' abilities as communicators and negotiators. While another physiotherapy manager was particularly critical of the profession as a whole and pessimistic about its future.

> "*So I think there are major problems there but again I think the profession as we know it will fizzle out in this country, it will fizzle out of this state*." PTM011 Private Practice

Also within this theme were comments about the professional body, the ISCP. One manager highlighted the importance of the role of the ISCP:

"*As a professional body our only lobby group is through the ISCP and the union IMPACT, and it's really important that all physiotherapists are aware of that*." PTM017 Primary care

However, another manager was critical of the ISCP and perceived that it was not effectively fulfilling its role, particularly with regard to protecting the title of physiotherapy in Ireland.

"*I think protection of the title; the opportunities have been lost to do it. There have been opportunities to do it and I think the society have failed. I think they haven't been aggressive, enough, they haven't taken the opportunities that were handed to them, and I know there were opportunities handed to them*." PTM011 Private practice

The physiotherapy managers also spoke of the Chartered Physiotherapists in Management group in the ISCP. Five of the managers spoke positively about this group. The courses run by the CPM and the opportunity to meet with other managers were found to be very helpful.

A smaller subtheme was around the female majority of the physiotherapy profession. One manager was critical of female physiotherapists not challenging themselves or taking risks. While two other managers spoke of the challenges of working in a team that is mostly women e.g. maternity leave, time off for sick children.

"*most of the people working with me are female so they have babies, they get pregnant, they have miscarriages, the babies are sick, the children are sick, all of factors can affect how the patients are treated because people have to cancel their lists or whatever*" PTM006 Private practice

6.3.9. Workplace

The final theme was 'Workplace'. This theme encompassed the many comments on the impact that their workplace has on their role as a physiotherapy leader and manager. The managers spoke of the challenges and benefits specific to their working environment and many made comparisons between their work environment and the experiences and conditions of other workplaces.

One subtheme within the 'Workplace' theme was the *Health Service Executive (HSE)*. The primary care managers demonstrated an awareness of, and took into account, the priorities and plans of the HSE in their work.

"*In terms of allocation, or deciding on quality initiatives, often it's based on identified goals, and part of what would feed into that sometimes would be profiling of waiting lists or other potential HSE priorities*." PTM004 Primary care

Also within the subtheme of the HSE were statements about difficulties with bureaucracy and the recruitment process.

"*I suppose the bureaucracy in the HSE and the fact that we are disempowered from doing certain things by systems and processes being pulled nationally, that things that should leave more local flexibility that we could do a few years ago, we've been disempowered from doing*." PTM007 Primary care/public hospital

A physiotherapy manager working in a voluntary hospital spoke of the flexibility that she had in certain aspects compared to being in a HSE hospital. Similarly, a physiotherapy manager who was currently working in a HSE hospital but who had previously worked in a voluntary hospital remarked on having less leverage in the HSE hospital.

"*Well, we're a voluntary hospital, which does give us a lot more flexibility. For example, my business plan would never have got passed if we were a HSE hospital because there is a little bit more autonomy.*" PTM002 Public hospital

In keeping with this, a physiotherapy manager working in a private hospital appreciated the greater level of flexibility and autonomy that she had because she did not work directly for the HSE.

"*the decisions regarding my areas are made locally as such, which is great, when I hear the frustration of other colleagues within the HSE*." PTM016 private hospital

A physiotherapy manager working in a specialist service spoke of the funding relationship that her workplace had with the HSE and thus the impact that had on them.

"*So we're funded by the HSE so it's an interesting relationship because while we have some autonomy I suppose, we've some autonomy as regards how the budget is spent we don't have obviously input as to how much of the budget we get so we're very much dependent on how much the HSE give in the budget."* PTM003 Specialist service

The primary care managers described challenges that were specific to their workplace. These challenges included the geographical spread of their staff, being unable to actively supervise the work of their team, the generalist nature of primary care practice and the on-going changes to primary care in Ireland.

"*And in actual fact if anything a community service given its complexity of staff numbers and geography and multi-services is much more difficult to manage than a one site hospital*" PTM004 Primary care

While the primary care managers spoke of the specific challenges that they faced in their role, three other managers were less accommodating of the perceived challenges and were critical of primary care services.

> "*thinking of the patient flow and things like that, community services can certainly be a barrier to how we work I suppose, services run within a hospital and the community aren't aligned, need to be more aligned. I think even professionally physiotherapy services between the acutes and primary care could be more streamlined but I think there needs to be more of an openness on how that's done, and I think there's a lot of work to be done*." PTM014 Public hospital

The differences between physiotherapy managers working in different areas were highlighted by several managers. Both physiotherapy managers working in primary care and in hospitals reported a divide between the two services.

> "*One concern that I have from a physio perspective is around physiotherapists who work in community services and who work in acute care and a lack of, in some ways, respect for each other. There's almost like a 'we're better than them' or 'they're better than us' type of mentality and I think that's very detrimental to our profession*." PTM004 Primary care

A divide between physiotherapists working in private practice and in hospitals was also noted by one private practice manager.

> "*Well first of all throughout my career there's a divide between the private physiotherapist and the hospital based physiotherapist, and patients will frequently come in and say, 'I mentioned that I was attending you and the physiotherapist gave out to me' or was nasty to me or have told me that I can't come to them anymore. I think physios have failed to behave professionally towards each other*." PTM011 Private practice

However, in contrast, another private practice physiotherapy manager spoke of being impressed by the leadership abilities of hospital physiotherapy managers.

> "*I'm very impressed with physiotherapy with how the hospital leaders, I know that they're very well qualified and I'm always really in awe of them and of their qualification.…and I think certainly that they have so much more to deal with than I might have in my private practice setting*." PTM010 Private practice

One private practice physiotherapy manager discussed the importance of the manager of a physiotherapy team in a hospital being a leader but reported that she does not see herself as a leader. However, later in the interview she reflected that she probably was a leader in private practice.

"it never occurred to me that I am a leader but I did think there probably aren't that many people in the private practice sector who are heading up a team of people of excellence so for that reason I probably am a leader." PTM006 Private practice

Another private practice manager perceived there to be fewer barriers to demonstrating leadership in private practice because they were only responsible to themselves and not answering to a higher authority.

"*I think again it's all relatively new and certainly from the private practice point of view we have no barriers, we can do a lot of what we want to do and we can put it into practice*." PTM012 Private practice

6.4. Discussion

The first objective of this study was to describe the perceived leadership capabilities of physiotherapy managers in Ireland using the four frames of the Bolman and Deal leadership model. The physiotherapy managers in this study demonstrated use of all four leadership frames, however, in keeping with the results of the survey in the first part of this study, the physiotherapy managers were more positively disposed towards working through the structural and human resource frames. The leadership capabilities described by the managers on each of the four leadership frames will be discussed below.

6.4.1. Theme 1: The Structural frame

The managers in this study indicated frequent use of the structural frame through their strategies to ensure the efficient and smooth running of their workplace in the *operations* subtheme, and through their approaches to goal-setting and planning, and adherence with policy and procedure in the *strategic planning and alignment* subtheme.

In 2002, Schafer wrote that there was scant literature describing the nature of physiotherapy managerial work (Schafer, 2002) and little has been added to this literature since then. However, the management and leadership skills needed by entry-to-practice physiotherapists (Lopopolo et al., 2004, Schafer et al., 2007), and the importance of managerial work categories for physiotherapy managers have been explored (Lopopolo et al., 2004). The *operations* subtheme in this study provides useful information on the administrative and managerial tasks that physiotherapy managers perform. The managers spoke of the strategies and approaches they used in co-ordinating their services: time management, meetings, delegation, and management of

team finances. Financial control and resource allocation were among the top five rated managerial roles in a survey of three groups of physiotherapists (Schafer, 2002). Resource allocation has been defined as 'to distribute resources to achieve organizational objectives related to outcomes, costs, and satisfaction' (Schafer et al., 2007). While only a small number of the physiotherapy managers discussed managing their budget or the financial aspect of their role, many of the managers spoke of monitoring staffing levels and moving team-members around as necessary to ensure that the needs of the service were met.

Time management was a prevalent subtheme within *co-ordinating services*. The managers discussed strategies they employ to manage their time effectively and of assisting others to manage their time. Effective leaders use self-discipline to organise tasks and assign priority to projects, as well as demonstrating delegation skills to effectively manage time (Contino, 2004). Delegation was a strategy used by many of the managers to share tasks and projects. Thompson (2012) spoke of the importance of appropriate delegation to prevent staffing problems in nursing and discussed how nurse managers can effectively delegate by taking a transformational leadership approach to their work e.g. stressing the importance of delegated tasks to the bigger project, being sensitive to subordinates' capabilities.

When working through the structural frame leaders clarify responsibilities and expected contributions, hold people accountable for their results, and develop clearly defined roles and relationships appropriate to what needs to be done (Bolman and Deal, 1991, 2008). This was reflected in the *accountability* subtheme in this study where the managers discussed reporting relationships within their organisations, performance reviews and documentation. Managers working in large hospitals or in primary care reported more complicated hierarchies and that they were accountable to more than one manager. The private practice managers, in contrast, had much simpler organisational structures and little hierarchy. The structure of an organisation is important to consider; formal structure enhances morale if it helps people to get their work done but it can have a negative impact if it gets in the way, buries people in red tape or makes it too easy for management to control others (Bolman and Deal, 2008). While most of the managers in this study spoke of their preference for clear structure and procedure, some of the managers in this study complained of bureaucracy in their workplaces. In a review of how organisational structure influences leadership behaviour, Brazier (2005) found that bureaucratic structures encourage a transactional style of leadership, whereas a transformational style of leadership is facilitated by a more organic structure.

Performance reviews were used by the managers to monitor the work of their team members, discuss key performance indicators or targets, and check compliance with department rules and procedures. In healthcare, performance measurement is used to monitor the quality of care within an organisation and to promote quality improvement activities (Mainz, 2003, Copnell et al., 2009). The CSP in the UK recommends that appraisals are completed on a regular basis (every 6-12 months) to provide evidence of skills and competencies, review attainment of objectives, consider any difficulties and reflect on progress (CSP, 2015). Performance review in terms of patient statistics and individual targets for team members was especially prevalent among physiotherapy managers in private practice. A private practice physiotherapy clinic is clearly a business (Wassinger and Baxter, 2011) and so it is unsurprising that these managers are focused on monetary targets. The results of the survey in Study 1 (see section 4.4.6) demonstrated that physiotherapists working in private practice rated business acumen as more important than physiotherapists working in other settings.

The physiotherapy managers guided, monitored and evaluated the work of their team through documentation. Documentation is an essential part of every health professional's daily activity. In healthcare, documentation needs to be of a high standard to ensure professional and legal requirements are fulfilled and to facilitate communication between healthcare professionals (Phillips et al., 2006).

The physiotherapy managers also spoke of documenting data and statistics for their service. The amount of data in healthcare is increasing at a fast rate (Wills, 2014). Healthcare data are increasingly relied on when targeting quality improvement efforts and are essential to performance assessment strategies (Pine et al., 2012). In this study, there were many examples of using statistics from their service to measure performance, guide development and monitor change. It is now widely accepted that the quality of health care should be systematically assessed and evaluated (Mainz, 2008). Physiotherapy managers can use quality indicators to identify gaps in care, measure achievement, undertake quality improvement initiatives, guide strategic planning, and report achievement of targets to key stake-holders (Westby et al., 2016). The managers were aware of the importance of having data to support their applications for additional staff or resources and to communicate the value of physiotherapy interventions. Quality-based care is central to physiotherapy and it is important that physiotherapists can make their treatment effectiveness evident to patients, managers, employers and funders (Westby et al., 2016).

The physiotherapy managers were able to assess the quality of the documentation in their department by performing audits. The Chartered Society of Physiotherapy (CSP) in the UK recommends in their Quality Assurance Standards document that regular audits of record keeping are planned, performed and action taken as a result (CSP, 2013c). Gumery et al. (2000) audited physiotherapy documentation at an adult cystic fibrosis unit and implemented recommendations based on this audit (e.g. in-service training, development of local standards) before re-auditing the service. Results demonstrated that the quality of physiotherapy record documentation was improved through audit and subsequent implementation of recommendations. In an Irish context, an audit of physiotherapy students' documentation was able to highlight areas in need of immediate improvement including consent and risk assessment (Groeger et al., 2015). Audits were also used by the managers to monitor compliance with departmental policy, to assess current practice and to guide quality improvement initiatives. Involvement in clinical audit allows healthcare professionals to increase their knowledge and understanding of effective practice and thus enhance the effectiveness of the care they deliver (Gumery et al., 2000).

The other subtheme within the structural theme was strategic planning and alignment. This subtheme encompassed planning, goal setting and adherence to policy and procedure. The importance of planning in healthcare leadership and management has been recognized (Schwartz and Pogge, 2000, Stefl, 2008). Managers from public hospitals and primary care in particular discussed strategic plans and planning for their department. Planning is an important leadership role and when done well may offer many benefits including: the promotion of strategic thinking, acting and learning, improved decision making, enhanced organizational effectiveness and legitimacy, and direct benefits for team-members by enabling them to better perform their roles and meet their responsibilities (Bryson, 2012). The managers in this study spoke of setting goals for the team, for individual team members and for patients. In the healthcare setting, goals help to keep managers focused on the big picture rather than getting lost in the minute details of planning (Marquis and Huston, 2009).

Policy and procedure were important to the managers in this study. The managers discussed how they used policy and procedure to induct new team members, provide clarity for staff, ensure that matters are conducted fairly, aid the development of new services and provide consistency and order. This was consistent with O'Donnell and Vogenberg (2012) who wrote that having policies and procedures in place helps

individuals to accomplish their work, facilitates decision making and reduces the likelihood of causing harm to patients. The importance placed on policy and procedure in this study also reflects the importance placed on professionalism in Study I (see section 4.3.4). In the survey in Study I professionalism was defined as 'align personal and organisational conduct with ethical and professional standards'. Respondents to the survey in Study I highly rated the importance of professionalism in the workplace, the healthcare system and society.

Clinical protocols and guidelines were discussed by some of the managers. The importance of following protocols in areas like orthopaedics or acupuncture was recognised and a small number of the managers reported being involved in writing clinical guidelines in their workplaces. Evidence is growing to support the effectiveness of using clinical guidelines in physiotherapy (Bekkering et al., 2005, Fritz et al., 2007, Rutten et al., 2010), so it is important that physiotherapy managers promote their use. In a study which investigated whether higher levels of adherence to physiotherapy guidelines for low back pain was associated with improved outcomes, Rutten et al. (2010) found that higher rates of guideline adherence were found to be associated with better improvement in physical functioning and with lower utilisation of care.

Individuals whose natural inclination is to work in the structural frame can make a valuable contribution to their organisation through their ability to organise teams, focus on the task and identify structural gaps or overlaps (Bolman and Deal, 2014). Analysis of the interviews with the physiotherapy managers in this study suggest that they use the structural frame in their work and, therefore, that they approach their work in a rational, logical way and use procedures, policies and goals to guide their team. However, Bolman and Deal (2014) warn that leaders who lean heavily towards the structural frame are at risk of becoming rigid, authoritarian micromanagers and may have difficulty seeing and dealing with messier and less rational human, political and symbolic issues.

6.4.2. Theme 2 – The Human Resource Frame

The language used by the managers in this study demonstrated the emphasis they place on relationships and working well with others and thus indicated their use of the human resource frame. The leadership capabilities discussed by the managers associated with human resource frame included development of others and themselves, interpersonal skills and communication strategies.

Developing the skills of their team and ensuring that they had access to appropriate training opportunities were emphasised by the managers. This finding is consistent with the healthcare literature, where the role of the manager in supporting continuous professional development (CPD) by permitting or with-holding CPD opportunities has been recognised (Gould et al., 2007, Haywood et al., 2012). It is the manager's responsibility to match staff development to service needs and identify individuals with the motivation and ability to maximise the benefit of CPD opportunities (Lillyman et al., 2008, Haywood et al., 2012). By facilitating and encouraging CPD activities managers are able to demonstrate the value they place on their team-members (Haywood et al., 2012). In a qualitative study which investigated nurses' perceptions of CPD, Gould et al. (2007) found that 'good' managers were perceived to be those who encouraged staff to take study days and were able to promote effective learning opportunities. Therefore, as reported by the participants in this study, managers should actively promote the provision of, engagement with and learning from CPD activities (Haywood et al., 2012).

As well as supporting the development of their team, the managers also spoke of the leadership development that they engaged in. The majority of the managers reported that they had participated in leadership development activities which suggests that they place importance on developing skills in this area. The managers were generally positive about these experiences, however, several also noted that experience of addressing situations that required leadership skills was also an important way to develop skills in this area. The role of experience in developing leadership skills has been recognised (Hezlett, 2016) and studies of physiotherapy students have demonstrated that experiential learning can be an effective way to develop leadership skills (Wilson and Collins, 2006, Black et al., 2013).

The managers in this study used several strategies to motivate their team including setting personal development plans, organising team-based activities and projects, giving feedback, encouraging new ideas and supporting individual's interests. These strategies again reflect the interest that the managers take in their team-members and their ambition to develop the people on their team. Motivating others is an important aspect of leadership (Mumford et al., 2000, Kark and Van Dijk, 2007) and was also highly rated as an important leadership capability in the workplace by physiotherapists in Study I (see Section 4.3.4).

Leadership qualities and skills that the physiotherapy managers perceived themselves to demonstrate, or to be important to leadership, included teamwork, social skills, self-awareness, respect, fairness and empathy. These were similar to the results of Heath et al. (2004) who conducted focus groups with nurses to validate the literature on what makes a healthy work environment. The characteristics of a healthy work environment were found to be respect from colleagues, caring relationships, teamwork, open communication and trust, and where team contributions are valued.

The value the managers place on contributions from their team was captured in the *open to ideas and opinions* subtheme. The many comments and language used in the communication subtheme demonstrated the high level of importance that the managers placed on effective communication with their team and others. This finding concurred with the results from Study I where respondents rated communication as the most important leadership capability in the workplace, the healthcare system and society (see Section 4.3.4). In the leadership literature, the importance of communication to effective leadership has been recognised (Madlock, 2008, Riggio and Reichard, 2008, Hackman and Jackson, 2013) and a leader's interpersonal communication style is appreciated as a core aspect of leadership (De Vries et al., 2010). In healthcare, Ennis et al. (2013) explored the attributes required for successful leadership in mental health nursing in a grounded theory informed study. Consistent with the perceptions of the physiotherapy managers in this study, the participants recognised that effective communication was essential for successful working relationships and clinical leadership.

The managers in this study recognised the importance of listening to their team members and of acknowledging their opinions and ideas. Bolman and Deal (2008) contend that giving team members more opportunity to influence work and working conditions, i.e. participation, is a powerful tool to increase both morale and productivity. If a leader is democratic, supportive, and welcomes challenges, team members are more likely to feel greater psychological safety in their team and thus more likely to feel that speaking up is safe (Nembhard and Edmondson, 2006). Human resource leaders ask others for their opinion of how things could be improved and involve others in decision-making (Bolman and Deal, 2008), thus demonstrating inclusive leadership. In a study of leader inclusiveness in neonatal intensive care units, Nembhard and Edmondson (2006) found that leader inclusiveness was positively associated with psychological safety and engagement in quality improvement work.

Many of the managers in this study appreciated the importance of both giving feedback to those they work with and of receiving feedback about themselves. By providing recognition of work well done, and constructive criticism when improvement is needed, the managers can facilitate team effectiveness and guide the continuing development of their team members (Künzle et al., 2010). Additionally, receiving feedback on their own performance may allow the managers to become aware of areas where they could improve. In healthcare, this feedback may be particularly important because a lack of upward feedback can have adverse effects on direct patient care and health outcomes (Adelman, 2012).

As with the structural frame however, leaders focused solely on leadership capabilities associated with the human resource frame may be limited in their effectiveness. Leaders who only use the human resource frame are at risk of being overly optimistic about meeting both individual and organisational needs, can have a romanticised view of human nature, and may neglect structure and the realities of scarcity and conflict (Bolman and Deal, 2008).

6.4.3. Theme 3 - Political Frame

While some people may not like working through the political frame, Bolman and Deal (2008) argue that political dynamics are inevitable under three conditions: ambiguity, diversity and scarcity, and these are conditions most managers face every day. The language used by the managers in this study suggested variation in their perceived effectiveness at demonstrating capabilities associated with the political frame. Some of the managers described successes in employing political frame strategies, however others reported difficulties or appeared less confident at demonstrating these capabilities.

The *organisational citizenship behaviour* subtheme encompassed activities that the managers engaged in to benefit themselves, their team, their organisation or their profession. In the political frame, leaders are advocates who build a power base and create coalitions (Bolman and Deal, 1991). By becoming involved in research or joining committees the managers may be able to increase their profile within their organisation and/or the health service (APA, 2015b).

Also within this subtheme, some of the managers spoke of promoting the physiotherapy profession and of looking for opportunities for themselves or their team. The need for physiotherapists to engage in advocacy for the profession has been highlighted (Malone, 2001, Desveaux and Verrier, 2014, Kelland et al., 2014, APA, 2015b). Desveaux and Verrier (2014) reported that advocacy is an essential component of leadership and that to raise the profile of the profession physiotherapists need to convey the value of physiotherapy to the success of the health care system. In its report on the future of the physiotherapy profession in Australia, the APA (2015b) argued that to successfully navigate the complex and dynamic public health system the physiotherapy profession requires clinicians and managers who can be influential advocates in the health system. Internationally there have been examples where sustained local advocacy has been successful in driving legislative change e.g. direct access to physiotherapy was attained in the Netherlands for the first time in 2006 (Kruger, 2010). Only a small number of the physiotherapy managers in this study, however, discussed the need to promote their service or the physiotherapy profession, and some of them were critical that opportunities to promote the profession were being missed. In a qualitative study where advocates in the physiotherapy profession were interviewed, Kelland et al. (2014) identified eight attributes perceived to be important for excelling in the advocate role and suggested that these skills be integrated in the development of advocacy skills.

The *collaborations* subtheme in this study encompassed working with others to achieve things, networking, and liaising with medical consultants and other managers. In discussing the importance of networking and building coalitions, Bolman and Deal (2008) contend that managers often fail to get things done because they rely too much on reason and too little on relationships. Bartol and Zhang (2007) argue that networking skills are critical to leadership because they help leaders to develop leadership capacities through leveraging existing connections and building new ones. In healthcare, Kelly (2011) advocated the importance of networking for nurse leaders. Networking is a valuable power strategy that refines interpersonal skills and creates a system of individuals who are sources of information, advice and support (Kelly, 2011). However, only a few of the managers recognised the importance of networking or gave examples of networking themselves.

Bolman and Deal (2008) contend that the first step in developing networks and collaborations is to determine whose help you need. Several of the managers in this study spoke of liaising with medical consultants or other managers. The managers perceived the consultants to have power and influence and thus believed that gaining

their support can help them to achieve their ambitions. Although medical dominance in the healthcare system has moderated over time it continues to have a relevance and an impact (Nugus et al., 2010, Bacon and Borthwick, 2013). In a study that investigated interprofessional relations in healthcare, Nugus et al. (2010) found that medical doctors see themselves as key decision makers in patient care and patient pathways through the health system, and in keeping with this study, that other clinicians share this perspective.

Political leaders recognise that power is central to their effectiveness and that they need to know how to use it judiciously (Bolman and Deal, 2008). In contrast, many of the managers spoke of feeling powerless at times in their role, of seeing their power lessen or of not being involved in decision-making in their workplaces. For public hospital and primary care managers there was frustration with the lack of physiotherapy representation at higher levels within their organisations or within the health service. The managers recognised the importance of having influence or power, however, the language of some of the managers suggested that they did not perceive themselves to have the level of power and influence over their service that they would like. There are a number of strategies that health care leaders can employ to build their personal power base including: developing effective communication skills, networking, goal-setting, mentoring, developing expertise and ensuring high visibility (Kelly, 2011).

There were contrasting opinions on levels of autonomy among the managers. While some of the managers described having the autonomy to make decisions in their workplace, others complained of being restricted in processes such as recruitment by legislation from the HSE. Sandstrom (2007) reported that there are two main sources of social force acting to restrain and redirect professional autonomy: threats external to the profession and weaknesses within the profession itself. The threats from outside the profession include professional domination, rationalisation and deprofessionalisation. Professional domination refers to the control of aspects of a profession's work by another profession, rationalisation refers to the tendency of people to organise society by developing formal rules, responsibilities and hierarchies, and deprofessionalisation refers to the objectification of the trust relationship between the professional and individual by rules, regulations and protocols. The internal threat to professional autonomy is insularity; the inward focus of a profession that ignores the social views and forces outside the profession. Sandstrom (2007) concluded that physiotherapists need to recognise these pressures on autonomy and the emergence of new opportunities in the health care system.

The managers discussed the strategies that they employed to effect change or acquire resources in their workplaces. These strategies included negotiating, campaigning, writing business plans, and taking a tactical approach. A small number of the managers spoke of the importance of negotiation or gave examples of negotiating in their role. Successful negotiators understand not only their own position but are also well informed about the position of the other side (Kelly, 2011). Another strategy for influencing change was business cases. Wassinger and Baxter (2011) emphasised the importance of business cases to new ventures in physiotherapy including the introduction of new services, the expansion of current services and the planning of new academic course offerings. The physiotherapy managers in this study used business cases to request additional staff or training opportunities. While most reported that these were successful, some were less positive about the effectiveness of submitting a business case to influence change.

The final subtheme was *conflict management* which encompassed the managers' perceptions of conflict within their team, and conflict between themselves, or their team members, and people external to the team. In the early 20th century, conflict was considered to be destructive and indicative of poor organisational management (Marquis and Huston, 2009). When it did occur, conflict was ignored, denied or dealt with immediately and harshly. However, current sociological view is that organisational conflict should be neither encouraged nor avoided but managed, and that the manager's role is to create a workplace environment where conflict may be used as a stimulus for growth, innovation and productivity (Marquis and Huston, 2009). Some level of conflict in an organisation appears desirable because an organisation without conflicts is characterised by no change, whereas an optimal amount of conflict will generate creativity, a strong team spirit, a problem-solving atmosphere and motivation of the workers (Strack van Schijndel and Burchardi, 2007).

The managers in this study used communication strategies and the empowerment of others to address conflict and as such appear to approach conflict from a human resource perspective. Managers working through the political frame approach conflict by developing power through bargaining, forcing, or manipulating others to win, while managers working through the human resource frame address conflict through developing relationships and having individuals address conflict (Bolman and Deal, 2008). Dealing with conflict by using communication strategies can be an effective approach. Conflict often results from poor communication (Strack van Schijndel and

Burchardi, 2007) and often can be resolved through effective communication and careful listening (Kelly, 2006).

The majority of the managers used language which suggested that they were confident of their ability to address conflict issues successfully, however some of the managers were less comfortable with conflict or less confident in their ability to manage it effectively. In a nursing case study, Vivar (2006) reflected that many nurse managers do not feel sufficiently prepared to deal with conflict and, therefore, concluded that further courses on conflict should be available to empower nurses to use acquired skills in the pursuit of conflict resolution. Physiotherapy managers may also benefit from specific training to learn about conflict resolution strategies and expand their approach to conflict management.

Another type of conflict was the inter-professional rivalry that some of the physiotherapy managers discussed. There were several comparisons made between the physiotherapy profession and other health care professions. In particular, there were comments regarding positions of power attained by nurses in their workplaces or the wider health system, and the subsequent influence that they have. The need to have nurse representation on healthcare boards has been recognised by the nursing profession (Hassmiller and Combes, 2012). Similarly, the CSP in the UK has recognised the need to have physiotherapy representation across the health system but notes that currently representation at board level for physiotherapists is rare (Thornton, 2016). By pursuing managerial and executive positions within healthcare institutions physiotherapists will be able to ensure that the profession's agenda is at the forefront of strategic decisions (Desveaux and Verrier, 2014).

6.4.4. Theme 4 – The Symbolic frame

Organisational culture is an important factor in the symbolic frame. Some of the managers in this study spoke of wanting to facilitate a particular type of culture in their workplace, and others acknowledged the importance of a positive workplace culture. An organisation's culture develops over time as members develop beliefs, values and practices that seem to work and are then transmitted to new recruits (Bolman and Deal, 2008). Managers have an important role in shaping organisational culture for their team and must actively work to create the kind of organisational culture that will bring success (Marquis and Huston, 2009). It is crucial that managers are aware of their roles and

responsibilities in shaping a positive workplace environment (Kane-Urrabazo, 2006). Related to organisational culture was the atmosphere or ambience of the workplace. A small number of the managers spoke of the importance of the atmosphere of their workplace and the effect it can have on team members or patients.

Symbolic leaders use ritual, myth, stories and ceremonies to instil a sense of enthusiasm and inspire others (Bolman and Deal, 1991). Some of the managers spoke of having celebrations to mark people's birthdays or social milestones. Ceremonies play four major roles in organisations: they socialise, stabilise, reassure, and convey messages to external agencies (Bolman and Deal, 2008). One manager described celebrating World Physiotherapy Day and another reported celebrating the opening of a new rehabilitation area. However, overall the managers did not describe using rituals or ceremonies to inspire their team and help them to find meaning in their work. This omission may be significant because the magic of special occasions is vital in building significance into organisational life (Bolman and Deal, 2008).

The managers cited a range of core values in their interviews. Values characterise what someone stands for; the qualities they deem worthy of esteem or commitment (Bolman and Deal, 2008). The most frequently cited value concerned patient care and providing the best possible service for patients. Other values that were commonly reported were respect, honesty, integrity, fairness, caring/kindness and developing the skills of others. These values reflect the people-centred approach of these managers and suggest that they are using the human resource frame to frame their values. Aguilar et al. (2013) found similar results in their investigation of the professional values of a purposive sample of Australian physiotherapists. The three themes in the data of this qualitative study were 'the patient and the patient-therapist partnership', which included concepts such as patient-centred care and understanding the patient, 'physiotherapy knowledge, skills and practice', which included evidence-based practice and updating skills, and 'altruistic values' which included honesty, fairness, compassion and respect (Aguilar et al., 2013).

The symbolic frame shares concepts with transformational leadership. Transformational leaders are visionary leaders whose leadership is inherently symbolic (Bolman and Deal, 2008). The idealised influence and inspirational motivation elements of transformational leadership are displayed when a leader envisions a desirable future, communicates how it can be achieved, acts as role model and demonstrates confidence and determination (Bass, 1999). The leadership attributes or behaviours associated with the symbolic frame

in this study were being future-oriented, seeing the big picture and having passion. Being future-oriented or having a vision is an important aspect of symbolic leadership. Symbolic leaders communicate a vision, a persuasive and hopeful image of the future, that addresses both the challenges of the present and the values of followers (Bolman and Deal, 2008). Only a small number of the managers spoke of having a vision and of communicating this to their team. Related to having a vision is seeing the big picture. Visionary leaders help their team to understand how their work fits into the big picture and so can maximise buy-in for the organisation's overall goals and strategy (Goleman et al., 2013). However, again, only a small number of the managers spoke explicitly of taking a big picture approach to their work. More of the managers spoke of having passion for their role or for the physiotherapy profession. In his study of what makes an organisation go from 'good' to 'great' Collins (2001) emphasised that passion must be part of the culture and that leaders must demonstrate passion as well as analytical skills. Passion has been identified as critical to effective leadership in healthcare as leaders face increasing demands and uncertainties in this time of healthcare reform (Piper, 2005, Sukin, 2009).

The final subtheme in the symbolic theme was *professional identity*. There were few comments about professional identity specifically, only two managers spoke about their physiotherapy identity. Some of the managers, however, did speak of the importance of clinical experience or maintaining a clinical role to allow them to demonstrate to their team that they understood the challenges they face. The managers' values of providing optimal patient care in their service could also be said to reflect their professional identity. In a systematic review of physiotherapists' experiences of working in the acute hospital setting, Lau et al. (2016) identified professional identity/role as one of the themes. This theme found that physiotherapists get personal satisfaction by being able to deliver high quality services to patients and believe that it is an integral part of their professional duty (Lau et al., 2016).

In the *perceptions of the profession* subtheme, several of the managers discussed the reputation of their service and/or perceptions of the physiotherapy profession in general. While some believed that their service or the physiotherapy profession was positively perceived by others, other managers reported that there was confusion in the understanding of the physiotherapy profession. This was consistent with Masley et al. (2011) who found that physiotherapists working in acute care settings believed that the role of physiotherapy can be misunderstood. The physiotherapy managers in this study also noted confusion about the physiotherapy profession among the public. In a survey

of physiotherapists in the UK, Holdsworth et al. (2008) found that only 34% of physiotherapists believed that the public understood what physiotherapy is and what it has to offer. Similarly, as described in section 1.2, confusion regarding the physiotherapy professional title in Ireland among the public has been recognised.

The final subtheme was *mentoring*. Many of the managers described their experiences of having a mentor, however, only three of the managers reported being a mentor themselves. More frequently discussed was being a role-model, however, again this was only reported by a minority of the managers. Mentoring can bring significant benefits to the mentee, the mentor and the organisation they work in, and is used to support the development of future leaders (Warren and Carnall, 2010). The importance of mentoring in physiotherapy has been recognised (Naidoo, 2006, Ezzat and Maly, 2012, Takeuchi et al., 2008). In a qualitative study investigating the meaning of mentoring in physiotherapy, building passion was one of the themes (Ezzat and Maly, 2012). The participants perceived that the foundation of a mentoring relationship in physiotherapy is infusing the mentee with passion for the physiotherapy profession (Ezzat and Maly, 2012) which highlights to symbolic underpinnings of mentoring relationships.

6.4.5. Theme 5 – Challenges

The second objective of this study was to investigate the experiences of physiotherapy managers in Ireland of working in formal leadership positions and the challenges they face. This objective was addressed in the themes 'Challenges', 'Clinical role', 'Physiotherapy profession' and 'Workplace'.

Four main challenges were identified in the interviews: time constraints, other professions, lack of resources, and changing structure. While the managers discussed their time management strategies in the structural frame, these strategies were not entirely successful because half of the managers reported the challenge of facing excessive work demands for the time available. The managers may need to employ political frame strategies to gain access to administrative staff to whom they could delegate tasks, or to secure additional staff who can give more support to their team and reduce the pressure of busy caseloads. Having insufficient time for participation as a leader has been identified as a barrier to nurse managers demonstrating leadership (Khoury et al., 2011, Peltzer et al., 2015). In a large study where 1500 opinion leaders in the US were interviewed by telephone, time constraints were identified as a barrier to

leadership and the authors highlighted that nurses spend an excessive amount of time fixing problems caused by inefficient processes and systems (Khoury et al., 2011). This may also be the case for the physiotherapy managers in this study and again suggests that the physiotherapy managers may need to demonstrate leadership capabilities beyond the structural frame to address these problems. The authors concluded that nurse managers must be given tools to reduce administrative burdens and be better supported in developing delegation skills (Khoury et al., 2011).

The *other professions* subtheme covered the resistance the managers perceived to come from other professions, positions of power being dominated by those in other professions, and competing with physical therapists or other professionals who treat the same conditions as physiotherapists. As recognised by Salhani and Coulter (2009), all health professions are pursuing consolidated or expanded professional boundaries, and striving for the right to, or defence of, self-governance and autonomy. In a qualitative study in Switzerland, Schoeb et al. (2014) found that sports education, osteopathy and the fitness industry were perceived to threaten the status of the physiotherapy profession. As described in section 1.2, in Ireland the physiotherapy profession is competing with physical therapists and other similar groups. Competition with these groups was noted as a challenge by some of the managers in this study. In an editorial, Jones (2006) posed the question, 'Is physiotherapy losing recognition or are competing disciplines gaining 'market share', or both?'. Jones asserted that if the physiotherapy profession is to survive as a unique profession it must provide evidence to justify its existence and demonstrate cost-effectiveness. This demonstrates the importance of leadership capabilities associated with the structural frame to provide the evidence of cost-effectiveness in physiotherapy, and the political frame to advocate for and ensure recognition of the value of physiotherapy.

There were several references in this study to the power of nurses and how they held positions of influence for which physiotherapists could compete. Salhani and Coulter (2009) documented how nurses in an interprofessional team gained substantial autonomy from medical dominion in an ethnographic study of the micropolitical struggles within a mental health team. Micropolitical struggles involve challenges to unequal control over organisational work processes and working to gain power to maintain, protect and improve professional prerogatives. The nurses employed power and political strategies to successfully achieve autonomy from medical professionals and resist the intrusion of other professions on their practice (Salhani and Coulter, 2009). Salhani and Coulters' study reinforces the importance of leadership capabilities associated with the

political frame to address potential challenges associated with working with other professions. Leadership capabilities associated with the human resource and symbolic frames will also be important in addressing this challenge. In a study investigating the factors that contribute to successful teamwork in a palliative care team, good interpersonal relationships and team commitment were found to be crucial for effective multiprofessional working (Junger et al., 2007) reflecting the importance of human resource frame capabilities. The importance of symbolic frame capabilities is reflected by the study of Schoeb et al. (2014). In their qualitative study exploring key stakeholders' perceptions of physiotherapy research in Switzerland, it was concluded that to enhance interdisciplinary work the physiotherapy profession needs to project a stronger professional identity.

Lack of resources was another challenge identified by the physiotherapy managers. The managers described limited resources, a lack of funding, insufficient staffing and recruitment controls. As described in Section 1.1, in the last decade Ireland has experienced a severe economic crisis which has led to reduced health spending. Carney (2010) outlined the resulting challenges facing health care professionals in Ireland including: budgetary constraints, non-replacement of staff and demand and capacity issues for hospitals. There was recognition from some of the managers in this study of the negative impact this lack of resources has on their team and the stress it causes. The lack of resources may also have a negative effect on the physiotherapy managers. In a study exploring organisational empowerment in nurse managers in Canada, Spence Laschinger et al. (2004) found that when nurse managers do not have access to the resources necessary to perform their role effectively they are at risk of developing emotional exhaustion and burnout. The managers in this study may benefit from addressing this challenge using capabilities from multiple frames. Collecting statistics and data to strengthen business plans that request additional resources, keeping staff motivated by addressing their concerns, negotiating and networking with stakeholders, and inspiring their team through their passion even during difficult times.

The final challenge was changing structure. Many of the managers discussed change in their organisations and/or the wider health system and the challenge this posed. Change in healthcare organisations can be particularly difficult because of the complex relationships between a wide range of organisations, professionals, patients and carers (NICE, 2007). In a qualitative study exploring the implementation of change in physiotherapy, Sanders et al. (2014) reported that innovations or changes that make sense or add meaning, that professionals actively engage in, and whose proposed

benefits are understood, are more likely to succeed. The managers in this study, however, spoke of uncertainty around future changes, of not being kept informed regarding change, and subsequently of not being able to explain why changes were occurring or to keep staff informed of changes that may occur. This uncertainty and lack of clarity may make impending changes more difficult to manage. Four of the themes described by Blau et al. (2002) in a phenomenological study describing the experiences of physiotherapists during a time of systemic change were loss of control, stress, discontent, and disheartenment. However, a fifth theme, find the silver lining, was more positive and suggested that despite the unpleasant changes the physiotherapists were able to identify positive aspects of change. Strong leadership and motivated staff with a desire for continuous improvement can help to foster an environment that is conducive to change (NICE, 2007).

In a qualitative study of physiotherapists involved in the introduction of a quality improvement intervention, Sanders et al. (2014) noted that even minor changes to clinical work were difficult to implement in physiotherapy. Despite the benefits of the change being clear, the physiotherapists voiced concerns regarding the practical aspects of the change and how a change in their working pattern would impact on their own and their colleagues' roles. Introducing the change was an ongoing challenge which required continued re-assessment, re-evaluation, and negotiation of roles and responsibilities (Sanders et al., 2014). The NICE (2007) guidelines for identifying and understanding barriers to change advise that factors to consider when implementing change include: knowledge and awareness of what needs to change and why, motivation, people's beliefs, skills required, practicalities and the external environment. The physiotherapy managers should be aware of these factors as they address the changes occurring in their workplaces and the health system, however, given that these changes are mostly being imposed from outside the physiotherapy team this may be particularly challenging.

To address the challenge of changing structure, the physiotherapy managers will need to demonstrate use of all four frames to effectively guide their teams through potentially turbulent times. The structural frame to plan strategically and effectively, to ensure alignment with changing policy and procedure, and maintain efficient co-ordination of services. The human resource frame to ensure team members get the opportunities to develop their skills as needed, to keep them motivated and to ensure that their team's voice is heard. The political frame to manage inevitable conflict both within and outside the team, to negotiate and influence to acquire the resources needed, and to compete with other professions for positions within changing organisations. And lastly, the

symbolic frame to ensure the physiotherapy identity of the team is not lost, to encourage team bonding and to inspire team members to believe in the work that they are doing even when times are difficult.

6.4.6. Theme 6 - Clinical role

The 'Clinical role' theme encompassed the managers' perceptions of clinical work, physiotherapists' focus on the clinical aspect of their role, and clinical concepts (patient centred care, health promotion and evidence-based practice). The managers who maintained a clinical role alongside their managerial duties spoke of enjoying this aspect of their work, and in some cases of preferring it. In contrast, there was criticism from some of the managers of physiotherapists being too clinically focused and not engaging in roles and development beyond their clinical roles. The need for physiotherapists to develop professional skills beyond their clinical skills has been established (Bryan et al., 1994, Schafer et al., 2007, Adam et al., 2011). These comments reflect a subtheme from Study I (see section 4.3.6); within the theme 'Organisational culture', the subtheme *barriers to leadership* included comments about the emphasis on clinical skills and low priority being placed on developing leadership capabilities.

In this theme, there were many references to patient centred care and ensuring optimal services for patients. These comments reflected the managers' values of providing quality care for patients as described in Section 6.4.1. Patient-centred care is accepted and promoted by the physiotherapy profession as being central to interactions with patients (Potter et al., 2003, Harman et al., 2011, Pinto et al., 2012) and has been endorsed by physiotherapy practice guidelines (APA, 2011, CSP, 2013c). The physiotherapy managers described ensuring quality care, promoting patient-centred care in their teams and doing their best for patients.

6.4.7. Theme 7 - Physiotherapy profession

This theme covered the managers' reflections on the physiotherapy profession. The managers' perceptions of the physiotherapy profession in Ireland were varied. While some of the managers spoke of the strengths of physiotherapists (e.g. natural leadership ability, enthusiasm, intelligence), a small number were less positive. These negative comments reflected comments in a theme found in Study I, 'Reflections on the physiotherapy profession' (see Section 4.3.6), where participants were critical of the

physiotherapy profession and leadership within it. Overall, however, there were more positive comments about physiotherapists and their leadership abilities. The CSP has documented the range of skills that physiotherapists can bring to managerial and leadership roles in the NHS (CSP, 2012a). There was recognition from some of the managers in this study that physiotherapists are well positioned to assume leadership roles and have skills that would be transferable to leadership roles.

The managers also spoke of the role of the ISCP and a specific group within it, the CPM. The managers were positive in their view of the CPM group and praised the development opportunities that it provided. One manager, however, was critical of the ISCP and perceived it to have missed opportunities to protect the titles of physiotherapist/physical therapist in Ireland (see Section 1.2).

A smaller subtheme in these interviews was the female dominance of the profession. Only one manager discussed differences between male and female physiotherapists; this manager perceived female physiotherapists to be less willing to take risks in their careers. Bolman and Deal found that men and women in comparable posts were very similar in their frame usage (1991, 2008). Similarly, in the physiotherapy literature, Chan et al. (2015) found that gender did not significantly influence the strengths in the leadership profiles of physiotherapy leaders. Similarly, LoVasco et al (2016) found that gender did not have a significant effect on Year 1 DPT students' perceptions of their leadership practices.

6.4.8. Theme 8 - Workplace

The final theme was 'Workplace'. This theme covered the managers' reflections on their workplaces and the impact their workplace has on their role. There was a perception that working in the HSE can be restrictive; limiting autonomy and placing restrictions on recruitment processes. The managers in primary care spoke of the difficulties that they faced specific to their workplace. As noted in Sections 1.1 and 1.2, primary care in Ireland is undergoing a period of significant reform. The difficulties cited by these managers included the large number and geographical spread of the staff they managed, the varied clinical caseload of physiotherapy in primary care, and the ongoing changes in primary care. In a recent qualitative study of musculoskeletal physiotherapists working in primary care in Ireland, French and Galvin (2016) found similar challenges including: the generalist nature of the role, the offsite location of team members, limited resource

allocation, and travel restrictions due to budgetary restraints. As well as these challenges, the physiotherapy managers noted a divide between hospital and primary care services, and there was criticism from both sides. Hospital managers reported difficulty accessing, and poor cohesion with, primary care services. Whereas, one primary care manager perceived there to be a lack of respect for primary care services from hospital managers. In some sites, clinical rotations of primary care physiotherapists into acute hospitals have been organised to improve communication between settings and allow physiotherapists to up-skill in certain areas (French and Galvin, 2016). French and Galvin (2016) acknowledged that enhancing relationships with acute hospital services could improve quality of care and efficiency. Suggested strategies to facilitate this included formal education events, standardised referral forms and building personal contacts.

In terms of the leadership capabilities described by the physiotherapy managers, there were some differences noted across the workplaces. These differences were most likely attributable to the different contextual factors associated with the different workplaces. In the structural frame, the private practice physiotherapy managers placed less emphasis on reporting relationships, hierarchy, and planning, and in the political frame they did not speak about influence, networking, collaborating or being on committees. This may have been because these managers worked in smaller organisations and did not have to report to a higher-level manager. In contrast, hospital or primary care managers must contend with more complex hierarchies, larger structures, and more complicated systems, and thus may be more likely to need these leadership capabilities.

Private practice managers were able to employ administrative staff to assist them with tasks associated with the structural frame, whereas public hospital and primary care managers discussed the problems they faced as a result of not having adequate administrative support. Similarly, public hospital managers reported being constrained by recruitment controls, whereas private practice managers faced a different recruitment challenge. Private practice managers needed to ensure they had an appropriate number of staff so that there were enough patients for physiotherapists to treat but also to ensure that patients didn’t have to wait to be seen.

With regard to goal setting, public hospital and primary care managers set goals for their department and were cognisant of the priorities of their organisation or the HSE. The private practice managers, in contrast, set goals on a smaller scale. They spoke of setting goals for individual patients for setting targets for team members. Primary care

managers reported that holding people accountable for their work and their results was more difficult in their setting because of the domiciliary aspect of primary care and the geographical spread of their team. There were also some differences noted in the managers' approaches to development and training of their team. Primary care managers spoke of bringing the members of their team together for meetings and in-services to encourage skill development and learning from each other. The public hospital managers used PDPs to facilitate the development of their team, and the private practice managers (who all maintained a clinical role) spoke of being actively involved in teaching their team members.

6.4.9. Limitations

As in Phase 1, this phase of the study was limited by the fact that the leadership capabilities of the physiotherapy managers were evaluated solely by their self-perceptions. Thus, the study is limited by the accuracy and reliability of the managers' accounts of their leadership capabilities. The managers may have wanted to present themselves and their team in a positive way and so there is a risk that there may have been some social desirability bias in the interviews (van de Mortel, 2008).

The interview schedule was developed based on previous qualitative studies which have used the Bolman and Deal framework (Bolman and Deal, 1992a, Schneiderman, 2005), and structured to give the managers an opportunity to talk about all four frames. As well as this, more general questions on leadership were included to allow the managers more scope to speak about leadership in a less structured way. Despite this, there is still the possibility that the managers demonstrate leadership capabilities associated with the different frames that did not come up in their interviews. Thus, the analysis of these interviews may not entirely reflect the full range of leadership capabilities of these managers.

The research sample was relatively small and meant that there was only a small number of managers from the different work settings. Including managers from a range of work settings, however, helped to improve the generalisability of the results. As well as this, many similarities were found in the leadership capabilities of physiotherapy managers from different workplace settings and the differences across the workplaces were highlighted. In qualitative studies the focus is on the value and richness of the information obtained from participants (Sandelowski, 2000) rather than the number of participants.

Participants in this study volunteered to participate which may have led to a self-selection bias. Self-selection bias occurs when the members of the target population who do not participate in research differ in a systematic way from those who do (Costigan and Cox, 2001). A self-selection bias may have meant that the sample consisted of managers who were confident of their leadership capabilities whereas those less confident of their knowledge and abilities in this area may have chosen not to participate. Managers from a range of workplaces and backgrounds, however, were represented in the sample.

Another limitation of qualitative research is the potential for the research to be influenced by the researcher's personal biases (Anderson, 2010). To mitigate for this, members of the research team reflected on and wrote a personal bias statement before conducting the analysis of the interviews. Additionally, an external, independent advisor coded a selection of transcripts to ensure the validity and comprehensiveness of the codebook.

6.5. Conclusion

The results of this phase of the study concur with the results from phase one; the physiotherapy managers were more positively disposed towards working through the structural and human resource frames. There was more varied use of the political frame among the managers. While some of the managers discussed strategies for influencing others, effecting change and managing conflict, there were also comments about powerlessness, a lack of autonomy and difficulties influencing others. The symbolic frame was underused by the managers; the activities and behaviours associated with the symbolic frame were not as prevalent in the interviews as those from the other frames.

The second objective of this study was to investigate the experiences of physiotherapy managers in Ireland and specifically the challenges that they identify as requiring leadership. The theme 'Clinical role' encompassed the physiotherapy managers' perspectives regarding the clinical work of their team and maintaining a clinical role. The 'Workplace' theme described the influence that the managers perceived their workplace to have on their work and leadership role. The theme 'Physiotherapy profession' included the managers' perceptions of physiotherapists, the physiotherapy profession and the physiotherapy professional organisation in Ireland. The physiotherapy managers in this study cited a range of challenges facing physiotherapy leaders. The most

prevalent of these were time constraints, lack of resources, other professions and changing structure. To most effectively address these challenges the physiotherapy managers will need to be able to reframe situations and use leadership capabilities from different frames as appropriate. Physiotherapy managers may benefit from specific training to develop leadership capabilities associated with the political and symbolic frames.

7. Chapter 7 – Study III: Leadership capabilities of physiotherapy clinical specialists and advanced physiotherapy practitioners

7.1. Introduction

The aim of this chapter is to present the methodology and results of the semi-structured interviews conducted with physiotherapy clinical specialists and advanced physiotherapy practitioners (APPs) for Study III of this PhD thesis. Analysis of the interviews with the physiotherapy managers in Study II demonstrated that while physiotherapy managers described working in all four leadership frames they appeared to most prevalently demonstrate capabilities associated with the structural and human resource frames. The results also suggested that they demonstrated political frame capabilities less consistently and that they underused symbolic frame capabilities. Differences were noted in the leadership capabilities of physiotherapy managers according to their workplace indicating that this was an important contextual factor to account for when exploring the leadership capabilities of physiotherapy leaders. The interviews also revealed that the four main challenges perceived by physiotherapy managers were time constraints, lack of resources, other professions and changing structure.

However, physiotherapy managers are only one cohort that may be considered leaders in the physiotherapy profession in Ireland. Leadership is broader than management because it involves influence in a variety of contexts, not just those based on formal authority (Hartley and Benington, 2010). To further investigate the perceptions of physiotherapy leaders in Ireland it is necessary to consider other types of physiotherapy leaders. Another cohort of physiotherapists who may be considered leaders in the profession are physiotherapy clinical specialists or advanced physiotherapy practitioners (CSP, 2016a). Clinical specialist physiotherapists apply advanced specialist knowledge and skills in their area of specialisation, act in an advisory role to both physiotherapy and multi-disciplinary team (MDT) colleagues, and develop and implement new service initiatives in collaboration with line managers and other stakeholders (HSE, 2008). Advanced physiotherapy practitioners have been defined as physiotherapists who complete formal continuing education to enable them to practice beyond the regulated scope of entry-to-practice physiotherapy practice (Yardley et al., 2008). This role can include role enhancement and role substitution related to traditionally performed medical procedures e.g. communicating a diagnosis, triaging potential surgical candidates and injecting medications (Desmeules et al., 2012). In the literature, the terms APP and

extended scope practitioner (ESP) are often used interchangeably (O'Mahony and Blake, 2017). In this study the term APP is used in keeping with the term used by the ISCP (ISCP, 2012).

While managers demonstrate formal, direct leadership, and may be clinical or non-clinical, clinical specialists/APPs can be considered to demonstrate leadership beyond authority (in that they may can be considered profession leaders but do not occupy formal leadership positions), work directly with followers and as the name suggests have clinical roles. Interviewing clinical specialists/APPs about their leadership capabilities allowed comparison between physiotherapy leaders in Ireland who demonstrate different characteristics of leadership. Unlike managers who are in formal positions of leadership authority, APPs provide clinical leadership rather than direct line management for team members and so must rely on their skills and knowledge to influence clinical service improvement and development (CSP, 2016a).

Therefore, the objectives of this phase of the study were to:
(1) Describe the perceived leadership capabilities of physiotherapy clinical specialists/APPs in Ireland using the four frames of the Bolman and Deal leadership model.
(2) Compare the leadership capabilities and leadership experiences of different cohorts of potential leaders in the physiotherapy profession in Ireland, namely physiotherapy managers and physiotherapy clinical specialists/APPs (formal vs informal, managerial vs clinical).
(3) Explore the experiences of physiotherapy clinical specialists/APPs in Ireland of working in informal leadership positions and the challenges they face.

These objectives and the results from Study II of this study led to the following research questions being formulated:

- Which leadership frames do physiotherapy clinical specialists/APPs predominantly use?
- Are the leadership capabilities of physiotherapy managers different to those of physiotherapy clinical specialists/APPs?
- What leadership challenges do physiotherapy clinical specialists/APPs perceive themselves and/or the physiotherapy profession to be facing? Are these perceived challenges different to those cited by the physiotherapy managers?

7.2. Methodology

Semi-structured interviews were conducted with a purposive sample of physiotherapy clinical specialists and APPs. As in Study II, a qualitative descriptive approach was taken in this study. The methodology in this study is similar to that used in Study II, however there were some necessary differences and these are outlined below. Ethical approval was granted by the Trinity College Dublin Faculty of Health Sciences Ethics Committee (appendix II – Pg 418).

7.2.1. Participant recruitment

A number of approaches were employed to recruit clinical specialists and APPs from a range of backgrounds. Physiotherapy managers in large or specialist hospitals where physiotherapy clinical specialists or APPs are employed were contacted by telephone or email. The physiotherapy managers were informed of the study and asked to forward information about the study to physiotherapists employed as APPs or clinical specialists. The managers therefore acted as gatekeepers and circulated the email inviting the clinical specialists/APPs to participate in the interview. The email informed recipients of the study and contained two attachments: the participation request letter (appendix VII – pg 465) and the information leaflet for the study (appendix VI – pg 463). Interested participants were asked to email the PhD candidate to indicate their interest or ask any questions they had regarding the study. The physiotherapy managers were contacted again two weeks after sending out the initial email to request that they send out a reminder email to encourage participation in the study.

A second recruitment strategy was to contact clinical specialists/APPs through a specialist group of the ISCP. The ISCP has a standing committee for professional development and a subgroup of this committee is for advanced practice in physiotherapy, the Advanced Practitioners Forum. Permission was sought and obtained from the ISCP Board to contact physiotherapists involved in this group regarding the study. An administrator from the ISCP acted as the gatekeeper and forwarded the email with the participation request letter and information leaflet to inform the members of the Advanced Practitioners Forum of the study and invite them to participate.

A final recruitment strategy was to place an advertisement in the ISCP e-zine. The e-zine is sent weekly to all members on the ISCP mailing list. Permission to place the advertisement was sought and obtained from the ISCP Board. The advertisement

included details of the study and specifically invited physiotherapists employed as clinical specialists or APPs to contact the PhD candidate if they were interested in participating.

Respondents who indicated that they wished to participate were sent a copy of the consent form (appendix VI – pg 462) by email and given the opportunity to ask any questions that they had before the interview. To ensure that clinical specialists/APPs from a range of backgrounds were included a sampling matrix was used. Factors in this sampling matrix included - workplace (public hospital, private hospital, private practice, primary care), gender, clinical areas (musculoskeletal, paediatrics, care of the elderly, respiratory and neurology) and whether they were a clinical specialist or an APP.

Eligibility criteria for participating in the interviews were:

- Currently employed as a physiotherapy clinical specialist or advanced physiotherapy practitioner
- Currently working in Ireland
- Currently working in a clinical role

7.2.2. Participants

The demographic details of the participants are displayed in Table 7.1. To maintain the confidentiality of the participants the specific demographic details of the participants have been generalised into categories. Level of experience was categorised into low (0-5 years), medium (6-15 years) and high (16+ years). Participants who worked in a voluntary hospital or a HSE hospital were categorised as working in a public hospital. Physiotherapists who worked in orthopaedic, rheumatology, spinal triage or musculoskeletal positions were all grouped under musculoskeletal (MSK) for their clinical area of expertise. In the table the participants are marked as either clinical specialists (CS) or advanced physiotherapy practitioners (APP). This distinction was based on the participant's description of their role.

Table 7-1 Study III participant demographics

Participant	Position	Gender	Workplace	Clinical Area	Experience
CS001	CS	Female	Private hospital	MSK	Medium
CS002	CS	Female	Public hospital	Respiratory	Medium
CS003	CS	Female	Public hospital	Care of the elderly	Low
CS004	APP	Female	Public hospital	Paediatrics	Low
CS005	APP	Female	Public hospital	MSK	Low
CS006	CS	Female	Community	Palliative care	Medium
CS007	CS	Female	Community	Palliative care	Medium
CS008	APP	Female	Public hospital	MSK	Low
CS009	APP	Female	Public hospital	MSK	Low
CS010	APP	Female	Public hospital	MSK	Medium
CS011	CS	Female	Private hospital	MSK	Medium
CS012	CS	Male	Private hospital	MSK	Low
CS013	APP	Female	Public hospital	MSK	Medium
CS014	CS	Female	Public hospital	Neurology	Low
CS015	APP	Female	Public hospital	MSK	Low
CS016	CS	Male	Public hospital	Paediatrics	Low
CS017	APP	Female	Public hospital	Respiratory	Medium

7.2.3. Interview Schedule

The interview schedule from Study II was used in this study with slight adaptations to make it applicable to the clinical specialists/APPs (appendix X – pg 477-478). In the first section of the interview participants were asked about their career path to date, to describe their role and how many physiotherapists were on their team. These questions were more applicable to these participants than the questions used in the managers' interviews which had asked how long they had been a manager, whether they had a clinical role and how many physiotherapists they managed. The questions in the other sections of the interview schedule were the same as those in Study II, however some of the questions were slightly amended to make them applicable to a clinical specialist/APP rather than a manager. For example, the question in the interviews with the managers, 'Are there goals/targets/KPIs that your team aim to achieve?' was changed to, 'What are your organisational goals?'.

7.2.4. Interview Procedure

Interviews were conducted in person, audiotaped and additional notes were made by the PhD candidate. The interviews took place at the participant's workplace (n=16) or the Trinity Centre for Health Sciences at St James's Hospital (n=1), depending on the preference of the participant. The interview procedure was the same as that used in study II; the procedure was explained before the interview commenced and interviewees were given the opportunity to ask any questions they had before being asked to sign the consent form for the study. The interviews consisted of semi-structured, open-ended questions. Follow-up probes focusing on the participants' experiences were used to prompt the clinical specialists/APPs to expand on interesting points or to ask additional questions when appropriate. The interviews lasted for a mean time of 43 minutes and ranged from 26 to 66 minutes in length.

7.2.5. Data Analysis

The data analysis procedure in this study was similar to that in study II (see Section 6.2.5). The coding template used in Study II (appendix IX pg 471-475) was used as the basis for developing the codebook for this study.

7.2.6. Development of the Template

The development of the thematic coding template for this study roughly followed the six stages described by King (2012, 2016).

1. Define *a priori* themes – The themes and coding template from Study II were used.
2. Interview transcription – Interviews were transcribed verbatim and transcripts carefully reviewed to check for accuracy.
3. Initial coding of the data – Transcripts were coded using the coding template from Study II. New codes were devised to encapsulate themes and subthemes not covered by the current coding template.
4. Produce the initial template – The coding template from the previous study was amended to include the new codes found in this set of interviews. The new codes were sorted and added to existing subthemes where applicable. Existing codes and subcodes were modified when necessary and new codes and

subcodes were added to the codebook. This produced the initial coding template for this study.

5. Develop the template – The initial template was applied to the full data set. The template was modified whenever a piece of text did not fit into an existing subtheme, code or subcode, or where relationships between subthemes or codes/subcodes were noted. After the second round of coding, each section of text under each code was read and the code definition/description was amended where necessary. Codes that had very few or no sections of text under them were removed from the codebook and the data recoded as necessary. Through these changes the template was developed into its final form.
6. Interpretation and write-up – The final template was used to aid interpretation and write up of findings.

The initial coding of the data was conducted manually. Once the initial template had been developed a second round of coding was conducted using Nvivo 11 for Windows software. As described in Chapter 6 (see Section 6.2.6), the initial template was amended through a process of constant revision in response to pertinent findings in the data. Saturation was reached when 14 interviews had been analysed, the analysis of the remaining three interviews resulting in no further changes to the codebook (Guest et al., 2006).

As in Study II, the PhD supervisor independently coded six transcripts to check the validity of the codebook. The codebook was revised following feedback from the PhD supervisor. The revisions included adding three subcodes (Dual reporting, Career pathway and Affiliation with clinical team) to the coding template. NE again acted as an external, independent advisor on this study and was invited to give an unbiased view on the coding and codebook. The PhD candidate conducted a peer debriefing with NE to explain this study's objectives. NE then independently coded three transcripts using the revised coding template. It was deemed sufficient for NE to only code three transcripts in this study because the codebook had previously been validated by NE. The PhD candidate met with NE to discuss the coding and the validity of the codebook. The coding of the transcripts was compared and differences in the coding were addressed. NE was satisfied that the codebook was comprehensive. Minor amendments to the codebook were suggested by NE, these were discussed and two subcodes (Developing

protocols/SOPs/guidelines and Clinical advice/expertise) were added to give the final version the codebook.

The steps involved in producing the final version of the thematic coding template for this study, including the quality checks, are summarised in Figure 7.1.

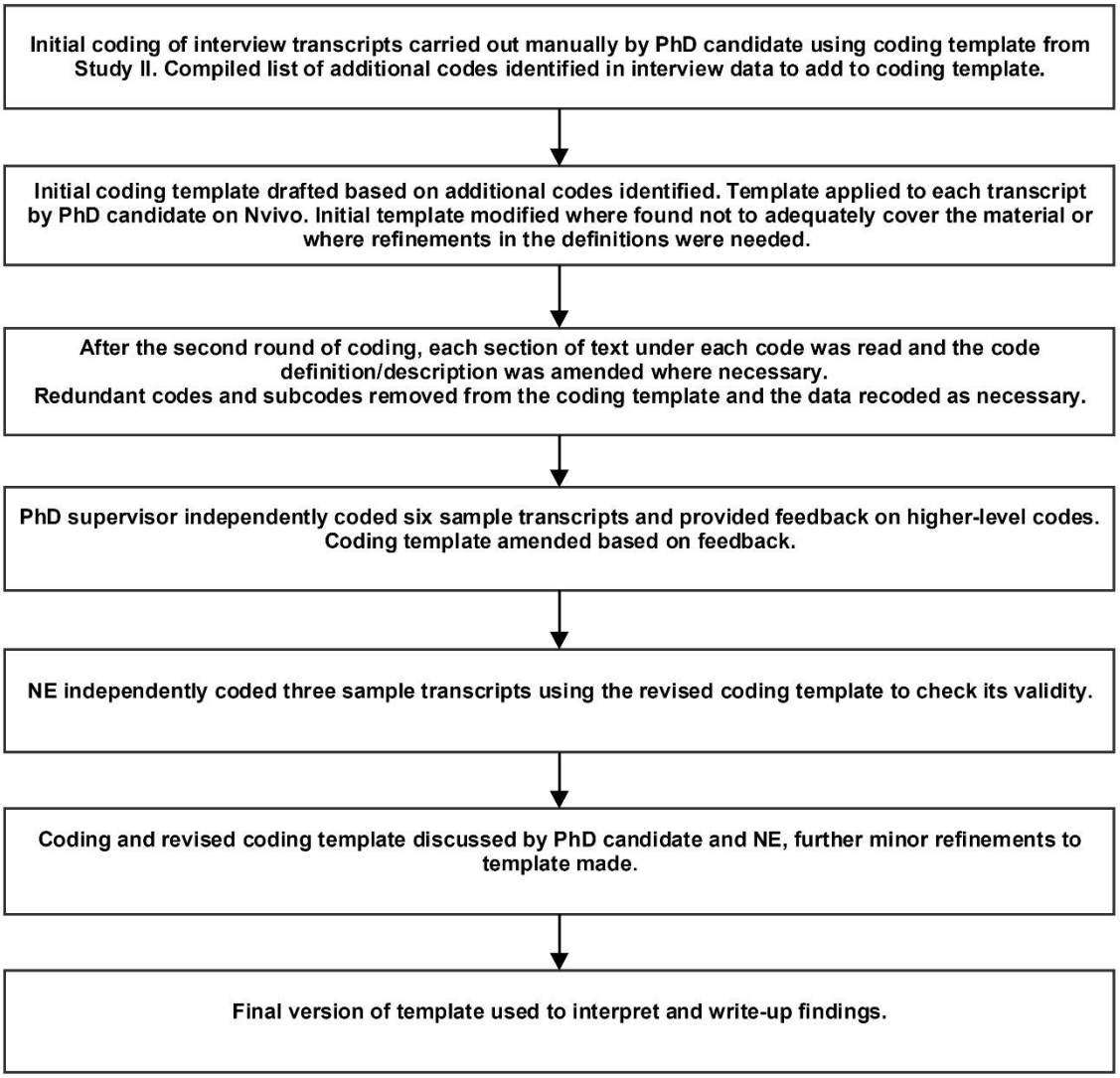


Figure 7-1 Process used to develop coding template in Study III

7.2.7. Quality Checks

The same strategies were used to enhance the quality of the data analysis as described in Chapter 6 (see Section 6.2.7). These were: independent coding among researchers, using an independent advisor to check the validity of the codebook, keeping an audit trail and member checking.

7.2.8. The Final Coding Template

The final coding template comprised six first level themes. These themes and their subthemes are outlined and used to structure the results section below. As well as describing the shared themes across participants, differing perspectives have also been highlighted. The coding template and the definitions used for each code are displayed in appendix X (pg 479-484).

7.3. Results

The principal themes were 'Structural', 'Human resource', 'Political', 'Symbolic', 'Challenges' and 'Physiotherapy profession'. Two other themes were found in the data but these were less prevalent than the principal themes, 'Workplace' and 'Clinical role'. The principal themes and their primary subthemes are summarised in a simplified template in Table 7.2.

Table 7-2 The principal themes and their primary subthemes

Principal Theme	**Primary subtheme**
Structural	• Operations • Strategic planning and alignment
Human Resource	• Professional development • Qualities • Communication
Political	• Organisational citizenship behaviour • Engagement • Organisational interpersonal dynamics
Symbolic	• Organisational culture • Professional identity • Attributes-behaviours
Challenges	• Lack of resources • Time restraints • Other professions • Changing structure • Ordering images • Career structure
Physiotherapy Profession	• Clinical specialist/APP role • Management role

The themes and subthemes were the same as for Study II except that there was an additional theme in this study (Physiotherapy profession) and additional subthemes in the challenges theme (*ordering images or tests* and *career structure*). Each theme and associated subthemes will be presented and illustrated with supporting extracts of data. Differences noted between the different demographic groups of clinical specialists/APPs (workplace, clinical area, role) where present are highlighted.

7.3.1. Structural Theme

The primary, secondary and tertiary subthemes associated with the 'Structural' theme are displayed in Table 7.3. The subthemes *recruitment* and *budget and funding* which were found in the interviews in Study II were not found in the interviews in this study. However, there were additional subthemes in the clinical specialist interviews within the structural frame: *staff rotas, succession planning, waiting list management, developing service, decision making* and *developing protocols/SOPs/guidelines*.

The structural frame theme was again made up of two subthemes: *operations* and *strategic planning and alignment*.

Table 7-3 Structural theme

Theme	**Structural Frame**		
Primary Subtheme	**Operations**		
Secondary Subtheme	People Management	Accountability	Co-ordinating Service
Tertiary Subtheme	• *Staff rotas* • *Succession planning*	• *Reporting Relationship* • *Performance Review* • *Waiting list management* • *Statistics/data* • *Audit*	• *Delegation* • *Meetings* • *Time Management* • *HR/admin support*
Primary Subtheme	**Strategic Planning and Alignment**		
Secondary Subtheme	Planning	Policy and Procedure	
Tertiary Subtheme	• *Planning* • *Developing service* • *Goals/KPI* • *Decision making*	• *Positive and negative statements about policy and procedure* • *Developing protocols/SOPs/guidelines* • *Rules/guidelines* • *Bureaucracy*	

7.3.1.1. Operations

Within the *operations* subtheme, the clinical specialists/APPs discussed activities that they engaged in to ensure high standards of work from their team, strategies used to monitor the efficiency and effectiveness of their service, their dual reporting relationships and the hierarchy within their workplaces.

Co-ordinating service

The clinical specialists/APPs did discuss strategies and activities associated with co-ordinating the smooth running of their service. However, there were fewer comments in this theme than had been the case in the interviews with the managers. This subtheme encompassed time management, meetings, delegation and having HR or admin support.

One APP spoke of being fussy about the way that things are done in her department and a clinical specialist spoke of 'micromanaging' her service. Five of the participants spoke of the importance of being organised in their role.

> *"I like things to be nice and organised, I have my assessment forms and I have my tick-boxes and I have my checklists."* CS008 (APP in MSK)

The importance of effective time management was highlighted by four of the participants. Assisting others with time management and managing schedules for their department were also discussed. The concept of protected time for non-clinical work was spoken about by seven of the clinical specialists/APPs. There was some variation between the participants in the amount of protected time that they had for non-clinical work; from getting no protected time, to expecting to have 20% or 50% of their time assigned to non-clinical activities.

> "*We are meant to be governed by our non-clinical time which I suppose as a clinical specialist in, when they did the, I suppose in theory we're meant to be 50/50, like 50% clinical, 50% non-clinical emm, the workload for the non-clinical I think it depends on what project that you're involved in and I definitely would spend a lot more time than 50% of my time, I'd say like I'd spend about 75, 80% of my time would be clinical*" CS005 (APP in MSK)

One clinical specialist spoke of being too busy with clinical work to schedule time for other projects and an APP reflected that she was not good at setting aside time for completing projects.

> "*I'm probably not the best at that because even though I set time aside to do certain little projects other things keep landing on my desk.*" CS013 (APP in MSK)

Also within the *time management* subtheme were comments about efficiency and streamlining processes for patients.

> "*trying to streamline the service a little bit better for the coming year and aligning ourselves a little bit more closely with the consultant clinics to try and improve efficiency*" CS010 (APP in MSK).

Meetings were used as a strategy for co-ordinating services within the workplaces of the participants. Several of the participants reported that they had regular team meetings and four commented on the importance of these meetings.

> "*But it's meetings yeah, that's probably our big valve, our big release valve, our big talking session, our big sharing of information sessions, our big debriefing*" CS006 (CS in palliative care)

However, one APP felt that her team had too many meetings.

> "*We have lots of meetings, I think we have too many meetings*" CS017 (APP in respiratory)

Delegation was an aspect of co-ordinating service that several of the clinical specialists/APPs discussed and examples of delegating tasks were given. Five cited delegation as an important leadership skill.

> "*You need to delegate, is a big thing because you can't do everything on your own. And to trust the people that you're delegating to*." CS007 (CS in palliative care)

However, one APP reported that it was difficult for her to delegate tasks because of the nature of her role.

> "*I'd maybe delegate jobs but again from that, but I wouldn't be heavily involved in the running of OPD so it's more that if I bring triage and OPD together I'm involved in that point of view, so no I wouldn't delegate jobs that emm, that easily*." CS009 (APP in MSK)

Fewer references were made by the clinical specialists/APPs about the administrative support they receive than were made by the physiotherapy managers. While one APP spoke of how good it was that her administrative needs were covered by the orthopaedic administrative team, two other APPs complained about not having administrative support.

> "*I suppose the bit I don't like I should mention is the writing up of my letters, it drives me mad, but anyway [both laugh] what can you do, everyone here knows my thoughts about that."* CS008 (APP in MSK)

<u>Accountability</u>

Within the accountability subtheme, the clinical specialists/APPs spoke about being responsible for particular tasks, monitoring the work of others, and having their

performance evaluated. This subtheme was more prevalent for clinical specialists/APPs working in hospitals than for those working in the community.

There were several comments about responsibility; feeling responsible for the results of other team members, being responsible for their own patients, recognising the responsibility of others to contribute to the service and ensuring the competence of the physiotherapists on their team.

> *"Each staff member has a responsibility to contribute, help with the development of the department, service initiatives."* CS011 (CS in MSK)

The participants spoke of being responsible for the performance and practices of the members of the team. One clinical specialist gave an example of resolving a problem caused by junior members of her team in a way that allowed it to be a positive learning experience for them but that also addressed the issue.

The clinical specialists/APPs were involved in monitoring the performance of their service and several reported completing performance reviews. The clinical specialists reported completing performance reviews of their team and also of having their own performance review conducted by their manager. One clinical specialist gave a specific example of having to manage an under-performing team member.

> *"There was an area recently where there were key performance issues of a physiotherapist where time management was an ongoing problem, doing patient paperwork and record keeping in a timely fashion for the senior level that that physiotherapist was at."* CS001 (CS in MSK)

There were also many references to ensuring a high standard of quality in their service and patient care, and to involvement in quality improvement projects.

> "*So I'm responsible for the service provision. What that ensures for me is that quality of service so that who works with me, so the staff grades and the seniors are providing the best quality, timely, effective care to the patient."* CS002 (CS in respiratory care)

Eleven of the clinical specialists/APPs reported collecting statistics and data. Participants spoke of the importance of recording and monitoring things like patient outcomes, number of patients seen and waiting lists.

> *"looking at productivity essentially, like fiscal accountability I suppose, like how much everybody is bringing in, how much dead time there is and trying to minimise all of that*." CS012 (CS in MSK)

Data was collected on several variables including:

- Specific patient groups
- Number of referrals
- Number of patients seen
- Did Not Attend (DNA) rates
- Outcome measures
- Patient admissions and length of stay

One clinical specialist spoke of communicating the importance of capturing data to his team.

> "*you need to either capture what you're doing, capture the outcome measures and actually show that you're doing something effective, because no-one's going to remember you because you spoke nice to the patient*" CS016 (CS in paediatrics)

There were several references to waiting list numbers and APPs working in MSK in particular reported monitoring these figures.

> *"And I know here, I mean everyone's very focused on waiting list numbers and how many you take off and waiting list times but we're also trying to address things like the waiting lists for MRI and the secondary waiting list for physio because it's no point in taking you off a waiting list here if you're just going to sit on another waiting list."* CS008 (APP in MSK)

Audit was another strategy commonly employed by the clinical specialists/APPs; nine reported having conducted an audit to monitor the performance of their service. Audit was used to evaluate record keeping, new treatment modalities, compliance with national guidelines, the service provided to patients, productivity and as evidence to argue for more staff or to create a new service.

> "*So looking at auditing, auditing of our staff, auditing of new referrals, numbers, productivity, then drawing up a report based on that and presenting it to your manager or senior management, to try and yeah for example to get more staff or develop a new service"* CS011 (CS in MSK)

Two of the participants gave specific examples of using audit to effect change within their workplaces.

> *"We recently did an audit on our new outcome measure in intensive care and showed that we have a huge deficit where we don't have a medical rehab physio to look after these patients when they come out of intensive care. So, we appointed half of one of our team to look after these patients for ten days after they come out of intensive care as opposed to just giving them to the ward staff and that way we*

have shown that we need to have more physiotherapy input into these patients." CS017 (APP in respiratory)

However, one clinical specialist reported that clinical audit was not a part of her role that she enjoyed.

Also within the accountability subtheme were references to the hierarchy and reporting relationships in their workplaces.

"So I suppose we would have, we've staff grades within each of our different components, we've wards, stroke, ED, rehab, we've five different areas and we've seniors in all of those areas, and then I'm clinical specialist so I'm over, my role is to have an overview of all of it, so that would be kind of the structure we would have." CS003 (CS in care of the elderly)

All the clinical specialists/APPs said that they reported to the physiotherapy manager. Additionally, several of the clinical specialists/APPs whose clinical area was musculoskeletal referenced that they had a dual reporting structure in their work; they reported to the physiotherapy manager in their department and to the medical consultant in their area.

"*At the moment I have a dual reporting relationship, so [name] is my physiotherapy manager, so I report to her for kind of every day physiotherapy things as regards my time keeping, my annual leave, my sick leave, any of my physiotherapy related issues [physio manager] would be my manager but as regards any clinical issues or clinical governance to do with the orthopaedic patients it's depending on the orthopaedic consultant that they're under*." CS008 (APP in MSK)

There was variation in the comments regarding whether the participants had physiotherapists reporting to them. Five clinical specialists/APPs reported that they don't have anyone directly reporting to them.

"[Colleague name] and I share the load and there isn't any seniors or basics under us. We would work very closely with other physios on the ground but no, there would be nobody reporting to me, line reporting to me no." CPM006 (CS in palliative care)

However, a small number of the respondents did speak of other physiotherapists in the team having a reporting relationship with them.

"they would have their overarching PDPs and performance reviews with the manager but yeah they would report through me in terms of team meetings which

we'd have once a week and I'd go through separate reviews in terms of CPD with them. Yeah so they are my responsibility." CS016 (CS in paediatrics)

One APP complained of the flat hierarchical structure of the outpatients department where she worked. Two clinical specialists who worked in private hospitals also remarked on the flat hierarchy of their workplaces.

"I suppose we're clinical specialists but we're working within a team of very senior physiotherapists so there doesn't really seem like there's a hierarchy there but that's the title and that's the way it is." CS011 (CS in MSK)

People management

The final subtheme within *accountability* was *people management*. There were fewer comments within this subtheme for the clinical specialists/APPs than there had been for the physiotherapy managers. The physiotherapy clinical specialists/APPS did not discuss recruitment of staff as the managers had. There was only one reference to ensuring that the right people were in the job.

"*Getting the right people into the job is crucial, people who want to work in it, not just people who want a senior job, it's been very important and everyone who's in this service wants to be there*." CS003 (CS in care of the elderly)

There were some references to managing staff rotas and to ensuring that there was an appropriate level of cover and mix of experience levels within different areas of their services. One clinical specialist spoke of disliking having to do staff rotas, while another said that there was relatively little people management within their role.

"So myself and [CS colleague] would I suppose manage the outpatients department and try and you know oversee that schedules are full and people are being productive and all the rest of it, but there's very little people management involved, people come in and their schedules are open and generally the caseload just builds." CS011 (CS in MSK)

Another recurring idea within the interviews that fell within this subtheme was succession planning. Four of the participants spoke of wanting to ensure that they had the right people in their team and that they were being adequately prepared to take over more senior posts in future.

"So it's ongoing but I'll always help them and I have to step back from doing it myself, I would love to just take these things on and do them myself but that's not

going to help the girls and I'm always thinking about succession, like who's going to replace me when I'm gone." CS017 (APP in respiratory)

7.3.1.2. Strategic planning and alignment

The *strategic planning and alignment* subtheme encompassed service development and planning activities, decision making and the design and implementation of policies and guidelines. This subtheme was more prevalent among the clinical specialists/APPs who worked in public hospitals than those who worked in private hospitals or primary care.

Planning

Five of the clinical specialists/APPs spoke about planning for their department. There were fewer references to planning than there had been in the interviews with the physiotherapy managers suggesting that the clinical specialists/APPs were less involved in this. However, the importance of careful planning was acknowledged by some of the participants.

"be prepared is really important I think, knowing being very clear on what you want and what your plan is, if you go into something a bit vague you've no chance, but being able to go in with a very clear plan will help a lot" CS003 (CS in care of the elderly)

More of the clinical specialists/APPs spoke of developing and improving their service. The participants spoke about spending their non-clinical time completing service development activities and about the need to continually strive for service development.

"*I always want to be like strategically thinking about who's going to do what and how we're going to bring new services in and new ideas in our service."* CS017 (APP in respiratory)

A leadership skill related to planning and service development was decision making. Five of the participants spoke of the importance of being decisive.

"within extended scope I've learned you have to think very quickly on your feet, you have to have confidence in your decision-making abilities and you have to learn to make a decision quickly and have faith in it, to follow through because if you're always doubting yourself you'll always be chasing your tail" CS004 (APP in paediatrics)

Also within the planning subtheme were comments related to goal-setting and to achieving goals.

> "*from a leadership point of view, everyone knowing where they're going, having set goals, everyone being on the same playing pitch is so important."* CS003 (CS in care of the elderly)

The clinical specialists demonstrated that they were patient focused in their goal setting; the majority cited goals related to improving services for patients.

> *"Our goal is that we provide a high quality, accessible and cost-effective service for everyone who attends our service."* CS014 (CS in neurology)

The clinical specialists/APPs spoke of setting targets for the number of patients that physiotherapists on their team should attain, setting goals with individual patients, setting service development goals with their manager, meeting HSE waiting list targets, and of having their own personal development goals e.g. improving their management skills, developing specific care programmes. Four of the APPs in MSK reported that they were in targeted positions and so had a set target of new patients that they were expected to see every month/year as part of their role.

> *"So the expectation was that you would do five orthopae-, five clinics a week not necessarily orthopaedics, and that you would see 25 new patients a week in clinic and a target of 1000 a year*" CS008 (APP in MSK)

In contrast, another APP in MSK acknowledged the importance of set goals but highlighted that patient care should always be central.

> *"I understand the importance of key performance indicators and I understand the importance of outcome measures, I think it's often driven by what we professionally see each other as and I'm not saying it doesn't give the patient better service, that's the goal of it, but sometimes spending all the time doing one thing and losing sight of the fact that you're there to treat the individual in front of you"* CS013 (APP in MSK)

<u>Policy and procedure</u>

The clinical specialists/APPs generally agreed that policy and procedure were important within their role. Three of the APPs reported that policy and procedure or protocols were strictly adhered to in their workplaces.

"Oh, it's the law, it's the law here and it's just something that has to be done, so any treatment we give or any pathway we follow has to have a policy and a procedure" CS017 (APP in respiratory)

Policies and procedures were regularly reviewed and amended as needed.

"we would have policies and procedures that you check regularly, read regularly and we sign off on regularly and amend and whatever." CS006 (CS in palliative care)

The majority of the clinical specialists/APPs spoke about their involvement in writing or developing new procedures or protocols. Many of the participants had been involved in the introduction of new services to their workplaces and so they spoke of developing policy and procedure or protocols for these new services.

"because essentially what we've done has been brand new, we've had to develop our own SOP for the service…..it wasn't just me, the whole team we've put it together, that literally from morning when we walk into the door of ED, it's really procedural, we do this, we do this, and we do this." CS003 (CS in care of the elderly)

The participants also spoke of developing clinical guidelines and pathways.

"to make sure that our therapeutic and rehabilitation guidelines are current and up-to-date so that that can go with the patient plus the surgical information so that their rehabilitation journey is appropriate and safe and as current as possible" CS013 (APP in MSK)

While the participants mainly described developing and using the clinical guidelines or protocols themselves, one clinical specialist did also speak about ensuring that other members of the team were following protocols.

"again it's trying to make it about instances or about episodes where protocols haven't been followed and you know that's again it's like, 'This is where it is, this is where it's written down, this is what you need to do'" CS002 (CS in respiratory)

There were three negative comments about policy and procedure. One participant complained that there were too many standard operating procedures (SOPs) in their workplace, even one for answering the phone. Another participant said that he disliked policy and procedure because he felt that it reduces independent thinking. While another participant complained of bureaucracy in their workplace and there being too many processes involved which slows things down.

"*it's more just going into a big organisation again and finding that there's, there's a document for everything, there's a meeting for everything, and nothing happens very quickly*." CS009 (APP in MSK)

7.3.2. Human Resource Theme

The primary, secondary and tertiary subthemes associated with the 'Human resource' theme are displayed in Table 7.4. The clinical specialists/APPs indicated that they worked through the human resource frame through the value they placed on fostering and maintaining relationships with others in their organisations and the efforts they made to develop the knowledge and skills of others.

"*I suppose I value the relationships of the people that I work with so when everybody is working well, you know when everybody is happy and everyone within the team is quite happy I would consider that quite a success" CPM008* (APP in MSK)

There were additional tertiary subthemes in the human resource frame in this study than there had been for the interviews with the managers. The subtheme *development/training* was further expanded upon and differentiated for this study to include *teaching role, peer review* and *continual learning*. However, the subthemes *staff preference* and *self-awareness* were removed because they were not recurring concepts in this set of interviews.

Table 7-4 Human resource theme

Theme	**Human Resource Frame**		
Primary Subtheme	Professional Development		
Secondary Subthemes	Development/ training	Encouragement /motivation	Support
Tertiary Subthemes	• *Teaching role* • *Peer review* • *Continual learning* • *Leadership training*		• *Assisting others* • *Empowering*
Primary Subthemes	Qualities	Communication	
Secondary Subthemes	Qualities	Communication	
Tertiary Subthemes	• *Empathy* • *Fairness* • *Respect* • *Teamwork* • *Social interaction*	• *Open to ideas* • *Feedback*	

7.3.2.1. Professional development

The *professional development* subtheme was particularly prevalent for the clinical specialists/APPs. This wide-ranging subtheme encompassed the teaching role of the participants, the learning opportunities that they afforded others and engaged in themselves, motivation strategies and the support and assistance they provide to others.

Development/training

All the clinical specialists/APPs spoke of their involvement in the education or development of others. The clinical specialists/APPs used their knowledge and experience to train other physiotherapists.

"*if they want to be trained up in orthotics, or they want to be trained up in ultrasound, or they want to be trained up in something a bit more specialist we would guide them through that."* CS015 (APP in MSK)

Frequently cited training/teaching opportunities were in-service training and peer review. Eight of the participants reported giving or organising in-service training and five spoke of conducting reviews or appraisals with members of the team.

"we have like we do in-services weekly, so we'll take a round every year where there'll be posters everybody is to present a poster for the in-service with the hope that that will help them to go on to presenting that maybe at a meeting." CS004 (APP in paediatrics)

Many of the clinical specialists/APPs spoke of the teaching aspect of their role. Several commented that they enjoyed teaching and there were also comments that it was an important aspect of the clinical specialist/APP role.

"*I like working with clinicians who have different interests and different expertise I enjoy teaching and working with colleagues*." CS001 (CS in MSK)

Some of the participants reported involvement in teaching outside of their team. Six of the clinical specialists/APPs reported lecturing or teaching students.

As well as directly training others, the clinical specialists also were involved in indirectly developing skills in the physiotherapists on their team.

"*there's a lot of informal peer assisted learning, communication, discussing cases, looking for advice, feedback, you know if you do have an interesting case discussing the assessment and treatment plan with your colleagues*" CS011 (CS in MSK)

Several of the participants reported providing opportunities for others to learn and develop new skills and five reported guiding the learning or development of others.

Many of the clinical specialists/APPs spoke of their own development and training and reported that they were continually learning in their role.

"*I have learnt so much working closely with orthopaedics in five years, it's been phenomenal, and it's a constant challenge, and there's so much that I have to learn and I love that I'm still learning loads of stuff"* CS004 (APP in paediatrics)

One participant spoke of continually learning to ensure that they can be a good source for others in their team

In terms of leadership development training, a range of training types were cited by the participants including: courses run through their organisation, in-services, coaching courses, management training, modules on Masters programmes and quality improvement courses. However, six of the participants reported that they had not completed any formal leadership development training.

> *"well I think for a start I think leadership skills or training is something that I've not really done very much*" CS005 (APP in MSK)

Other participants remarked that leadership training is something that they would like to do.

> "*you get taught how to be a physio, how to be a clinician, you don't necessarily get taught how to be a manager, or a leader, or a businessperson, you know. And those are things you do need to do, you know to effect change."* CS002 (CS in respiratory)

In contrast another participant remarked that leadership development was less of a priority because of the time needed to stay up to date clinically.

Many of the participants were positive about the training that they had completed and felt that it had been of benefit to them.

> "*as part of the Masters, I did a module on leadership in Great Ormonde Street, and I found that very useful. It was like five day long course and a lot of it was about personality, characteristics, and working within teams, and talking about followership, and mentoring, and working with different people, and being able to work around people."* CS016 (CS in paediatrics)

However, another participant reported that she did not feel that the small amount of leadership development that she had completed influenced her practice.

<u>Encouragement and motivation</u>

Another subtheme within *professional development* was *encouragement and motivation*. Several of the participants perceived being able to motivate others to be an important skill.

> *"I think with, motivation is an important part of leadership, without a doubt you want to bring people in the team along"* CS010 (APP in MSK)

The clinical specialists/APPs reported many different strategies for motivating their team including: assisting them to work through issues, placing patient care at the centre of everything, highlighting positive patient outcomes, keeping the work interesting,

encouraging people and organising social events. The most commonly cited strategy to motivate others was to demonstrate their motivation or to lead by example.

> "*I suppose if you're interested and motivated in your own job and you feel passionate about it then hopefully that will you know have an effect on people around you*." CS009 (APP in MSK)

Another common strategy to motivate others was to provide feedback and give praise or recognition for results.

> "*Other helpful motivational factors within the team, loads of praise, recognition when a job is done well, constructive...feedback, good teaching and learning from each other"* CS001 (CS in MSK)

In contrast one APP reported that she expects others to motivate themselves.

> *"I do feel that I do leave it to people to self-motivate themselves*" CS015 (APP in MSK)

As well as this, four of the participants reported that their team was generally well motivated.

> *"I think most of them are extremely self-motivated, extremely high-achieving and so they really don't need much motivation in terms of achieving those goals of patient satisfaction because they've got that."* CS012 (CS in MSK)

<u>Support</u>

The clinical specialists/APPs also discussed the different ways that they supported members of their team; both when they were having difficulties or when they wanted to develop professionally. Seven of the participants spoke of wanting to help and guide others and of ensuring that team members get the support they need.

> "*if you're helping people you're automatically stepping into a bit of a leadership role, you're showing, they need something from you and it's really important to make time for that for your team."* CS004 (APP in MSK)

There were several references to assisting others, these included helping with projects, research or challenging clinical situations.

> "*A lot of them would come to me looking for advice or looking for an idea if they can't think of anything and I'd help them with that. A lot of them might decide to do an audit of something during their rotation and I would do the statistics for them on that*." CS017 (APP in respiratory)

Another form of support that some of the clinical specialists/APPs provided was to empower members of their team to develop their skills through experience.

"*Leadership for me is empowering people to be able to have their own areas of expertise and go off and develop those*" CS001 (CS in MSK)

7.3.2.2. Leadership Qualities

When asked about the leadership skills they perceived to be important for a clinical specialist/APP to demonstrate there were a range of answers. These included goal-setting, the ability to motivate, decisiveness, adaptability and communication. Many of the leadership qualities described in the interviews were related to the human resource frame and so are presented here. The most prevalent of these were: social skills, teamwork, respect, fairness and empathy.

The participants spoke of enjoying the social aspect of their role; working with other physiotherapists, members of the wider MDT and patients. Several of the clinical specialists/APPs recognised the importance of having social skills to effectively read situations and manage people.

"probably one of the skills I think I've learnt over the years is knowing how to read people and being able to judge that" CS003 (CS in Care of the Elderly)

Participants also spoke of working as part of a team and of sharing tasks with others. There was recognition of the importance of working well with others and of maintaining harmony within the team.

"so our sort of ethos here is nobody finishes work until everybody finishes work, so there'd be some days where one ward is totally slammed with new referrals and people would be expected to help…..we've a very good policy here where everybody helps everybody." CS017 (APP in respiratory)

Six of the clinical specialists/APPs spoke of the importance of having respect for others.

"*And to be fair I think as well, and to have respect for all your team-members and to kind of emm know where everyone's coming from"* CS014 (CS in neurology)

Empathy and fairness were also seen as important.

"*Or if there's leave to be taken there's no hierarchy to it, there's just fairness in terms of discussion, being cognisant of what everyone else and that's kind of the service that I would envisage running,"* CS013 (APP in MSK)

7.3.2.3. Communication

There were many references to the importance of effective communication and to the communication strategies employed by the participants throughout the interviews. Many of the clinical specialists/APPs perceived communication to be an important part of their role and that communication skills were key to effective leadership.

"*develop communication skills, I think over the years as a physio I've learnt lots as I've met different clinicians, as I've treated patients I've developed more effective communication skills, listening skills and this has been a journey*" CS001 (CS in MSK)

A component of communication, listening to people, was cited as important by nine of the participants.

"I would say watch and listen to people, always have time, time to listen to people, it can be very draining and you can be really, really busy but if somebody seeks you out for your opinion and something is bothering them you should listen to them and give them that opportunity" CS004 (APP in paediatrics)

In terms of communication, the participants discussed communicating with patients, members of the MDT and other physiotherapists. The importance of effective communication with other physiotherapists in the wider physiotherapy team was highlighted.

"a big part of our role would be to refer the cases on that we feel could be seen by the physios on the ground, so a lot of it would be, a big part is communication with other team members and physiotherapists in the local areas." CS007 (CS in palliative care)

There were also comments from the participants about involving others in decision-making; listening to people's opinions on changes and getting ideas from them.

"So it's very much a joint decision, it's not like we're told, you do this, you do this, it's very much an open forum of communication and people just put their hand up to do X, Y and Z so that's how we do it." CS011 (CS in MSK)

As well as being open to ideas and opinions from others, the participants also discussed being open to receiving feedback on their performance and the performance of their service. The clinical specialists/APPs received feedback from patients, consultants and their managers. As well as this they gave feedback to members of their team about their performance and recognised when they were doing well.

> *"I'd always give an opportunity to whoever I'm working with, obviously my manager or other teams, an opportunity for them to give their thoughts and feedback on my service as well*" CS014 (CS in neurology)

7.3.3. Political Theme

The primary, secondary and tertiary subthemes associated with the political theme are displayed in Table 7.5. Some changes were made in the tertiary subthemes in the political frame in this study from those there had been for the interviews with the managers. In the subtheme *collaboration*, the tertiary subthemes *liaise with managers* and *liaise with medical consultants* were removed and the tertiary subthemes *relationship with medical consultants* and *affiliation with specialist team* were added. In the subtheme *career progression,* the tertiary subthemes *into managerial role* and *beyond managerial role* were removed and the subtheme *career pathway* was added.

Table 7-5 Political theme

Theme	**Political Frame**		
Primary subtheme	Organisational Citizenship Behaviour	Engagement	
Secondary subtheme	Organisational Citizenship Behaviour	Collaboration	Career progression
Tertiary subtheme	• *Committee membership* • *Promoting the profession* • *Looking for opportunities* • *Research involvement*	• *Networking* • *Relationship with medical consultants* • *Affiliation with specialist team*	• *Career progression* • *Career pathway*
Primary subtheme	Organisational Interpersonal Dynamics		
Secondary subtheme	Influence	Effecting Change	Conflict management
Tertiary subtheme	• *Autonomy* • *Powerless* • *Power structure*	• *Accessing resources* • *Business case/proposal* • *Campaign/lobby* • *Tactical approach* • *Negotiation*	• *Conflict management* • *Inter-profession rivalry*

Related to the political frame in general were references to the politics in the participants' workplaces. Two of the participants spoke negatively of the politics in their workplaces.

> "*There's an awful lot of politics [EMcG: OK] there's an awful lot of politics and it's very frustrating*." CS004 (APP in paediatrics)

7.3.3.1. Organisational citizenship behaviour

The primary subtheme *organisational citizenship behaviour* encompassed the activities that the clinical specialist/APPs engaged in for the benefit of their team, organisation and/or profession. These included committee membership, promotion of the profession, looking for opportunities and research involvement.

Seven of the clinical specialists/APPs spoke of their involvement in committees or clinical care programmes. This subtheme was more prevalent among the APPs than the clinical specialists. These committees were either within their workplaces or special interest groups in the ISCP. One APP spoke of how she plans to become a member of the APP Forum in the ISCP to work towards gaining ordering rights for physiotherapists.

> "*I wouldn't mind then getting more involved in like an APP type Forum in the ISCP, so I said I'd get involved because we can't order any radiological investigations*." CS009 (APP in MSK)

However, another participant expressed frustration with committee membership and that it was not worth the work required.

There were a few references to looking for opportunities. Five of the participants spoke of looking beyond their day-to-day work and to embracing possible opportunities.

> "*So you have to volunteer, or you have to take the initiative to lead on some projects that you feel more strongly about*" CS016 (CS in paediatrics)

Promoting the profession was a prevalent subtheme and the majority of the participants spoke of highlighting the role and value of physiotherapy or of advocating for their service in their workplace.

> *"You have to claim what you do, you've to stand over it and go actually, and be quite loud about it and go, 'I did this and it's a really good job and it's worthwhile'"* CS004 (APP in paediatrics)

Several participants commented that physiotherapists need to become better at promoting themselves and their profession.

> "*I think it's highlighting our role and the benefit of our role. I think it can be, and it's as well in today, you know anyone can call themselves a physiotherapist, it's, and especially in the community or people working in private practice, it's highlighting the role of chartered physiotherapists and the benefit of a chartered physio*." CS007 (CS in palliative care)

There were also several comments about educating other health care professionals about physiotherapy and promoting their service to GPs, nurses and consultants.

"*there's been education of GP teams in Dublin, as well as presenting to members of the multidisciplinary team in rheumatology and orthopaedics*" CS010 (APP in MSK)

Promoting the profession was a particularly prevalent subtheme for one participant who did a lot of advocacy in her organisation to ensure funding for her post.

"*we started to set up neurology fundraiser groups, and we started to have service-user days and stuff to promote the service and get PR around the post, so it was gaining momentum to the point that I actually had an opportunity to present my case to the CEO of this hospital where I had to show him the cost effectiveness of this post*" CS014 (CS in neurology)

Another subtheme within *organisational citizenship behaviour* was research involvement. This subtheme was more prevalent among the clinical specialists/APPs than it had been with the managers and ten of the clinical specialist/APPs spoke of their involvement in research. Four commented that research was an important part of their role.

"*the second bit then would be research, how I would be involved in that would be guiding, mentoring projects within my service, doing projects myself"* CS002 (CS in respiratory)

Completing research was seen as a sign of leadership success and one participant commented that her research involvement had improved perceptions of her role in the organisation.

"they're definitely treating me differently since I've started to submit to orthopaedic journals and present at orthopaedic conferences and I'm, because I'm actually doing the research, the role is carrying more weight so I think I can argue more strongly" CS004 (APP in paediatrics)

7.3.3.2. Engagement

The secondary subtheme *engagement* encompassed *career progression* and *collaboration*. The clinical specialists/APPs discussed their overseas experiences and the additional study they had completed to progress to this point in their career, their future career plans, their working relationships with medical consultants and other members of their specialist team, and the networking and collaborating that they engage in in their workplaces. This subtheme was particularly prevalent among the clinical specialists/APPs working in public hospitals.

Career progression

The clinical specialists spoke of how they had progressed in their careers to date and some spoke of their ambitions and how they would like to continue to progress. One clinical specialist spoke of being comfortable in her current role while another described how she aimed to become a physiotherapy consultant.

> "*I want to see consultant physiotherapists in Ireland before I'm finished my career, I'd like to be one of them you know, I want us to develop that much"* CS004 (APP in paediatrics)

One participant spoke of the importance of working in different workplaces to broaden experiences and ideas, and another clinical specialist described how much she had gained from her experience of working outside of a clinical physiotherapy position.

> *"I think for someone who wants to be a leader they need to step outside of the physio world, because you will learn so much more about politics, negotiating, picking your battles, the right time, right place, all of this stuff"* CS003 (CS in care of the elderly)

The clinical specialists/APPs spoke of planning their careers and strategically working to progress in them. One participant spoke of having a five-year plan while another described having to leave one hospital for another because she was not being promoted to a clinical specialist position. Two participants described how they worked to establish more specialised and elevated roles for themselves within their organisations.

> "*I knew that they were doing rheumatology triage in the UK, so I got in touch with people who were doing rheumatology in the UK and asked them to send me their protocols, and met with the rheumatologist, I'd drawn up a business case to say look this is something that I think that I have the skills to do, if you'd be happy for me to do it."* CS015 (APP in MSK)

Within career progression the attainment of higher qualifications was a common theme. Thirteen participants reported that they had completed a Masters and two of these reported that they were working towards attaining a PhD. One participant advocated the importance of doing further education.

"I definitely think that you need to go on and do further post-graduate training in whatever area you need to do and then you need to go on and look at what else you can do, look at the bigger picture." CS009 (APP in MSK)

Another prevalent theme in the career paths of the clinical specialists/APPs was gaining international experience. Eight reported that they had experience of working in another country. One participant reported that this experience had been important to her career and that she would recommend other physiotherapists to get a broad range of experience.

"I think getting as broad an experience as possible is helpful, certainly I think that it's helped me that I've worked in different areas and in different places because you get to see a little bit how things are done elsewhere" CS010 (APP in MSK)

Collaboration

The *collaboration* subtheme encompassed the working relationships that the clinical specialists/APPs had fostered with people outside of the physiotherapy team, the networking they engage in and their affiliation with the specialist (rather than physiotherapy) team. The participants spoke of the importance of forming good links with other healthcare professionals and teams. In particular, the clinical specialists/APPs spoke of building good working relationships with medical consultants.

"*So that for me has been good, I've been in working with the same consultants for the last 8 years, and new ones have come in, but they trust me, and that's been crucial for helping develop our service."* CS003 (CS in care of the elderly)

Six of the participants spoke of the importance of having the support of a medical consultant in their workplace.

"I think what got it across the line was a consultant pulling the CEO out of his office and getting it sorted. Which again I think that's a lesson learnt for physio, it's really important that we have good connections with consultants and that we prove our value and worth to consultants because I think definitely they are the key stakeholders." CS014 (CS in neurology)

While most of the clinical specialists spoke positively about working the consultants, three were more critical. One clinical specialist spoke of auditing the service of two consultants and of their negative reaction when the audit results were not positive. Another clinical specialist reported that she had to work hard to maintain a working

relationship with the consultants in the service. While an APP complained that the consultants were poor at communicating with them in a timely manner.

> "*I just feel that we just constantly have to sell ourselves, and be made aware that we're there because sometimes if you don't go into them for a week or two they'll forget your name*." CS009 (APP in MSK)

As well as maintaining professional relationships with the consultants, seven of the clinical specialists/APPs also spoke of their affiliation with the specialist team that they worked on.

> *"it's very different working in the clinic, but there's a whole team down there, between the admin staff and the nursing staff and everyone that works down there in clinic it's just a different, different than what I'm used to in the physio department, it's good*." CS008 (APP in MSK)

Some of the participants reflected that they were more connected with the specialist team that they worked on than the physiotherapy team.

> "*it's a kind of a unique post in that it's home-based as well and it's based more in the multi-disciplinary health care team as opposed to the physio team"* CS006 (CS in palliative care)

Also within collaboration was the subtheme networking. This subtheme was prevalent among the participants who work in a public hospital. Six of the clinical specialists/APPs spoke of networking in their role.

> "*to be able to network within a hospital, I was spending a lot of my time when I came here first in the canteen meeting different departments, finding out who's who and networking around the hospital, building up the trust in the different areas"* CS016 (CS in paediatrics)

Three of the participants gave specific examples of networking within their roles.

> "*it's a good way of me maintaining that sort of network and intercommunications with surgeons and with my colleagues in the surgical world"* CS013 (APP in MSK)

7.3.3.3. Organisational interpersonal dynamics

The *organisational interpersonal dynamics* subtheme was a wide-ranging subtheme covering perceptions of power and influence within their workplaces, conflict management strategies, inter-profession rivalry and approaches to effecting change.

Conflict management

The participants reported a range of strategies and approaches that they adopt when addressing conflict.

> "*I've had conflict over the years, I think that's part of the job, and I have been fedback that I would be a good communicator and that I would have dealt well in the past from line managers, from seniors at the time*" CS014 (CS in neurology)

The most commonly cited strategy for managing conflict was clear communication and to discuss issues with the people involved. All of the clinical specialists/APPs spoke of listening to people, discussing problems or being open and direct.

> "*I mean often you do need it to discuss things and to get things out in the open but I think you need open communication and I suppose that's what I would try to do to deal with things before they happen*." CS005 (APP in MSK)

Related to communication, was the approach of exploring the cause of conflict. Eleven of the clinical specialists/APPs spoke of trying to find out what had caused the conflict so that it could be addressed. One participant commented that it was important to learn from conflict.

> *"you actually break it down and look at the root analysis quite often you'll find something like human error, fatigue, stress, and it's getting to the bottom of that and learning from it is most important."* CS016 (CS in paediatrics)

Nine of the clinical specialists/APPs spoke of addressing conflict situations quickly or of identifying potential conflict situations and dealing with them before they become conflicts.

> "*I don't avoid the issue, I think the most important thing to do is to deal with it immediately, and don't let it fester, so immediate one-to-one, face-to-face with the person who you feel there might be an issue of conflict with."* CS017 (APP in respiratory)

One participant felt that conflict was too strong a word to describe the disagreements that she deals with in her workplace because they are addressed before they become conflict situations.

Another strategy employed by many of the participants was to get advice or support from others, in particular the physiotherapy manager.

"*Speak directly if you can to whoever you have conflict with and hopefully come up with a plan of action to resolve it. And if that doesn't work, yeah discussing it with your manager, looking for advice and seeing where else you can go with it."* CS011 (CS in MSK)

One participant spoke of her limitations when dealing with conflict and of therefore referring people on to the physiotherapy manager when needed.

As well as strategies for managing conflict several of the clinical specialists/APPs reported that they didn't have to deal with many conflicts in their workplaces.

"I really have personally had very little personal experience of it, difference of opinion, not necessarily all agreeing with the same thing but not a conflict." CS013 (APP in MSK)

Two of the participants spoke of trying to avoid conflict.

"I know others probably would deal with the thing, if something needs addressing, something needs sorting it would be sort of met head on, head-on, I wouldn't be that personality type now myself to tell the truth, I definitely would be trying to emm calm the waters and avoid the conflict" CS006 (CS in palliative care)

A potential source of conflict that was described by the clinical specialists/APPs was inter-profession rivalry.

"*And then at that there's a whole band of people that are fighting for clinical leadership, so you have non-consultant experienced doctors, you have nursing staff, you have allied health, now not just physios you have like ourselves, OTs, you have umm you know the whole range, so we're all fighting for leadership*." CS002 (CS in respiratory)

There were comments about competition with the nursing profession. Four participants made comparisons between the physiotherapy and nursing professions and two referenced the hierarchical positions of power occupied by those from a nursing background.

"*more physios need to move into management as well, and be involved in like hierarchical management, within hospitals I'd say it's probably very nursing dominated within the hospital within the HSE but physios need to move into it but emm, listen, that's not for me*." CS004 (APP in paediatrics)

As well as the nursing profession, there was also rivalry noted with the medical profession. Some of the participants spoke of how they perceived doctors to have more power than physiotherapists.

> "*if leadership is change management then change management nearly needs to be either facilitated by a doctor, and which is very depressing, and very old fashioned but that's my experience. It's very, I think healthcare is so hierarchical, like at one point I was like, I even said it to someone recently, 'Like if you actually want to change something in healthcare then go back to medicine, go back and do medicine, you'll be much more effective than going off to do a Masters'*." CS002 (CS in respiratory)

Influence

The subtheme influence was not as prevalent a theme in the clinical specialists'/APPs' interviews as it had been in the managers' interviews. However, some of the clinical specialists/APPs did discuss influence in their workplaces, perceptions of autonomy or having a lack of power. This subtheme was more prevalent among the clinical specialists/APPs who worked in public hospitals.

One participant spoke of using their connections with medical consultants to have more of an influence in their workplace. While another participant spoke of identifying those who have influence and using appropriate information and evidence to influence them. Three of the participants reflected on not having influence in their workplaces. One participant spoke of not being listened to by her colleagues while another spoke of having difficulties with other physiotherapists accepting their decisions. Another participant reflected that she needed to liaise with her manager or with medical consultants in order to have an effect.

> "*And some of it is a personal thing, you know, but I sometimes think that you don't get listened to very much and some of that like you do have to keep presenting yourself and being consistent with what your message is but it's damn hard sometimes."* CS002 (CS in respiratory)

There were a several references to autonomy in the interviews; some participants spoke of having autonomy in their work whereas others complained that this wasn't true for them.

"*And I think another frustration would be sometimes within the hospital system your lack of autonomy."* CS015 (APP in MSK)

One participant reported that they had more autonomy in their role now that they were a clinical specialist.

"*And being given the clinical specialist role, like I would have had the same ideas when I was a senior but I wasn't allowed to do anything about them. But suddenly, that was on a Tuesday and then the Wednesday I got the job and suddenly I was allowed do what I wanted, not do what I wanted of course but you're allowed, suddenly your ideas seem more important, more conspicuous*" CS003 (CS in care of the elderly)

In terms of power, four of the participants spoke of not having power in their workplaces.

"*it's not my decision, it's not her decision, it's not the CEO's decision, it's the HSE, that we can't have more staff to set up new services at the moment, so the power is not in our hands."* CS017 (APP in respiratory)

The clinical specialists/APPs discussed the power structure in their workplaces. There were a range of answers given to the question, 'Who do you perceive to have the most power in your organisation?' The most commonly cited answer was consultants; ten of the participants answered that consultants had a lot of power.

"*Within orthopaedics [name] has the most power, he's the lead consultant. And he probably has the most power within the hospital, one of the most powerful consultants within the hospital [EMcG: Yeah? OK] and probably one of the most powerful consultants in Dublin…. he's very powerful"* CS004 (APP in paediatrics)

Another frequent answer was the CEO; seven of the participants answered that the CEO in the organisation had a lot of power. Three of the participants discussed the physiotherapy manager in their workplace when answering this question.

"my first line manager would have the most power because she probably can influence us a bit more than other people, so probably our physiotherapy manager." CS009 (APP in MSK)

Other answers included the doctors, the heads of department, patients, the HSE and the government.

Effecting change

The final subtheme of *organisational interpersonal dynamics* was *effecting change*. The participants discussed driving changes in their workplace and the strategies that they

employed to do this. These strategies included writing business cases, negotiating, campaigning and taking a tactical approach.

Participants recognised that effecting change can be difficult and that you need to be persistent.

> *"I think change in healthcare is very difficult, mmm because it's so populace in some ways, it's people, healthcare is primarily about the people and that's their greatest resource. And everybody has their own opinions and just getting a co-ordinated effort sometimes takes a lot of resilience and a lot of persistence, yeah*." CS002 (CS in respiratory)

Changes that the clinical specialists/APPs were trying to achieve included accessing resources such as additional staff or equipment. Five of the participants spoke of successfully acquiring additional resources.

> "*we tend to get resources when required, and also there's good support in terms of you're doing research and audit there's always finances available, if you're willing to seek it out*." CS016 (CS in paediatrics)

One clinical specialist described how she was the best person to advocate for the funding for her post.

> *"I felt I suppose a lot of it was down to me to do a ten minute presentation to him and as nerve-wracking as that was I felt I was probably the best equipped to take that role and just to promote the service and sell it to the CEO."* CS014 (CS in clinical specialist)

Four of the clinical specialists spoke of negotiating for changes. They negotiated with medical consultants about the management of patients, discussed issues with their manager to try to find a resolution and negotiated with nurses and other colleagues about setting up their service.

> *"And I would tend to get on well with, like I know the nurses down in OPD so I would have said, 'Just wondering would you be able to help me out?' You know so I did a lot of negotiating to set up the clinic."* CS015 (APP in MSK)

One participant conceded that negotiation is not always successful.

> *"so that's what you do, you get that information together and then you go to your manager, they are also working in the constraint they have available to them and we have a discussion. And sometimes we come to some sort of solution and other*

times there is no solution to be found in that framework, what can you do? [Laughs] What can you do?" CS013 (APP in MSK)

Many of the clinical specialists/APPs described taking a tactical approach to campaigning for change where they read the situation or people involved, collaborated with appropriate people, monitored results and adapted their strategy as necessary.

"*reading the people, reading the situation, sometimes it's ok to push, sometimes it's not, biding your time I think is really important, you may want it to happen today but today mightn't be the right day and even waiting another week until the consultants are ready to hear it, whatever it takes, you just have to bide your time a little bit and picking the right battle"* CS003 (CS in care of the elderly)

A common approach for effecting change was to write a business case. Eight of the participants reported compiling business cases to argue for new services or additional staff in their workplaces.

"*you have to be very, very structured, if you want something new you have to have the business plan and the stats to show it, and that's how we'll lead organisational change."* CS004 (APP in MSK)

Five of the clinical specialists/APPs described how their business cases were successful in implementing change.

"*I think in my time as Chair of the physio department that I co-ordinated and largely wrote a number of business cases, that cumulatively over time have resulted in two changes that have been of benefit. The first was additional staffing to OPD to specifically address the waiting list."* CS010 (APP in MSK)

One of the participants advocated that physiotherapists need to be more business minded and use economic data to back up their claims of cost-effectiveness.

7.3.4. Symbolic Theme

The primary, secondary and tertiary subthemes associated with the symbolic theme are displayed in Table 7.6. There were some differences in the secondary subthemes in the symbolic frame in this study to those in the interviews with the managers. In the subtheme, *organisational culture*, the secondary subtheme *mission statement* was added and the secondary subtheme *open door policy* was removed as this was not a theme in the clinical specialist/APP interviews. The secondary subtheme *time with staff socialising* was renamed *team bonding* as it better described the data in this subtheme.

Identity as a physiotherapist was not a theme within professional identity in the interviews with the clinical specialists/APPs and so was removed.

Table 7-6 Symbolic theme

Theme	**Symbolic frame**	
Primary subthemes	Organisational Culture	Attributes-behaviours
Secondary subthemes	• *Atmosphere/ambience* • *Team bonding* • *Celebrations* • *Mission statement* • *Values*	• *Passion* • *Big picture* • *Future oriented*
Primary subthemes	Professional Identity	
Secondary subthemes	Perceptions of physiotherapy/reputation	Mentor
Tertiary subthemes	• *Value of physiotherapy*	*Role-model*

7.3.4.1. Organisational culture

The primary subtheme *organisational culture* encompassed awareness of the atmosphere or ambience of the workplace, facilitating staff morale and team bonding, their mission statements and leadership values.

Some of the participants described actions they take to facilitate a positive workplace culture. One participant spoke of bringing in cake to thank colleagues who had helped her, another spoke of putting an inspirational quote up on their team board.

> "*I put up the odd quote on the board [EMcG: Do you? (laughs) very good], what's the quote I have at the minute? It's not, I just like it because I saw it on the Forbes*

website, 'It's not ok just to be busy so are the ants, it's what you're busy doing that's important.'" CS016 (CS in paediatrics)

Six of the participants demonstrated an awareness of the ambience or atmosphere of their workplace. One clinical specialist spoke of wanting to change perceptions of how the emergency department in the hospital is viewed and making it a more positive place to work. Two participants reflected on the negative impact that staff shortages have on the workplace atmosphere and team morale.

"we've had a lot of maternity leaves, we've had a lot of people leaving, people get down and fed up because of staffing challenges and that really effects the moral of the department as well and that can be difficult when morale is low because there's just no staff" CS004 (APP in paediatrics)

One participant complained of the physical environment in which she works and its negative impact.

"*it's not the greatest place to work but I think the building is by far and away the worst aspect of working over there, which is, you know, not a bad thing to say but it's very hard to sometimes be, feel that you're valued if you're working in a prefab that's like maybe 20 years past its sell-by date*" CS002 (CS in respiratory)

However, another two clinical specialists reported that there was a positive atmosphere in their workplaces.

"*there's a good atmosphere in work with those kinds of things which always brings the team together"* CS007 (CS in palliative care)

While some of the participants did speak about the atmosphere of their workplace there weren't many comments about activities or strategies that they engaged in or initiated to ensure a positive atmosphere or ambience.

Also within *organisational culture* was the subtheme *mission statement*. Five of the participants discussed the mission statement of their workplace or their guiding principles.

"I guess it sort of fits a little bit with the mission statement, striving to provide excellence within a neuromusculoskeletal field and looking after patients and quality of care" CS001 (CS in MSK)

A prevalent subtheme within *organisational culture* was *team bonding*. This covered the activities that the clinical specialists/APPs engaged in to promote bonding and improve morale in the team. There were several comments about the importance of team building activities within their workplace.

"*they're important, and when they're lost it can be really fragmenting, it fragments teams, and I don't know, I think that's difficult, I think really to get the best out of a group of people, you've got to treat them as a group, we're individuals but you got to bring everybody together on it*." CS013 (APP in MSK)

The activities reported included nights out socialising, lunches, in-service training and educational sessions, and also more informal activities such as going for coffee.

"*our department has been quite good at organising team events which have been daytime and evening time and I think as physios we are generally quite a sociable bunch"* CS005 (APP in MSK)

However, one of the participants described how she had pulled away from engaging in team activities when going through a stressful period at work.

Several of the participants reported that team meetings were a good way to facilitate team bonding.

"I think our team meetings do help and any of the educational stuff that we do because we are bringing the whole team together, I think anything that brings the team together where you're communicating as a whole will improve team bonding." CS010 (APP in MSK)

Two of the participants spoke of celebrating team-members' birthdays and another spoke of celebrating a team member's success by organising a team lunch.

"I suppose we'd always reward good work with you know for example the MS OT recently finished a post-grad there, we all went out for lunch together, and I would kind of organise that quite a bit." CS014 (CS in neurology)

Four of the clinical specialists/APPs reported that they did not have organised team bonding activities in their workplaces.

"We don't do anything specific, like we have a general in-service once a month, which but you know we all sit there, it's very didactic, so it's not very umm, it's not very like involved as such….But you know it would be nice to sometimes have a broader appreciation of kind of what goes on, I suppose but no we don't do anything formally." CS009 (APP in MSK)

One of the participants commented that they do not currently engage in team building activities but that this was something that they want to do. While another participant reported that it was difficult to justify doing activities that were not clinical.

The final subtheme within *organisational culture* was *values*. Frequently cited leadership values were honesty, respect, to lead by example, involve people, have open

communication and fairness. Communication was the most frequently cited answer when the participants discussed their leadership values. The clinical specialists spoke of the importance of being approachable, a good listener and of open and transparent communication.

> *"I think communication, so both how you communicate and that you have approachability do you know? So, that's within communication, that people can come to you and that you're a good listener, so active listening is good*." CS015 (APP in MSK)

Six of the participants spoke of leading by example as being a leadership value of theirs. The clinical specialists spoke of leading by example in the way they treated patients, kept up do date with research and promoted physiotherapy.

> *"so I lead by example in that way, would be the big thing, myself, seeing me doing that with patients so I hope that that then filters down to people, and hard work, and it again inspires others to work hard."* CS003 (CS in care of the elderly)

Five of the clinical specialists/APPs reported that honesty was a leadership value of theirs and respect was also cited as a leadership value by five of the participants.

> "*to have respect for all your team-members and to kind of emm know where everyone's coming from*" CS014 (CS in neurology)

Fairness and involving people were also cited by several of the participants as leadership values.

> "*I think patience is one of them [pause], being able to influence in a non-didactic manner, to be fair, and I think to acknowledge the good work of somebody else, to give criticism but to be very, very fair with the criticism."* CS017 (APP in respiratory)

7.3.4.2. Attributes or behaviours

The second subtheme within the 'Symbolic' theme was *attributes or behaviours*. This subtheme covered attributes and behaviours that would fall within the symbolic frame, namely being passionate, seeing the big picture and having vision or being future-oriented.

The majority of the clinical specialists/APPs spoke of their passion or love for their role or aspects of their role.

> *"it would be to really improve the care of older people in the hospital, it's something I feel really strongly and passionately about*" CS003 (CS in MSK)

There was recognition of the importance of being passionate in your role.

> "*pick something you have a passion for, I think then all the rest like getting your clinical skills, promoting your service, research, education, promoting your team, they all seem easy if you believe in something and you really enjoy what you do"* CS014 (CS in neurology)

Four of the participants demonstrated awareness of the effect their passion can have on those that they work with.

> *"I suppose if you're interested and motivated in your own job and you feel passionate about it then hopefully that will you know have an effect on people around you."* CS009 (APP in MSK)

Many of the clinical specialists/APPs discussed the importance of being able to take a step back and appreciate the bigger picture in their role.

> "*it's always looking at the bigger picture and where is it going, where is the hospital going and all that kind of stuff*." CS011 (CS in MSK)

Two participants spoke of the need for physiotherapists to think beyond the physiotherapy profession and take ideas and inspiration from other industries.

> "*have an open mind, like I find the biggest barrier to physios that I come across is they're quite in their shell in terms of all of their learning is within physiotherapy, one thing that opened my mind when I was in the UK was the fact that, one of my modules was Health and Safety where they take inspiration from different industries"* CS016 (CS in paediatrics)

Five of the clinical specialists/APPs spoke of having a vision or planning for the future.

> *"I think as a clinical specialist you also need to show leadership in terms of the direction that the service is taking, so being innovative in terms of how services are provided but also in terms of having a vision of where the service is going in the future"* CS010 (APP in MSK)

One participant spoke of anticipating and dealing with challenges that may potentially face physiotherapy in the future.

> *"so I think a lot of physiotherapy is going to change to health promotion and health management as opposed to dealing with the problem when it arises but I think that's going to be a difficult one to negotiate between primary care and secondary care and tertiary care and what services go where"* CS008 (APP in MSK)

7.3.4.3. Professional identity

The final subtheme in the 'Symbolic' theme was *professional identity* which covered the mentoring relationships of the clinical specialists/APPs, leading by example and perceptions of the physiotherapy profession.

The clinical specialists/APPs were asked if they had a mentor or role model. Eight of the participants reported that they did have a mentor or role model.

> "*There's some fantastic leaders within the hospital, probably my main mentor and role model would be [name], she's the [high level position] here but she was the [profession-specific manager] years ago, she's just a force of nature, she's just so patient-centred."* CS003 (CS in care of the elderly)

The majority of the clinical specialists/APPs reported that they did not currently have a mentor, however, six reported that they had previously had a mentor.

> "*I have had a mentor in the past, I don't have one currently. I think I'm quite comfortable in my current job so if I was to step outside of that, which I might, I think at that stage that I'd have no problem about getting another one, a role model."* CS002 (CS in respiratory)

One participant speculated that it may be harder to have a mentor when you have progressed to the level of APP. Two of the participants reported that they would like to have a mentor and another spoke of encouraging others to have a mentor.

> *"Yeah, we've a few people training, just like new seniors and a few of the more senior staff training to go to clinic and I strongly encourage all of them to have a mentor, just someone to talk to about their ideas."* CS005 (APP in MSK)

Mentoring other physiotherapists was also discussed by many of the clinical specialists/APPs; seven of the participants reported mentoring others.

> *"so I would have a role in mentoring some of the junior staff"* CS011 (CS in palliative care)

Being a role model was also very prevalent in the clinical specialists'/APPs' interviews. The participants spoke of the importance of having role models and people to inspire others in the profession.

> "*we need leaders out there to keep driving us forward and role models really to kind of inspire younger staff coming through so"* CS005 (APP in MSK)

Fourteen of the participants spoke of leading by example.

> *"I mean I try and just lead by example I suppose, I mean when you're up here in the physiotherapy department people are quite open to things and I suppose if you*

take the lead and if you show them that you're doing it and it works for you" CS008 (APP in MSK)

There were also comments that effective leaders lead by example and don't just tell others what to do without doing it themselves.

"*definitely I think leading by example. There's nothing worse than someone who talks the talk and then they don't actually do it."* CS014 (CS in palliative care)

Perceptions of physiotherapy

The second subtheme within *professional identity* was *perceptions of physiotherapy*. This subtheme encompassed recognition of perceptions of the physiotherapy profession, the need to change perceptions of the physiotherapy profession and efforts made to ensure that physiotherapy has a positive reputation.

Six participants described making efforts to ensure that physiotherapy is positively viewed and its role understood in their workplace.

"*branding physiotherapy around the hospital and making sure that when it comes up for funding applications or research applications, that we have good representation."* CS016 (CS in paediatrics)

There was recognition that an outdated view of physiotherapy is held by some people and that there is a lack of understanding of the physiotherapy profession among both healthcare professionals and the public.

"*to be honest with you I think we're underused and undervalued in certain jobs at the moment."* CS014 (CS in neurology)

Six of the clinical specialists/APPs spoke of the need to change perceptions of the physiotherapy profession and educate others about the role of physiotherapy.

"*we have to start to change perception about us a little bit, about the roles we can perform and what we can do."* CS004 (APP in paediatrics)

7.3.5. Other Themes

Additional themes and subthemes in the data that were not accounted for within the four frames of Bolman and Deal's framework (1991) are displayed in Table 7.7. As described above, 'Challenges' and 'Physiotherapy profession' were found to be principle themes in the interviews whereas 'Workplace' and 'Clinical role' were less significant themes.

The additional themes were the same as those in Study II, however there were differences in the subthemes. There were two additional subthemes within challenges for the interviews with the clinical specialists/APPs: *ordering images or tests* and *career structure*. The subthemes in physiotherapy profession were different for the clinical specialists/APPs: *clinical specialist/APP role* and *management role*. The subthemes *health promotion* and *clinical focus* were not included within the theme 'Clinical role' and subthemes *clinical excellence*, *advanced clinical skills* and *clinical advice/expertise* were added to this theme.

Table 7-7 Additional themes

Theme	**Subthemes**
Challenges	• Time Constraints • Lack of resources • Other professions • Changing Structure • Ordering images • Career structure
Physiotherapy Profession	• Clinical specialist/APP role • Management role
Workplace	• Voluntary hospital • Primary care/community • Private practice/private hospital • HSE
Clinical role	• Clinical excellence • Advanced clinical skills • Evidence Based Practice • Patient centred care • Clinical advice/expertise

7.3.6. Challenges

The theme 'Challenges' encompassed the challenges that the clinical specialists/APPs perceived themselves to be facing in their role as physiotherapy leaders and the challenges facing the physiotherapy profession. The most prevalent of these formed the subthemes within this theme. Other challenges cited by the clinical specialists and APPs were: the politics of their organisation, balance with their personal life, the ageing

population and obesity crisis, and that physiotherapists don't see themselves as leaders. Three of the participants reported protection of the title of physiotherapist or statutory registration as a physiotherapist to be challenges facing physiotherapy leaders.

> *"Challenges. I think one of the big things is the statutory registration, it's very hard for us to drive the profession when that isn't in."* CS015 (APP in MSK)

7.3.6.1. Time constraints

Time pressures and being too busy were discussed by many of the clinical specialists/APPs. Twelve participants described difficulties associated with not having sufficient time.

> "*I certainly feel that emm, that leadership role, that I'm not able to fulfil it in the same way as in my last job and the biggest reason is time."* CS010 (APP in MSK)

Time constraints had an effect on their activities beyond their clinical caseload, activities associated with the leadership aspect of their role. Nine of the participants reported that a lack of time impacted their ability to engage in tasks beyond their clinical role. One participant described how seeing patients and completing patient paperwork was prioritised over other tasks and thus they do not have much time to dedicate to other tasks. Several of the participants reported that they would like to be able to spend more time on research, audit or service development.

> "*I'd love to do more research or I'd love to do a bit more service development and stuff but it does make it a little bit harder. But at the same time if you're setting up a service from the start and you're having to liaise with people inadvertently you're doing all that leadership stuff anyway but yeah, I'd prefer if there was a little bit more time, but like in the real world [both laugh] I can't really*." CS008 (APP in MSK)

7.3.6.2. Lack of resources

Lack of resources was also frequently reported by the clinical specialists/APPs.

> "*So I think the health system has to change in relation, and a lot of physios have the motivation, they have the drive but they can't be leaders because they don't have the resources and the time. And I think that's a, that's a big thing, a big problem"* CS014 (CS in neurology)

The participants spoke of a lack of resources in general but also specifically of a lack of staff, equipment and space.

"you can see that there are limited resources within which we work sometimes. Equipment. [EMcG: Really?] Yeah, things like we're trying to go electronic and the hindrance is the fact we don't have enough computers" CS002 (CS in respiratory)

There was recognition that the lack of resources influenced their work and the services for patients.

"*We would probably, we do more calls, we would probably refer more to the local physios if there were the resources there but you know they are on maternity leave they're stretched, so someone that they could see we are keeping on to help them out"* CS007 (CS in palliative care)

Six participants spoke of needing more resources to grow and develop their services or to demonstrate leadership in the profession.

"*I think resources is a big, is another barrier, so if we want to lead and develop….If we want to lead and develop, we need to have more resources and more respect as a profession"* CS015 (APP in MSK)

7.3.6.3. Other professions

The clinical specialists/APPs also discussed the challenges and difficulties of working with other professions. As noted in the *conflict* subtheme above, many of the participants spoke of rivalry with other healthcare professions. The clinical specialists/APPs reported the need to address resistance from other professions, to change beliefs about the physiotherapy profession and of other professions encroaching on physiotherapy practice.

There was recognition of the importance of having medical support when developing new services. One participant reported that it can be difficult to initiate new services without medical backing.

"I suppose our team has very much taken the lead, we're a therapy team with no medical support and have gone and done something so there's been big push back from consultants, they weren't overly happy to see us being leaders in care of the elderly when I suppose in theory that should be a doctor, so that has created challenges external to us that we can't control." CS003 (CS in care of the elderly)

Two of the participants spoke of the challenge posed by competing professions such as physical therapists.

"when you saw loads of physical therapists setting up clinics, that has a knock on effect was there was less physios employed in the outpatient sector" CS012 (CS in MSK)

The participants also spoke of the challenge for physiotherapists to get recognition from other professions and acknowledged the barriers that can be put up by other professions.

"*I think just ensuring that we keep getting recognition for our profession I think is a big challenge for, that we need leaders to push, physiotherapy is relatively small in the grand scheme of nursing and medicine and everything else we need leaders out there to keep driving us forward."* CS005 (APP in MSK)

7.3.6.4. Changing structure

The *changing structure* subtheme was less prevalent among the clinical specialists/APPs than it had been in the managers' interviews. However, there were comments about changes in staffing, the structure of their organisation and the physiotherapy profession.

"I think the overall hierarchy of physio is going to change as regards, again the same the management structure of, is it going to be a physio manager managing physio? Is it going to be, there's talk that maybe is it going to be an occupational therapy manager managing a certain team as opposed to specific managers so I think that will bring emm challenges in itself" CS008 (APP in MSK)

Two participants spoke of the changes happening in the hospitals in which they work. One was critical that change was not always well managed.

"It's a great idea to bring in a new initiative but only a new initiative when all the stake-holders have been advised and included maybe in that change process, in my opinion, and it doesn't always happen." CS013 (APP in MSK)

One participant gave an example of managing a period of change in his department as a specific occasion when he had demonstrated effective leadership. While another participant spoke of having difficulty getting people to accept change in their workplace.

"*Getting people to accept change, it's very difficult when you're extremely busy and you're doing a thing a certain way for a certain number of years and you only have the time to do it that way in your daily work schedule to accept change and do things differently. So, that's a big change, a big problem, accepting change*." CS017 (APP in respiratory)

7.3.6.5. Ordering images

A challenge reported by clinical specialists/APPs who specialise in musculoskeletal conditions was ordering images. The MSK clinical specialists/APPs reported difficulties with ordering x-rays or MRIs for their patients.

> "*one of the main things for those patients is investigations and I can't order them, so I'm hanging around corridors trying to meet up with consultants, trying to meet up with junior doctors, you know somebody who's qualified maybe a week can order x-rays and I can't, and it's just very frustrating because it hugely impacts on our work."* CS015 (APP in MSK)

The clinical specialists/APPs described having to liaise with non-consultant hospital doctors (NCHDs) or consultants to be able to order images for their patients.

> *"that's where the NCHDs come in, so I will meet them every Tuesday morning usually or once a fortnight to discuss the case and say look it this person needs X, Y and Z and then they can facilitate the ordering of it"* CS008 (APP in MSK)

Some participants spoke of inefficiencies and frustrations associated with not being able to order images.

> *"that's sixteen consultants that we need to liaise with which has proved quite inefficient really in particular because we cannot order investigations ourselves, that all has to go through consultant discussion."* CS010 (APP in MSK)

However, others reported that they had a system in place with the consultants/NCHDs that was working well.

7.3.6.6. Career structure

The final subtheme within challenges was career structure. The clinical specialists/APPs spoke of the limitations of the current career structure for physiotherapists in Ireland. Two of the participants perceived the career structure for physiotherapists to be better in the UK.

> *"In England I would have seen a better career structure/pathway within the physiotherapy profession, even from a junior to a senior two to a senior one and I know it moved into banded grades and then more recently to consultant level. The roles are clearly defined and recognised by the Chartered Society of Physiotherapy."* CS001 (CS in MSK)

The poor career structure was seen as a reason that physiotherapists moved away from clinical physiotherapy roles. One clinical specialist observed that she would have to step away from clinical work in order to continue to progress in her career. Another clinical specialist remarked that the poor progression in pay scales meant that the physiotherapy profession lost people to the medical profession.

The participants spoke of the flat structure within physiotherapy at present and the lack of opportunity to progress to more senior roles.

> *"the profession, because of the financial climate, has been quite static and a lot of people in particularly at junior level have been stuck, or at basic grade level, essentially see themselves in the same role for a very long time with very limited possibilities for career advancement, so I think that is a problem."* CS010 (APP in MSK)

7.3.7. Physiotherapy Profession

The theme 'Physiotherapy profession' encompassed the clinical specialists'/APPs' comments on their profession. While there were few comments on the profession in general, two strong subthemes were found in this theme: *the clinical specialist/APP role* and *the management role*.

7.3.7.1. Clinical specialist/APP role

The subtheme *clinical specialist/APP role* encompassed the participants' perceptions of their roles. The clinical specialists/APPs discussed the different components of their roles, the frustrations and responsibilities, and made comparisons with other countries. A range of examples of the roles and responsibilities of clinical specialists/APPs were given. These included their clinical role, teaching, service development, research, designing the service, supporting the manager and quality improvement.

> "*you have to be able to switch over and back between research and patient management and you have to be able to incorporate the two"* CS004 (APP in paediatrics)

All of the clinical specialists/APPs reported that they enjoy their role or enjoyed it most of the time.

"*I enjoy being a physio and I always have, I find the job very interesting, I find it very challenging, very stimulating"* CS010 (APP in MSK)

Participants reported that they enjoyed the varied nature of their roles. However, the participants also noted that the role can be challenging.

"It's hard work at, you feel a lot of responsibility I think sometimes, and I think working in clinic a lot you've got the risk of, like you've to find the balance between keeping your physio skills, like what we're trained to do versus just seeing patients all the time in clinic and that's hard, like it's hard to balance, it's busy and you've a lot of time chasing people up" CS005 (APP in MSK)

Five of the APPs described how their role in their specialist clinic was different to working in the physiotherapy department.

"I bring physio skills to the table up there which I'm more than happy to do but it's not a physio session, I'm bringing my skills in terms of expertise and experience in musculoskeletal assessment and knowledge in an MSK and orthopaedic setting to that clinic." CS013 (APP in MSK)

Two of the APPs reported that they missed working in a purely physiotherapy role.

"I probably miss a bit, I'm not doing as much hands-on treatment as I used to do so that's probably, I probably miss that a little bit but I mean when you balance it up it's, and it's very different working in the clinic." CS008 (APP in MSK)

Six of the participants spoke of the leadership aspects of their role, describing themselves as leaders, team leads or clinic leads.

"*as a clinical lead within outpatients and I think this is where my head of department would see it and that what it entails. So, clinical lead to the neuromusculoskeletal physiotherapy therapy team"* CS001 (CS in MSK)

However, some of the participants reported that clinical specialists/APPs were not leaders necessarily or that some did not perceive themselves to be leaders.

"*within the department I think clinical specialists have always been perceived to be clinical, an expertise in clinical care, which it is, but I don't know if clinical specialists have ever seen themselves as leaders"* CS003 (CS in care of the elderly)

One APP described how her role involved being a resource for advice on patients rather than assigning duties or instructing other team members.

The clinical specialists who work in the community recognised that their roles were quite different to clinical specialists who work in a hospital.

"I suppose clinical specialist now in palliative care would be very different from my role that I would have previously done as clinical specialist in [Hospital name]" CS007 (CS in palliative care)

Seven of the clinical specialists/APPs made comparisons between the clinical specialist role/APP in Ireland and in other countries. All seven participants perceived Ireland to be behind the UK in terms of the development of the clinical specialist role.

"*from an MSK ESP point of view Ireland are very much behind in comparison to the UK so our organisational goals from let's say an orthopaedic point of view because that's where most of our triage clinics are, are to improve access for patients"* CS009 (APP in MSK)

One clinical specialist made comparisons with Australia where she perceived clinical specialists to be more vocal on the team.

The roles of clinical specialist and APP were discussed by a number of the participants. There was recognition that there is a difference in these roles. Five of the participants described their understanding of these different roles.

"the Australian Association have got two definitions, they say clinical specialist is basically being a specialist and expert in your area and kind of within your scope whereas advanced practitioners are within your, outside your extended scope of practice" CS014 (CS in neurology)

One clinical specialist described how he turned down the opportunity to become an APP because this was not the type of role that he wanted.

"I decided against it because it didn't feel, from my friends that had already gone into it, that it was something for me, purely because I felt that they were almost the poor man's registrar so to speak in the sense you were just there to clear waiting lists and it didn't seem to be something that interested me." CS016 (CS in paediatrics)

Participants also noted that there is confusion regarding the terminology of these roles within the physiotherapy profession.

"So I work in advanced practice, or ESP as the terminology is all over the place in Ireland, so we'll call it ESP, so extended scope practice, I work in rheumatology clinics, I work in orthopaedic clinics" CS015 (APP in MSK)

One participant spoke at length about the confusion over the titles of clinical specialist and advanced physiotherapy practitioner and advocated that the terminology needs to be better defined.

Seven of the clinical specialists/APPs expressed frustration within their role. Frustrations included difficulty accessing MRIs for patients and being unable to order investigations.

> "*we can't order any radiological investigations, so as a part of my job you know to get a diagnosis for an MSK patient I need an investigation I can't do that which I find very frustrating"* CS009 (APP in MSK)

There were also frustrations with inefficiencies within the health service and delays in being able to implement changes.

> "*I don't enjoy some of the tedium of the endless, the having to be persistent about change, the having to like, it's the same in everything, it's like you have to have four meetings before not necessarily before the decision is made but before the decision is made by, and then supported and followed through, everything just takes forever."* CS002 (CS in respiratory)

One APP spoke of how inefficiencies in the Irish healthcare system caused her frustrations within her role compared to a similar role she had had in the UK. Another APP expressed frustration at the lack of recognition of her hard work.

> "*If you work hard you get the same, if you don't work hard you get the same so it can be frustrating, you have to have that internal drive"* CS015 (APP in MSK)

As well as discussing their frustrations, several of the clinical specialists/APPs spoke of the need to be resilient.

> "*So you'd have persistence, resilience, those are things that you will need to store up by the bucket load and get what joy you can from the little things because you know it'll be, like any sort of leadership is um is a bit of a battle."* CS002 (CS in respiratory)

Five of the participants spoke of encountering barriers in their roles but that they persevered and kept working towards their goal.

> "*you just have to, any set-backs you have to just keep, keep working and that emm, I think just train yourself to be the best you can be, don't take no for an answer*" CS005 (APP in MSK)

In discussing their clinical specialist/APP roles several of participants spoke of how their role had been newly introduced or that they were the first to have that role in their organisation.

> *"So it's a role where, there is no role in clinical specialist in care of the elderly [EMcG: yeah] so it's brand new, like for instance when I got the contract there was*

no job specifics because there is no-one else to base it on" CS003 (CS in care of the elderly)

Many of the participants spoke of setting up new services within their roles.

"*So I suppose when I took over the role I kind of was involved in setting up the service, it hadn't been really run before, so that involved meeting all my stakeholders, getting my key performance indicators, and I suppose initially getting the post up and running*." CS014 (CS in neurology)

One APP described how she was the first to set up a particular type of clinic in Ireland and that now she guides other physiotherapists to set up similar clinics.

"*I've trained nearly every advanced practice physio in Ireland in rheumatology triage, so I would definitely be called on a lot, been asked to go to [place name] and various sites to give in-services on rheumatology triage, I suppose they'd be leadership skills in a way*" CS015 (APP in MSK)

7.3.7.2. Management role

As well as discussing the clinical specialist/APP role, many of the participants also gave their views on the management role or managers that they have worked with. Of the participants who commented on their manager most were positive. They reported working well with them and that their managers were supportive.

"I mean from any, if there's ever a question of, not necessarily clinical issues, just more management, legal, that kind of stuff, [physiotherapy manager] is very open so I go to her all the time" CS008 (APP in MSK)

However, one APP was critical of her manager and reported that she didn't feel that her role was respected or her hard work recognised.

"*I think that's the biggest thing, is that you get no thanks for working hard at all from management, from anybody, yeah."* CS015 (APP in MSK)

Four of the clinical specialists/APPs described working with their manager on tasks or projects.

"then you definitely have to work and liaise closely with your manager as well if you've a change that you want to implement or something that you wanted to try." CS006 (CS in palliative care)

An overlap with the management role was also described by some of the clinical specialists/APPs.

"*when our previous manager in the physio side of the service was here over her tenure of 20 years here I would have stepped in and out of that role as required for maternity cover and stuff like that."* CS013 (APP in MSK)

However, one clinical specialist was adamant about maintaining a distinction between her role and the management role.

"If my head of department were off then I would be responsible for some of her duties. At times, there is overlap of my role into an acting manager position, I've always been clear and protective about my role and keeping it as it is. Because I want to remain a clinician and not move into a management role per se." CS001 (CS in MSK)

Other participants also differentiated between the clinical specialist/APP and managerial roles.

"*knowing my boundaries and my role, I'm not the manager, I can't make big decisions for people."* CS003 (CS in care of the elderly)

7.3.8. Workplace

Workplace was a less prevalent theme in the interviews, however there were some comments from the clinical specialists/APPs about the impact that their workplace had on their role. One APP spoke of the difference of working in a small hospital compared to the large hospital that she had previously worked in and the effect this had on the influence she had. Another APP described her transition from private practice to working in a public hospital and how she found the bureaucracy associated with the public hospital to be frustrating.

"the bureaucracy, especially coming from private practice and being pretty independent, coming back into the public sector there was definitely kind of an organisational culture shock" CS009 (APP in MSK)

Six of the participants spoke of the HSE and the impact that it has on their work. One participant who works in a private hospital hypothesised that there could be better development of the physiotherapy career structure in the public sector because of the better structure and resources afforded by the HSE. However, participants who were working in primary care or public hospitals spoke of a lack of resources and of the control that the HSE has over their services.

"it's maybe you don't necessarily agree with how the whole HSE is being run and where things are going, but some things are beyond, it's not that we can't feed in

and maybe be part of that process but it's a little beyond the moment that you're in" CS013 (APP in MSK)

There were also comments about primary care and community services. One clinical specialist noted that working in the community is different to working in a hospital.

"*community is just very different to the hospital [EMcG: yeah], you know you're on the road, you're definitely your own master to a certain extent, you, you, the buck stops with you, you have to have everything in order"* CS006 (CS in palliative care)

Three of the participants spoke of the relationship and interdependency between hospital and primary care services.

"there's no carers in the community to give people the care they need so patients are staying in beds in hospital while waiting on the care, so it's something we can't control at all, it's external to us, and the staff can get quite frustrated with them so keeping giving people that perspective - we can't do anything about it, you just have to remember that." CS003 (CS in care of the elderly)

Two of the participants perceived there to be differences in the roles of clinical specialists in the private sector compared with the public sector. One spoke of the differences in allocating non-clinical time to team members and to the high level of experience that all team members need to have to work in the private sector. Another clinical specialist working in a private hospital spoke of the focus on customer service in the private hospital.

"I suppose working in the private sector it's definitely customer service related as well you know if there's demand for evening appointments you know, when I first started here we didn't offer any evening appointments, but you have to, you just can't work from 8 to 4 in the private sector. People need to feel that they can come in at half seven in the morning or seven in the evening, that's definitely a way that we react to external demands." CS011 (CS in MSK)

7.3.9. Clinical Role

The clinical specialists/APPs discussed the clinical aspect of their roles. This theme encompassed the participants' perceptions of their clinical work, their advanced clinical skills, patient-centred care and evidence-based practice. The participants spoke of how much they enjoyed assessing and treating patients and how they found this to be rewarding.

"I think clinically is where like my main love of physio is" CS005 (APP in MSK)

Six of the clinical specialists/APPs reported wanting to stay working clinically and not to move into more managerial roles.

"*I don't really see myself going into management, I see myself always being in clinical"* CS009 (APP in MSK)

One clinical specialist felt that it would be a waste of their skills if they didn't work with patients and an APP described the importance of working with patients for keeping in touch with what patients need.

"*For me as a clinician I do like my clinical work, but if I was to step up I'd step away from that completely and I think that's an awful waste of the skills that I've acquired, and my ability to teach and my ability to provide patient care, so I think that's a waste."* CS002 (CS in respiratory)

Advanced clinical skills

The majority of the clinical specialists/APPs spoke of having advanced clinical skills or clinical expertise and how this was part of their role. In terms of advanced skills, the clinical specialists/APPs spoke of being qualified in injection therapy, casting and taking and reading arterial blood gases.

"I would have done advanced practitioner work in relation to injection therapy in Botox, so on top of that I did casting so I was becoming more and more specialized" CS014 (CS in neurology)

The participants also spoke of seeing more complex or complicated clinical cases.

"So the consultants may send people from their rooms for example to see me particularly because we obviously have a working relationship, maybe slightly more complicated patients" CS013 (APP in MSK)

Ten of the participants described giving advice or sharing their expertise with others. One clinical specialist spoke of advising the medical team about the care of patients.

"And another thing I suppose clinically would be being able to be a resource for the medical teams so they might come to you for opinions about differential diagnosis, so you kind of have to work at that higher level." CS014 (CS in neurology)

Five of the clinical specialists/APPs spoke of the high level of clinical care that they aimed to provide within their services.

"I think as a clinical specialist one of the very important parts of that is in the name itself, I think that you do need to be clinically excellent to be a clinical specialist.

Your knowledge should set you apart from that of a senior physio." CS010 (APP in MSK)

Related to this was the concept of patient-centred care. Providing a high-quality service and excellent patient care were important to the clinical specialists and APPs.

"*patient-centred care, put it at the top or at the centre for everything"* CS002 (CS in respiratory)

The participants spoke of aiming to improve services for patients and about trying to consider all aspects of patient care rather than merely focusing on outcomes.

As well as providing patient centred care, many of the clinical specialists/APPs also spoke of the importance of providing evidence based practice and of keeping up to date with current research.

"*So I would really be passionate about putting the evidence into practice and disseminating that amongst people that I work with and people that I have contact with*" CS015 (APP in MSK)

7.4. Discussion

The first and second objectives of this study were to describe the perceived leadership capabilities of the physiotherapy clinical specialists/APPs using the four frames of the Bolman and Deal leadership model, and to compare the leadership capabilities and leadership experiences of different cohorts of physiotherapy managers and physiotherapy clinical specialists/APPs. The clinical specialists and APPs described using all four leadership frames, however, the language used and examples given suggest that they work predominantly through the human resource frame. There were many similarities between the leadership capabilities of the clinical specialists/APPs in this study and the physiotherapy managers from Study II as demonstrated by the minimal changes made to the coding framework, however differences were also noted. The leadership capabilities described by the clinical specialists and APPs on each of the four leadership frames will be discussed and compared with those of the physiotherapy managers below.

7.4.1. Theme 1: The structural frame

The clinical specialists/APPs demonstrated similar leadership capabilities in the structural frame to the physiotherapy managers. The clinical specialists did discuss activities associated with co-ordinating their service, however, this subtheme was less prevalent than it had been for the physiotherapy managers. The clinical specialists/APPs commented more about being organised in their own work, and on the way that the service was run in general, rather than giving specifics about being involved in running the service. This was most likely because activities such managing a budget, holding meetings and co-ordinating the team would be considered managerial roles and therefore may not have been as much of a focus for the clinical specialists/APPs. As noted by the CSP in their report on the role of advanced practice in physiotherapy, APPs provide clinical leadership rather than direct line management of team members (CSP, 2016a).

An additional subtheme in the interviews with the clinical specialists was the concept of protected time. Protected time referred to time that the clinical specialists/APPs had for non-clinical activities. Having protected time for non-clinical activities may be important for the leadership of clinical specialists/APPs. Large and increasing caseloads were identified as limiting the time available to engage in leadership activities in a review of barriers of and enablers to leadership in advanced nurse practitioners (Elliott et al., 2016).

Similar to the managers' interviews, the accountability subtheme encompassed monitoring results, evaluating performance and holding people accountable. The clinical specialists spoke about being responsible for their own results and some also spoke of being responsible for the results of their team. Several of the clinical specialists/APPs spoke of the importance of quality, ensuring that they deliver a high-quality service for patients and of being involved in quality improvement projects. This was in keeping with the CSP who have emphasised the role of all physiotherapists in promoting and ensuring quality clinical practice (CSP, 2013c). Regarding advanced physiotherapy roles, Morris et al. (2014) highlighted the importance of being able to demonstrate quality in an exploration of stake-holders' perspectives on the introduction of advanced physiotherapy roles to an Australian hospital. Clear evaluation strategies were deemed necessary to demonstrate the quality and accountability of the new service and thus assure its sustainability (Morris et al., 2014).

The clinical specialists/APPs did not discuss documentation in terms of writing or producing reports as some of the managers had. However, the clinical specialists/APPs did discuss recording statistics/data for referral rates, the number of patients seen and outcome measures. Many of the clinical specialists/APPs reported conducting audits to evaluate their service. One subtheme in these interviews that was not found in the managers' interviews was waiting list management. A few of the managers had spoken of managing waiting lists but it had not constituted a subtheme in Study II. In contrast, nearly all the APPs (except the respiratory APP) discussed waiting lists and trying to minimise them. This focus on waiting lists is unsurprising because APP roles were established in orthopaedics and rheumatology because of unacceptable waiting times (Murphy et al., 2013), and thus from the outset an objective of these posts has been to reduce waiting times for patients (O'Mahony and Blake, 2017).

In discussing the hierarchy and reporting relationships in their workplaces, all the clinical specialists/APPs stated that they reported to the physiotherapy manager. Additionally, many of the MSK clinical specialists/APPs described a dual-reporting relationship where they were also reporting to the consultant(s) in their service. This dual-reporting relationship may contribute to the importance the participants placed on their working relationship with the consultant(s) in their service which is further discussed in the political theme section below.

The *people management* subtheme was different for the clinical specialists/APPs than it had been for the managers. There were fewer comments in this subtheme for the clinical specialists/APPs and they did not speak about being involved in the recruitment of team members. A small number of the clinical specialists, however, did discuss organising staff rotas and making sure there was an appropriate mix of experience levels in their service. Additionally, within this theme a small number of the clinical specialists/APPs spoke of succession planning. They were cognisant of the need to ensure that there were appropriately trained people to take their role in the future. Clinical specialist/APP roles are relatively new in the Irish healthcare system (Murphy et al., 2013) and so these professionals may have felt the need to identify suitable people to move into these roles in the future to ensure the continuation of the role. Morris et al. (2014) highlighted the importance of succession planning for the sustainability of advanced level physiotherapy positions.

The *strategic planning and alignment* subtheme encompassed goal-setting, service development and planning, and the design of policies and service guidelines. Planning

was less prevalent for the clinical specialists/APPs than it had been in the managers' interviews suggesting that the clinical specialists/APPs were less involved in this and that it may be more a managerial role. A related subtheme that was discussed by many of the clinical specialist/APP was *developing their service*. Many of the participants discussed the importance of service development, growing their service or working to improve the service they provide for patients. Morris et al. (2014) noted that to ensure successful initiation and sustainability of advanced practice physiotherapy roles these professionals need to evaluate the service being provided and demonstrate commitment to ensuring good quality and efficient patient care. Similarly, the CSP report indicated that physiotherapists working at an advanced level should initiate and guide clinical service development and improvement (CSP, 2016a).

Related to planning and service development, the clinical specialists placed importance on decision-making. Decisiveness has been recognised as important to effective leadership (Dries and Pepermans, 2012) and leaders are expected to be decisive, assertive and independent (Ibarra et al., 2013). Decision making ability is also important in the clinical aspect of these physiotherapists' roles. Physiotherapists working at an advanced level need high level skills and knowledge for the complex decision-making processes required in the management of patients with a range of presentations (CSP, 2016a). Decisiveness demonstrates confidence in your abilities and thus would be advantageous for the clinical specialists/APPs to project to help them to build their reputation in their workplace.

The goals set by the clinical specialists/APPs indicated their focus on providing the best possible service for their patients. This was in keeping with the results of a survey of physiotherapists and employers in Canada which found that physiotherapists' primary motivation to pursue clinical specialist or APP roles was to improve their clinical reasoning skills with the goal of improving patient outcomes (Yardley et al., 2008). The clinical specialists also spoke of setting specific targets for themselves and for members of their team. As previously mentioned in this section, the clinical specialist/APP roles in Ireland were initially developed to reduce demands on non-consultant hospital doctors, inappropriate referrals to consultants and waiting times for patients (Moloney et al., 2009, Murphy et al., 2013, O'Mahony and Blake, 2017). As a result, the professionals in these roles have specific targets to demonstrate that these goals are being met. The clinical specialists/APPs would, therefore, be aware of the need to reach these targets to ensure the sustainability of, and justification for, their role.

The clinical specialists/APPs described the use and importance of policy and procedure in their workplaces. Working in new or innovative areas it may be particularly important to for clinical specialists/APPs to have policies or protocols to guide their decision making. Dawson and Ghazi (2004) found that APPs experienced anxiety when performing procedures carrying a degree of risk, e.g. therapeutic injections. Adhering to strict protocols and procedures in implementing these treatments may help to alleviate some of this anxiety. The clinical specialists/APPs placed more emphasis on developing new procedures and clinical guidelines than the managers who had spoken more about updating current policies and ensuring adherence to them. This may have been because many of the participants in this study were in relatively newly established positions or were the first person to occupy that role in their organisation. The clinical specialists/APPs also placed more emphasis on clinical guidelines and protocols than the managers had done. As clinical experts, in predominantly clinical roles, this focus was unsurprising. The clinical specialists/APPs discussed following best practice guidelines, and of taking these into account when developing their own protocols and procedures.

7.4.2. Theme 2: The human resource frame

The clinical specialists'/APPs' focus on developing themselves and others, and on their interpersonal relationships demonstrated leadership capabilities associated with the human resource frame. The professional development subtheme reflected the emphasis placed on teaching and ensuring the development of skills in themselves and others. All the clinical specialists/APPs spoke of being actively involved in developing others, either through direct teaching, peer review, or organising learning opportunities. This was in keeping with a report by the CSP which advocated that physiotherapists working at an advanced level should design and deliver learning activities to meet learners' needs and enable them to develop their practice (CSP, 2016a). The language used by the clinical specialists/APPs suggested that they viewed the development of others, either through direct teaching or facilitating learning opportunities, to be key aspects of their roles. While the managers from study II had spoken about ensuring the development of their team, there was more focus on teaching among the clinical specialists/APPs. Some of the clinical specialists/APPs reported conducting peer reviews with members of the team which was a development activity that the managers had not reported engaging in. Peer review is a common method of clinical supervision (CSP, 2010) and has been defined as 'an exchange between practicing professionals to enable the development of

professional skills' (Butterworth and Faugier, 2013). The principles of clinical supervision are that it should be distinct from formal line management supervision, and that it should develop skills in reflection to support and enhance practice (CSP, 2013a).

Another related subtheme in this study was *continual learning*. The clinical specialists/APPs spoke of continually developing in their role and of their engagement in training activities. Working in roles with complex patient caseloads and where they undertake tasks traditionally performed by medical practitioners (Murphy et al., 2013, O'Mahony and Blake, 2017) physiotherapists working at an advanced level require additional training, competency development and significant clinical experience (Gilmore et al., 2011). Gilmore et al. (2011), however, noted that training of extended scope allied health professionals has been provided mostly on an ad hoc basis, i.e. by a specialist working in the institution, which has resulted in poor recognition and definition of these roles. Consequently, Gilmore et al. advocated that for sustainability of these roles there should be collaboration with accredited educational institutions to provide core educational courses. Similarly, in an Irish context, O'Mahony and Blake (2017) found that there was a lack of formal educational opportunities for APPs and that informal education was more likely within the clinic setting. O'Mahony and Blake recommended that guidelines are formulated for formal education of APP roles in Ireland.

Many of the clinical specialists/APPs had completed some form of leadership development training. Others, however, reported that they had not participated in leadership development training and some reported that they would like the opportunity to complete training in this area. It is important that the clinical specialists/APPs recognise the leadership capabilities needed in their role and have the opportunity to develop these. The HSE has listed leadership and service development as a competency that physiotherapy clinical specialists should demonstrate (HSE, 2008). In the HSE competency document the leadership role of clinical specialists encompasses: acting as a supportive and positive team leader, identifying changing needs and opportunities, driving change and encouraging others, and implementing new service initiatives.

The clinical specialists/APPs cited a range of answers when asked about the leadership skills that they perceived to be important for a clinical specialist to demonstrate. In keeping with the physiotherapy managers, they discussed capabilities associated with the human resource in their interviews including teamwork, social skills, respect, fairness and empathy. The CSP (2016a) outlined integration and teamwork as central to the role of physiotherapists working at an advanced level. Advanced level physiotherapists

should work effectively with others, foster collaboration and information sharing, and implement strategies to ensure the effective and efficient working of teams (CSP, 2016a). In a systematic review of quantitative and qualitative studies on the role of musculoskeletal physiotherapy APPs, 'Interpersonal skills' was a theme (Thompson et al., 2016). This theme highlighted the importance of the ability to communicate at a high level for physiotherapists working at an advanced level.

Communication was a prevalent subtheme in the clinical specialist/APP interviews, as it had been in the managers' interviews. The clinical specialists/APPs recognised the importance of effective communication and listening to people. Physiotherapists working at an advanced level should use a range of advanced communication skills to share complex information and ideas, and modify their communication as appropriate to take account of the needs of different audiences (CSP, 2016a). Several of the clinical specialists/APPs spoke of involving others in decision making and taking their opinions into account thus demonstrating a participative approach indicative of the human resource frame (Bolman and Deal, 2008).

The clinical specialists/APPs were open to receiving feedback on their performance from patients, team-members and their managers. Working in relatively newly established roles or services it is important for these professionals to get feedback from service users and other healthcare professionals regarding the service they provide. Studies have demonstrated that feedback from patients (Kennedy et al., 2010, Thompson et al., 2016) and other health professionals (Oldmeadow et al., 2007, Moloney et al., 2009) regarding the service provided by clinical specialists or APP has+ been largely positive. However, as with any model of care it can be beneficial to continue to get feedback from both patients (Kennedy et al., 2010) and healthcare professionals (Ivers et al., 2012) to enable further development.

7.4.3. Theme 3: The political frame

APPs should have awareness of the political factors that influence the design and development of the health system (CSP, 2016a). The language used by the clinical specialists/APPs suggested that they used some leadership capabilities associated with the political frame, however, other leadership capabilities associated with the political frame were not discussed or were discussed less frequently. The clinical specialists/APPs spoke of promoting the profession, collaborating with consultants,

managing conflict, writing business cases and taking a tactical approach in effecting change. However, networking, negotiating, and demonstrating influence were not commonly discussed by the clinical specialists.

In the *organisational citizenship behaviour* subtheme, *promoting the profession* and *research involvement* were prevalent subthemes for the clinical specialists/APPs. In contrast, *looking for opportunities* was less prevalent in these interviews. Some of the clinical specialists/APPs reported that they were on committees or involved in special interest groups. Committee membership offers a potentially valuable opportunity to make contacts and highlight non-clinical skills to others (Bender, 2005). Gilmore et al. (2011) highlighted the need for allied health professionals working at an advanced level to promote their role both within and outside their profession to ensure successful implementation and sustainability of the role. Advanced practice professionals need to educate other health professionals and the public about their scope of practice (Gilmore et al., 2011). The clinical specialists/APPs in this study recognised the importance of promoting the physiotherapy profession and their role. However, to most effectively promote the value of the physiotherapy clinical specialist/APP role to the health service economic evaluation is needed. There has been a call for research exploring the economic benefits and impact on waiting lists of physiotherapy clinical specialists/APPs (Murphy et al., 2013, Ashmore et al., 2014). One clinical specialist in this study had been able to secure funding for her role by presenting economic data demonstrating the savings made by the hospital through her role.

Research involvement is expected of physiotherapists working at clinical specialist or APP level. In a survey of physiotherapists' perceptions of clinical specialisation and advanced practice in physiotherapy, Yardley et al. (2008) found that research was perceived to be a necessary component for attaining clinical specialist or APP status by the majority of the respondents. The clinical specialists'/APPs' research activities may have an impact on the wider physiotherapy team. Janssen et al. (2016) found that where managers or senior physiotherapists were involved in research physiotherapists in the same area were more focused on research and flexible about spending time engaged in research.

The *career progression* subtheme encompassed the ways in which the clinical specialists/APPs had worked to progress in their careers to date and how they want to continue to progress. Most of the clinical specialists/APPs in this study reported that they had attained a Masters and many described working overseas to broaden their

experience. Working in positions that demand advanced clinical knowledge and skills, as well as leadership abilities (CSP, 2016a) clinical specialists/APPs may benefit from a broad range of experience and advanced education. In Study I, an association was found between having attained a Masters or doctoral degree and self-perception as a leader. These posts have generally been introduced without nationally planned training and credentialing (Dawson and Ghazi, 2004, Stanhope et al., 2012, Morris et al., 2014) and, as a result, there is no formal pathway for attaining a clinical specialist/APP position.

Only a small number of the clinical specialists/APPs spoke of collaborating with nurses or other professionals. It is important for clinical specialists/APPs to work well with other professions because, while clinical specialists/APPs work autonomously in their clinics, adequate collaboration with the medical and nursing team is needed to ensure the highest quality of care for patients (Moloney et al., 2009). The language used by most of the clinical specialists/APPs suggested that they place significant importance on their working relationships with the consultant(s) in their clinical area. The participants spoke of working to establish a good working relationship with medical consultants and of the importance of having the support of consultants in their role. This finding echoes previous studies which have explored the experiences of APPs (Dawson and Ghazi, 2004, O'Mahony and Blake, 2017). Dawson and Ghazi (2004) found that success and satisfaction for APPs are dependent on their relationship with the consultant and medical team. Participants perceived the consultant to be an important source of support, offering practical help and encouragement. Similarly, in a mixed methods study exploring the APP role in Ireland, the importance of the relationship with the consultant and medical team was a theme (O'Mahony and Blake, 2017). Encouragingly, 79% of APP respondents to the survey perceived that they had a good relationship with their consultant(s).

Also within the *collaboration* subtheme was the concept of networking, however, as in the interviews with the physiotherapy managers only a small number of participants discussed networking. Networking can be a useful way to build links from the clinical environment to the administrative arena (Bender, 2005). The clinical specialists/APPs may miss valuable opportunities for themselves and their role if they are not networking and making connections with others beyond their physiotherapy or specialist team. Elliott et al. (2016) found that a key enabler to leadership enactment for advanced nurse practitioners was having networking opportunities both within their organisation and with external groups. Networks enabled advanced practitioners to develop a 'global' perspective and thus act as change agents at clinical and strategic levels. The CSP has

also recognised the need for physiotherapists working at an advanced level to network, reporting that they should be involved in professional and policy networks that inform the development and implementation of policies relevant to physiotherapy practice (CSP, 2016a).

Communication strategies were the most commonly used strategy to address conflict. As with the physiotherapy managers in Study II, the language used by the clinical specialists/APPs suggested that they approach conflict management through the human resource frame: listening to people, getting advice from others, exploring the problem and trying to resolve it quickly. Some of the clinical specialists/APPs reported that they didn't have much conflict in their workplaces or that they avoided conflict. This may work if the source of the conflict is temporary but often conflict suppressed early has a tendency to resurface (Bolman and Deal, 2008). Leaders need to recognise conflict, and that it can be productive or debilitating, so that they can most effectively manage it (Bolman and Deal, 2008).

Many of the clinical specialists/APPs also discussed inter-profession rivalry, particularly with the nursing and medical professions. The participants spoke of the power of the medical profession and of competition with the nursing profession for influential positions and because they can order imaging. As the clinical specialists/APPs undertake roles traditionally performed by other healthcare professionals (Kennedy et al., 2010, Desmeules et al., 2012), it is unsurprising that there may be resistance from these professions. The clinical specialists/APPs in this study may need to demonstrate political frame capabilities e.g. advocacy, making business cases and negotiation, to successfully compete with other healthcare professions in the changing healthcare landscape.

Influence, autonomy and power were not as prevalent in the clinical specialist/APP interviews as they had been in the manager interviews. There were a few comments about the importance of having influence and of working with others who are perceived to have influence. There were also some comments about having autonomy and being able to make decisions in their service. APPs should have high levels of personal autonomy and should use networks and strategic relationships to broaden their sphere of influence to effect change across professional and organisational boundaries (CSP, 2016a). However, there were comments from the clinical specialists/APPs about not having influence and of feeling powerless.

When discussing the power structure in their workplaces, the majority of the clinical specialists/APPs perceived the consultants to have a lot of power. There were comments about needing to get support from consultants when trying to implement change. In the study by Dawson and Ghazi (2004), APPs described feeling that their post was still evolving and that further development was dependent on the goodwill of the consultants. As described previously, most of the clinical specialists/APPs in this study placed significant importance on their relationship with the consultant(s) in their service. The clinical specialists/APPs also recognised the power of the CEO and only a small number perceived the physiotherapy manager to have a lot of power.

Elliott et al. (2016) advocated that advanced practice nurses need to develop skillsets to allow them to understand and appropriately intervene in political processes if they are to demonstrate leadership in increasingly complex business-orientated healthcare systems. Some of the clinical specialists/APPs described taking a tactical approach and writing business cases to effect change in their workplaces. Similar to the physiotherapy managers, however, there were fewer references to negotiating or campaigning for change. To effectively demonstrate leadership, physiotherapists working at an advanced level may also need to develop skillsets that include political leadership capabilities such as negotiation, campaigning and lobbying skills.

7.4.4. Theme 4: The symbolic frame

Clinical specialists and APPs are in roles where they are expected to demonstrate leadership (HSE, 2008, CSP, 2016a). To most effectively do this they will need to be able to demonstrate leadership capabilities associated with the symbolic frame (Bolman and Deal, 1991, 2008). The language used, and examples given, by the clinical specialists/APPs suggested that they do demonstrate some leadership capabilities associated with the symbolic frame. The concept of being a role model and leading by example was prevalent in the clinical specialists'/APPs' interviews. These participants also discussed their passion for their roles, seeing the big picture, mentoring others and perceptions of the physiotherapy profession. Other leadership capabilities associated with the symbolic frame, however, were less prevalent in these interviews. There were few references or examples given of organising rituals/ceremonies, fostering a positive culture or communicating their vision.

The *organisational culture* subtheme encompassed awareness of the atmosphere of the workplace, team bonding, and values, as it had done in the managers' interviews. Some of the clinical specialists discussed the atmosphere of their workplace and the effect that it has on the team. Mancini (2011) spoke of the need for nurse leaders to assess and understand the organisational culture of their workplace, asserting that with a good understanding of organisational culture nurses may be better able to effect change and transform the organisations in which they work. While it is important to assess and understand organisational culture, it is also important that leaders actively participate in shaping organisational culture and ensuring a positive atmosphere in their workplace (West et al., 2015). There were only a small number of examples given by the clinical specialists/APPs of how they facilitate a positive workplace culture and atmosphere.

Similar to the physiotherapy managers, when asked about facilitating team bonding, the clinical specialists/APPs spoke of engaging in social events with the team. However, there were few references to these being organised by the clinical specialists/APPs. In addition to social events, some of the clinical specialists/APPs perceived team and in-service meetings to be an opportunity for team bonding. There were only a small number of references to celebrations and few examples given of ceremonies, traditions or rituals. As noted in Chapter 6 (section 6.4.4), ceremonies and rituals bring significance and meaning to organisational life and can be used to instil enthusiasm and inspire others (Bolman and Deal, 1991, 2008).

Many of the clinical specialists demonstrated passion for their role through their language. Being passionate was a more prevalent subtheme in these interviews than it had been in Study II. Passion can help to motivate team members and increase overall performance and creativity (Piper, 2005, O'Neill, 2013). In a qualitative study of leading advocates in physiotherapy in Canada, passion was identified as an essential component of advocacy (Kelland et al., 2014). To create the drive and momentum needed for change and improvement in healthcare, leaders need to demonstrate passion for and commitment to quality (Lukas et al., 2007). Some of the clinical specialists discussed the importance of passion and the effect it can have on others. This was in keeping with Piper (2005) who asserted that the key to leadership is not only having passion but creating passion in team members.

The need to see the big picture and look beyond their immediate environment was acknowledged by several of the clinical specialists/APPs. Hartley and Benington (2010) advocated that leaders have an important role in 'big picture sense making' and helping

others to understand the context and the challenges ahead. Only a small number of the clinical specialists/APPs spoke of having a vision and thinking about the future. In discussing the clinical and professional leadership role of APPs, Morris et al. (2014) advocated that APPs should be able to share their vision for their role. Effective leaders are futuristic and understand that the ability to communicate and promote their vision is a vital part of achieving it (Evans, 2011).

The *professional identity* subtheme encompassed mentoring, leading by example and perceptions of the profession. The clinical specialists/APPs were positive about the concept of mentoring and most either had a mentor, or had had one in the past. The CSP (2016a) has recommended mentoring as a method for advanced physiotherapists to maintain required competence but acknowledged that due to the nature of advanced roles, mentorship may need to be sought outside the physiotherapy profession. More clinical specialists/APPs than physiotherapy managers reported that they mentored other physiotherapists. These clinical specialists/APPs, however, were in the minority and a greater number did not report mentoring others. In contrast, leading by example or being a role model was a very prevalent subtheme for the clinical specialists/APPs. Leading by example can be an effective way to influence people and thus effective leaders do not send team members to do a job but, rather, lead them toward a mutual goal (Evans, 2011). Many of the clinical specialists/APPs recognised the importance of demonstrating behaviours themselves rather than just telling people what to do.

Perceptions of the physiotherapy profession were discussed by some of the clinical specialists/APPs. This was consistent with Morris et al. (2014) who asserted that APPs are discipline leaders who should promote the nature and effectiveness of the physiotherapy profession to other healthcare disciplines. There was recognition that there can be misunderstanding or outdated views of the role of physiotherapists and some of the participants spoke of actively working to improve understanding and perceptions of the physiotherapy profession. In a study investigating patients' knowledge of and attitudes towards physiotherapy, Webster et al. (2008) found that while physiotherapy was regarded positively there was a distinct lack of knowledge about the profession and how it can assist in managing health. The clinical specialists/APPs in this study recognised that there is a need to educate others both on the clinical specialist/APP role and about the role of physiotherapy more generally. Lefmann and Sheppard (2014) highlighted the importance of building a clear identity in their study exploring the introduction of physiotherapists to the emergency room. Making their presence felt and understood in the emergency room helped to build the authority of the

physiotherapists with the medical team. Similarly, Thompson et al. (2016) noted that APPs need to be able to educate patients and referring health professionals about their scope of practice so that they are clear about the service they provide.

7.4.5. Theme 5: Challenges

The third objective of this study was to explore the experiences of physiotherapy clinical specialists/APPs in Ireland and the challenges they identify as requiring leadership. This objective was addressed in the themes 'Challenges', 'Physiotherapy profession', 'Workplace' and 'Clinical role'. *Time constraints, other professions, lack of resources* and *changing structure* were subthemes within the 'Challenges' theme in the clinical specialists/APPs interviews as they had been in the interviews with the physiotherapy managers. Two additional challenges, *ordering images* and *career structure*, were also found to be subthemes in these interviews.

Time pressures and difficulties associated with being very busy were reported by the majority of the clinical specialists/APPs. These time constraints impacted on their ability to engage in activities beyond their clinical role and participants spoke of wanting to spend more time on research, audit or service development. This result was the same as a key finding of Elliott et al. (2016). In a scoping review exploring barriers and enablers to advanced nurse practitioners demonstrating leadership, Elliott et al. (2016) identified that the combination of large clinical caseloads and a lack of administration support limits the time that advanced nurse practitioners have available for leadership activities and research.

The *other professions* subtheme encompassed resistance from other professions, the need to change beliefs about the physiotherapy profession and other professions encroaching on physiotherapy practice. In this theme, there were comments about difficulties posed by their medical colleagues with references to resistance to new services, needing medical support to enact any change and services being too medically led. Gilmore et al. (2011) warned that when introducing advanced practice roles there needs to be a sound business case supporting the role extension and blurring of professional boundaries to prevent role confusion and professional barriers. Lefmann and Sheppard (2014) found that doctors and nurses were wary about physiotherapists assuming advanced practice roles in the emergency department and reported that it was important to ensure that other professions did not feel usurped. In discussing the

introduction of advanced practice roles, Morris et al. (2014) emphasised the need to communicate the purpose of the new role to others and identify any perceived threats e.g. threats to the status quo or to individual roles and positions. Support should be provided to individuals from other professions who may be relinquishing their traditional tasks to an APP (Morris et al., 2014).

A lack of resources was reported by nearly all the clinical specialists/APPs. The participants highlighted the impact that this can have: limiting progress, affecting patient services, impacting morale and restricting service development. Limited resources have also been found to be a barrier to advanced nurse practitioners demonstrating leadership (Elliott et al., 2016). In the political frame theme, some of the clinical specialists described successfully securing funding or other resources through business cases, advocacy and campaigns. Clinical specialists/APPs may benefit from developing leadership capabilities associated with the political frame to enable them to compete successfully for scarce resources (Bolman and Deal, 2008).

The *changing structure* subtheme was not as prevalent for the clinical specialists/APPs as it had been in the managers' interviews and was only discussed by a small number of the participants. Some of the clinical specialists/APPs remarked on changes in staffing, the hierarchy of their organisations, management structure and the physiotherapy profession. The reason that ongoing changes in the health system and physiotherapy profession were not discussed to the same extent by the clinical specialists/APPs as they had been by the physiotherapy managers is unknown. However, as leaders within the physiotherapy profession (Morris et al., 2014, CSP, 2016a), it is important that clinical specialists and APPs can successfully negotiate and manage change. Clinical specialists should be able to identify and prioritise the requirements of change within their service, their organisation and the healthcare system (HSE, 2008). Bolman and Deal (2008) advocate that the frames offer a checklist of issues that leaders must recognise and respond to when dealing with change. They assert that change initiatives fail when there is too much focus on reason and structure, and human, political and symbolic elements are neglected.

In Ireland, physiotherapists (including clinical specialists/APPs) do not have legal autonomy to order x-rays for patients (Moloney et al., 2009). The musculoskeletal clinical specialists/APPs spoke of difficulties and inefficiencies in organising radiological investigations for their patients. Some of the participants reported local arrangements where they could liaise with medical staff to arrange referrals for imaging for their

patients. However, frustrations were voiced about the inefficiencies of this system. O'Mahony and Blake (2017) also found concerns regarding access for patients to further investigations including radiology among physiotherapy managers and APPs in Ireland. Appropriately trained physiotherapists in the UK (Kilner and Sheppard, 2010), parts of Canada (Chong et al., 2015) and Australia (Farrell, 2014) are able to order imaging for their patients. Holdsworth et al. (2008) surveyed GPs and physiotherapists about their views of physiotherapy scope of practice. Both physiotherapists and GPs perceived it to be beneficial to patients for physiotherapists to be able to order x-rays, however, physiotherapists perceived greater potential benefits than GPs. This is an area where advancement of the profession in Ireland is needed. The clinical specialists/APPs will need to demonstrate leadership beyond their workplaces to effect change in the legislation.

The final subtheme in *challenges* was *career structure*. Limited opportunities for career progression can result in dissatisfaction and the potential loss of experienced staff members from allied health professions (Bender, 2005). Many of the clinical specialists/APPs discussed the limitations of the physiotherapy career structure in Ireland and comparisons were made with the career structure in the UK. Frustrations with the physiotherapy career structure were previously noted in the *Barriers to leadership* subtheme in study I (see section 4.3.6). As discussed in section 4.4.8, in other countries there has been greater differentiation of physiotherapy levels and the role of physiotherapy consultant (considered a level above APP) has been developed (CSP, 2016a). Some of the clinical specialists/APPs spoke of the need for a more structured career pathway or more opportunities to progress for physiotherapists at all levels. Development pathways that create a path for clinicians who want to progress in their careers may increase job satisfaction and encourage retention of staff (Bender, 2005). Effective leadership will be required from physiotherapists at a local and national level to address this challenge. Allied health professionals may need to go beyond the traditional clinical ladder and proactively develop more career opportunities (Bender, 2005).

7.4.6. Theme 6: Physiotherapy profession

The clinical specialists/APPs reflected on their own role and the role of physiotherapy management. The participants recognised and discussed the non-clinical aspects of their positions, including teaching, service development, research and quality improvement. All the clinical specialists/APPs reported that they enjoy their role or enjoyed it most of the time. There was recognition, however, that the role can be

challenging and the language of many of the participants portrayed the frustration they can feel. Dawson and Ghazi (2004) found that the APP participants in their study expressed four main negative emotions in relation to their role; frustration, pressure, anxiety and dissatisfaction. The participants' reasons for frustration included political factors beyond their control, that their level of input had been restricted, and having to justify their role in the clinic. Similarly, in this study the clinical specialists/APPs expressed frustration at inefficiencies in the health system, not being able to order imaging and with the lack of recognition for their hard work. The need for resilience was recognised by some of the clinical specialists. Resilience is the ability to recover from stressors and adapt to change and in the uncertain environment of modern healthcare it has been recognised as increasingly valuable (Pipe et al., 2012). It is important for healthcare leaders to demonstrate resilience so that they can set a positive tone for their organisation and foster staff morale even in times of adversity (Wicks and Buck, 2013).

Several of the clinical specialists/APPs perceived the clinical specialist role to be better developed in the UK. The physiotherapy profession in the UK has progressed further than the physiotherapy profession in Ireland in terms of attaining prescribing rights (CSP, 2012b) and ordering images (Kilner and Sheppard, 2010), and as discussed previously has a more differentiated career structure. Many of the participants, however, discussed how they were in relatively new positions or how they were the first to have that role in their organisation. This may explain why this role is not as well developed as it is in the UK. This role was introduced to the UK more than 25 years ago and there has been significant interest and expansion of these roles in the NHS (Thompson et al., 2016).

Some of the participants discussed the differences between being a clinical specialist and being an APP and acknowledgement of confusion in the use of these terms. There was a perception that the APP role was concentrated on advanced skills whereas the clinical specialist role was broader and more inclusive of other roles such as service development and research. One clinical specialist spoke extensively on the confusion in the terminology and the need for role definition in Ireland. In the literature, the interchangeable use of the titles APP and clinical specialist (Dawson and Ghazi, 2004), and APP and ESP (Ashmore et al., 2014, O'Mahony and Blake, 2017), have been noted. The CSP has moved away from the term ESP to reduce confusion in terminology and instead uses APP to describe physiotherapists working at an advanced level (CSP, 2016a).

As well as reflecting on the clinical specialist/APP role, some of the participants also discussed the role of physiotherapy managers. Encouragingly most of the clinical specialists/APPs were positive about the physiotherapy managers that they work with. For physiotherapy clinical specialists/APPs to most effectively demonstrate leadership it is important that they feel supported in their roles. Elliott et al. (2016) found that managers are instrumental to advanced nurse practitioners' ability to enact leadership. Lack of support from nursing management was found to be a barrier, whereas mentoring and support from senior managers was an enabler to leadership role enactment. Elliott et al. (2016) concluded that without support from healthcare managers the leadership of advanced practice nurses will remain at the level of clinical practice and not progress to effecting change at the strategic level of service development.

7.4.7. Theme 7: Workplace

Workplace was a less significant theme in these interviews although there were some comments about the differences associated with different working environments for clinical specialists/APPs. There were no private practice clinical specialists/APPs in this study as this role title is not commonly employed in private practices in Ireland. There were, however, three participants who work in private hospitals. Differences noted by these participants were that there may be a more developed career structure for physiotherapists working in public hospitals, the high level of experience expected of all physiotherapists in private hospitals and the focus on customer service. Similar to the physiotherapy managers, the clinical specialists/APPs working in public hospitals or primary care reported a lack of resources and discussed the control the HSE has over their services. Dissatisfaction with the Irish health system has been noted in other health professionals. In a study exploring emigration of medical and nursing professionals from Ireland, Humphries et al. (2015) found that the participants perceived there to be a lack of respect for health professionals in Ireland in relation to staffing levels and working conditions.

7.4.8. Theme 8: Clinical role

Within the 'Clinical role' theme, the clinical specialists/APPs discussed their advanced clinical skills, evidence-based practice and patient-centred care. The participants were positive about the clinical aspect of their role and many discussed how they love working with patients. Several of the clinical specialists/APPs also noted that they wanted to

remain working clinically and did not want to move into a more managerial based role. Dawson and Ghazi (2004) reported that the APPs in their study felt their role had enabled them to make a progressive career move while maintaining their clinical skills. Similar to the participants in this study, the APPs were clear that they did not want to move from clinical to managerial roles, however, they were less sure about where they would progress to next in their careers (Dawson and Ghazi, 2004).

The clinical specialists/APPs acknowledged their advanced clinical skills and knowledge. Physiotherapists working at an advanced level should demonstrate technical mastery of complex skills (CSP, 2016a). The participants in this study described advanced skills including injection therapy, casting, taking arterial blood gases and diagnosing more complex presentations. Many of the clinical specialists/APPs spoke of sharing their clinical expertise with others. The competencies expected of a clinical specialist in Ireland include acting in an advanced clinical advisory role to other physiotherapists and the wider MDT (HSE, 2008). Other expectations for clinical specialists include delivering evidence-based and patient centred care (HSE, 2008, CSP, 2016a) and these concepts were discussed by some of the clinical specialists/APPs. Physiotherapists working at an advanced level should demonstrate patient-centred care by acknowledging the unique needs and preferences of individuals, and by providing information and support to empower individuals to make informed choices regarding their care (CSP, 2016a).

7.4.9. Limitations

The limitations of this study include those described in Chapter 6 (see section 6.4.9). The leadership capabilities of the clinical specialists/APPs were evaluated solely by their self-perceptions and thus there was a risk of social desirability bias in the interviews (van de Mortel, 2008). The interview schedule may have been insufficient to elicit discussion of all the participants' leadership capabilities and thus the analysis of these interviews may not entirely reflect the full range of leadership capabilities of these clinical specialists/APPs.

The research sample was small and the sampling approach required participants to volunteer to participate in the research which may have led to a self-selection bias. Therefore, as in Study II, a self-selection bias may have meant that the sample consisted of clinical specialists/APPs who were confident of their leadership capabilities whereas those less confident of their abilities in this area may have chosen not to participate.

Clinical specialists and APPs from a range of specialities and workplaces, however, were represented in the sample.

As previously mentioned, there were no clinical specialists/APPs based in private practice in this study which may affect comparison with the managers' interviews from Study II. There were, however, three clinical specialists/APPs from private hospitals which may have mitigated for this. As in Study II, the researchers reflected on their personal biases before conducting the analysis to minimise the potential for bias in the analysis, and an external, independent advisor coded a selection of the interviews to ensure the validity and comprehensiveness of the codebook.

7.5. Conclusion

The results of this study demonstrated that there were many similarities in the leadership capabilities of physiotherapy managers and physiotherapy clinical specialists/APPs. The clinical specialists/APPs demonstrated leadership capabilities associated with all four leadership frames, however, the language used and examples given demonstrated the importance they placed on interpersonal relationships and on developing the knowledge and skills of others and suggested that they favoured leadership capabilities associated with the human resource frame.

There were also differences noted between the leadership capabilities of the physiotherapy managers and the clinical specialists/APPs. In the structural frame, the clinical specialists/APPs placed less emphasis on co-ordinating the service and planning and were not involved in recruitment. There was more of a focus on waiting list management, being decisive and developing new procedures and protocols than there had been in the interviews with the managers. The leadership capabilities associated with the human resource frame reported by clinical specialists/APPs were very similar to those of the physiotherapy managers. For the clinical specialists/APPs there was a focus on teaching and acting as a clinical resource for others. In the political frame, the clinical specialists placed emphasis on promoting the profession, participating in research and collaboration with medical consultants. There was less focus on looking for opportunities and having influence. Similar to the physiotherapy managers, the clinical specialists/APPs gave few examples of networking and negotiating, and approached conflict management through the human resource frame. Leading by example, being a mentor or role model and demonstrating passion were leadership capabilities associated

with the symbolic frame described by the clinical specialists/APPs. There were fewer references to organising rituals or ceremonies, fostering a positive culture or communicating their vision. As with the physiotherapy managers, the clinical specialists underused the symbolic frame.

The experiences of the clinical specialists/APPs were reflected in the themes 'Challenges', 'Physiotherapy profession', 'Workplace' and 'Clinical role'. The participants mostly enjoyed their roles and in particular their clinical work, but they also recognised their non-clinical responsibilities including teaching, service development, research and quality improvement. The clinical specialists/APPs voiced frustrations with the health system and perceived the role to be better developed in the UK. Both clinical specialists/APPs and physiotherapy managers cited time constraints, lack of resources, other professions and changing structure as challenges. However, *changing structure* was not as prevalent a subtheme for the clinical specialists/APPs and two additional subthemes, *ordering images* and *career structure*, were found in the clinical specialists'/APPs' interviews. As noted in Chapter 6, the clinical specialists/APPs will need to be able to reframe situations and use leadership capabilities from all four frames to most effectively address these challenges. Physiotherapy clinical specialists/APPs may benefit from specific training to develop leadership capabilities associated with the political and symbolic frames.

Studies II and III explored the self-perceived leadership capabilities of two cohorts of physiotherapy leaders. However, an interesting question that arises from these studies is whether the leadership capabilities reported by physiotherapy managers and clinical specialists/advanced physiotherapy practitioners are the same as those that their colleagues consider physiotherapy managers and physiotherapy clinical specialists/advanced physiotherapy practitioners to demonstrate. Study IV will aim to explore this question.

8. Chapter 8 – Study IV: Experiences of leadership in physiotherapy in Ireland

8.1. Introduction

The aim of this chapter is to present the methodology and results of the survey conducted as the final study of this PhD thesis. This survey was conducted to explore clinical physiotherapists' experiences of physiotherapy leadership in their workplace. Studies II and III explored the leadership capabilities of two cohorts of physiotherapists who could be considered to be leaders in the physiotherapy profession. The results of these studies indicated that the participants predominantly used the structural and human resource frames and that the political and symbolic frames were underused. To further explore these results a survey was conducted with the clinical physiotherapists who work with these physiotherapy leaders to investigate their experiences of the leadership of physiotherapy management in their workplace. In this survey, the term physiotherapy management was used to encompass both physiotherapy managers and physiotherapy clinical specialists/APPs. Due to the similarity in the results of Studies II and III it was deemed acceptable to combine physiotherapy managers and physiotherapy clinical specialists/APPs into one category; physiotherapy management.

The aim of this study was to explore the clinical physiotherapists' perceptions of the leadership capabilities of physiotherapy management in their workplace. To gain a better understanding of the participants' perceptions of the leadership capabilities of physiotherapy management in their workplaces they were asked both how effective physiotherapy management in their workplace were at demonstrating the leadership capabilities and also how important they perceived each leadership capability to be for physiotherapy management to demonstrate. This allowed comparison of whether the leadership capabilities reported by the managers and clinical specialists/APPs in the earlier studies were perceived to be important by the physiotherapists who worked with them, as well as investigation of whether they perceived physiotherapy management in their workplace to be effective at demonstrating them.

Studies II and III investigated the leadership experiences of two specific cohorts of physiotherapists who may be considered to demonstrate leadership. However, this research project acknowledges that leadership is not dependent on having a specific role or position and that physiotherapists at any grade may demonstrate leadership. The need for all physiotherapists to demonstrate leadership and not just those in named roles

has been recognised (Massey, 2006, Wylie and Gallagher, 2009). For this reason, this study also investigates physiotherapists' perceptions of which grades of physiotherapist demonstrate leadership.

Based on these aims the objectives of the study were to:

(1) Investigate the physiotherapists' perceptions of the importance of physiotherapy management demonstrating specific leadership capabilities.

(2) Investigate the physiotherapists' perceptions of the effectiveness of physiotherapy management in their workplace at demonstrating specific leadership capabilities.

(3) Compare the physiotherapists' ratings of the importance of leadership capabilities as they relate to the four frames of the Bolman and Deal (2008) Framework.

(4) Compare the physiotherapists' ratings of the effectiveness of physiotherapy management in their workplace at demonstrating leadership capabilities as they relate to the four frames of the Bolman and Deal Framework.

(5) Compare the physiotherapists' ratings of importance of the leadership capabilities with their ratings of the effectiveness of physiotherapy management in their workplace at demonstrating them.

(6) Identify the grades of physiotherapist that the physiotherapists perceive to demonstrate leadership.

8.2. Methodology

8.2.1. Study Design

A quantitative, cross-sectional study was performed using a paper-based survey with a purposive sample of physiotherapists. The purposive sample of physiotherapists was made up of the physiotherapists who work with the physiotherapy managers and/or physiotherapy clinical specialists/APPs who participated in the interviews in Studies II and III. To protect the identity of the physiotherapy managers and physiotherapy clinical specialists/APPs who had participated in Studies II and III, physiotherapists working in ten workplaces not involved in Studies II and III were also included in the study. This meant that the physiotherapists who were invited to participate in this study did not know whether their manager or the clinical specialists/APPs that they work with had

participated in an earlier study or not. Ethical approval was granted by Trinity College Faculty of Health Sciences Ethics Committee (see Appendix II – pg 419).

8.2.2. Participant recruitment

The physiotherapy managers who had participated in the interviews in Study II were contacted to inform them of the study and to seek their permission to invite the physiotherapists on their team to participate. The physiotherapy managers of the clinical specialists/APPs who had participated in Study III were also contacted to inform them of the study and to seek their permission to include their team in the study. As noted above the physiotherapy managers of an additional ten physiotherapy teams were also contacted to inform them of the study and to seek their permission to survey the members of their team. A total of 34 workplaces were contacted regarding the study; thirteen were workplaces involved in Study II, six were workplaces involved in Study III, five were workplaces involved in Studies II and III, and ten workplaces were not involved in Study II or III. The managers were sent a letter explaining the study, the study information leaflet (Appendix VI, pg 464) and a copy of the survey instrument. The managers were advised in the letter that if we did not hear back from them assent was assumed.

8.2.3. Survey instrument

The survey instrument was paper based and required participants to complete it by hand (Appendix V, pg 453-459). The front page of the survey instructed participants to circle the appropriate answer to each question in section 1 and to tick the boxes to indicate their response to the questions in sections 2 and 3. The front page also provided the definitions of a leader and of physiotherapy management used in this study. The participants were informed that physiotherapy management refers to “the members of the physiotherapy team to whom you report or who are involved in management; this includes physiotherapy clinical specialists/advanced physiotherapy practitioners”. The front page of the survey also acknowledged that the participant may work in more than one workplace and requested that the physiotherapist respond to the questions in the survey per the workplace where they received the survey.

The survey was divided into three sections. The first section asked for the participants’ workplace and personal demographic details. The second section asked the participants to rate 24 leadership capabilities on two questions:

- How important are these capabilities for physiotherapy management to demonstrate?
- How effective is physiotherapy management in your workplace at demonstrating these capabilities?

The participants rated the capabilities on Likert-type scales from '1 - Not at all important' to '5 – Very important', and from '1 – Not at all effective' to '5 – Very effective', respectively. This section of the survey was designed based on the results of studies II and III. The 24 leadership capabilities included in the survey were derived from the leadership capabilities the physiotherapy managers and clinical specialists/APPs described in their interviews or perceived to be important. As with the structure of the interviews in studies II and III, the leadership capabilities in this study were based on the leadership framework of Bolman and Deal (1991, 2008). The subthemes found in the interviews were summarised and key capabilities were chosen for each frame; six capabilities for each frame. The survey was structured so that the leadership capabilities related to each frame were on a separate page e.g. the first page of section 2 had the six structural leadership capabilities, the second page had the six human resource capabilities and so on. For each frame, the six capabilities were grouped into two categories containing similar capabilities. For example, the capabilities related to the structural frame were grouped into co-ordination of operations and strategic planning and alignment.

The third section of the survey contained two questions. The first asked participants to indicate the grades of physiotherapist that they work with in their workplace. This question was included to give context to the second question. The second question asked participants to indicate the grades of physiotherapist that demonstrate leadership in their experience. If a participant indicated that they worked with a particular grade of physiotherapist but then did not mark that grade of physiotherapist as demonstrating leadership, then their response for that grade of physiotherapist was recorded as 'does not demonstrate leadership'. If a participant indicated that they did not work with a particular grade of physiotherapist and did not mark that grade of physiotherapist as demonstrating leadership, then their response for that grade of physiotherapist was recorded as 'not applicable'. Some participants did not indicate working with a particular grade of physiotherapist but still reported that this grade of physiotherapist demonstrates leadership. This may have been because the physiotherapist previously worked with that grade of physiotherapist or that they were aware of the leadership of individuals working at that grade who demonstrate leadership. For this reason, if a participant indicated a

particular grade of physiotherapist as demonstrating leadership, then their response was recorded as ‘demonstrates leadership’ whether they had indicated working with that grade of physiotherapist or not.

To ensure the readability and clarity of the survey the questionnaire was piloted on five physiotherapists. Based on their feedback, minor changes were made to the wording and layout of the survey instrument. This included adding the physiotherapy grade, physiotherapy peer, to the last question as this would be relevant to physiotherapists working in environments where the other grades of physiotherapist may not apply e.g. private practice.

8.2.4. Distribution of the survey

The physiotherapy team administrator in each workplace was contacted to request that they act as a gatekeeper for the study. They were given details of the study and their role as gatekeeper was described. If the administrator agreed to act as a gatekeeper, they were asked how many physiotherapists work on the team so that an appropriate number of surveys could be sent. The gatekeeper in each workplace was then sent information about the survey and the study documents by post or by delivery by the PhD candidate.

Each survey was placed in an envelope addressed to ‘Member of the physiotherapy team’. The envelope also contained a letter inviting the physiotherapist to participate in the survey (Appendix VII, pg 466), the survey information leaflet and a blank envelope for them to return their completed survey in. The participant letter informed the physiotherapists that by completing and returning the survey they were providing informed consent to participating in the study. The participant letter also clearly asked the physiotherapist not to complete the survey if they were the team manager or if they were not working clinically. A total of 583 surveys were delivered to the 34 physiotherapy teams.

The gatekeeper was asked to give an envelope containing the survey documents to each member of the physiotherapy team. They were also asked to provide a box in a communal area to allow the physiotherapists to return their completed survey anonymously. In one workplace, the surveys were placed in a box in a communal area with a poster informing the physiotherapists of the study and inviting the physiotherapists

to take a survey. There was another box beside this for these physiotherapists to return their completed surveys. To encourage participation in the survey the gatekeepers were contacted after two weeks and asked to send an email to the physiotherapy team to remind them about the survey. After three weeks, the gatekeepers were contacted again and asked to return the completed surveys by post or if the workplace was in an amenable location the completed surveys were collected by the PhD candidate.

8.2.5. Statistical Analysis

The data was entered from the paper-based surveys into spread sheet form using Microsoft Office Excel and double-checked for accuracy. The data was analysed using SPSS version 23. Non-parametric statistical tests were used to analyse the data because the data consisted of a combination of ordinal and categorical data.

To address the first and second objectives, frequency distributions and percentages were obtained for the ratings of importance and effectiveness of the leadership capabilities. The leadership capabilities were sorted in descending order from the capability with the highest percentage rating of 'very important' to the capability with the lowest percentage rating of 'very important'. Separately the leadership capabilities were sorted in descending order from the capability with the highest percentage rating of 'very effective' to the capability with the lowest percentage rating of 'very effective'.

To get a frame total score for each respondent, their ratings for each capability on that frame were added together. For example, to get a respondent's structural frame total for ratings of importance, their rating of importance for each of the six capabilities in the structural frame were added together. Similarly, to get their structural frame total for ratings of effectiveness, their rating of effectiveness for each of the six capabilities in the structural frame were added together. This meant that each respondent had a frame total score for importance and a frame total score for effectiveness for each frame (out of a maximum of 30 in each case).

To address objective 3, the respondents' frame total scores for importance were compared using the Friedman test with the significance level set at $p \leq 0.05$. When a significant result was found, post-hoc analyses were performed using Wilcoxon signed ranks test with the Bonferroni correction applied, resulting in a significance level set at $p \leq 0.0083$. Similarly, to address objective 4, the respondents' frame total scores for

effectiveness were compared using the Friedman test and post-hoc analyses were performed when a significant result was found.

The respondents' frame total scores for importance were compared to the frame total scores for effectiveness for each frame using the Wilcoxon signed ranks test to address the fifth objective. To compare the size of the difference between ratings of importance and ratings of effectiveness for each frame, a frame difference score was calculated. For each respondent, the difference was calculated between their frame total for importance and their frame total for effectiveness to give their frame difference score. For example, a respondent's structural frame difference score was calculated by subtracting their structural frame total score for effectiveness from their structural frame total score for importance. The frame difference scores for all the respondents were then compared across the frames. The Friedman test was used to identify if there was a difference in the size of discrepancy between ratings of importance and ratings of effectiveness between the frames. When a significant result was found, post-hoc analyses were performed using Wilcoxon signed ranks test with the Bonferroni correction applied, resulting in a significance level set at $p \leq 0.0083$.

Descriptive statistics (frequency and percentage) were obtained for the grades of physiotherapist that the respondents reported to demonstrate leadership to address the sixth objective.

8.3. Results

There were 303 responses to the survey. There were 35 surveys returned unopened. Where it was possible to do so, the gatekeeper was contacted regarding the unopened surveys. These were reported to be surplus due to physiotherapists being on sick leave or holidays. This gave a response rate of 55%. One respondent indicated that their job title was 'physiotherapy assistant' and so their data was excluded from the analysis as they were not working as a clinical physiotherapist. The demographic details of the respondents are displayed in Table 8.1. The reported percentages were calculated based on the total responses to each question and do not include respondents who skipped that question. Four respondents indicated two workplaces when responding to the question regarding where they work. These respondents' responses were not included in the analyses involving workplace.

Table 8-1 Demographic details of respondents

Variable (n=number of responses)	Results
Gender (n=294)	Male – 58 (19.7%) Female – 236 (80.3%)
Experience (n=301)	<2 years – 15 (5.0%) 2-5 years – 45 (15.0%) 6-10 years – 95 (31.6%) 11-15 years – 64 (21.3%) 16-20 years – 33 (11.0%) >20 years – 49 (16.3%)
Workplace (n=297)	Public hospital – 159 (53.5%) Private hospital – 23 (7.7%) Private practice – 29 (9.8%) Primary care – 66 (22.2%) Other – 20 (6.7%)
Team-size (n=300)	1-10 physiotherapists – 93 (31.0%) 11-20 physiotherapists – 99 (33.0%) 21-30 physiotherapists – 29 (9.7%) 31+ physiotherapists – 79 (26.3%)
Job title (n=301)	Staff-grade – 91 (30.2%) Senior – 169 (56.1%) Clinical specialist – 20 (6.6%) APP – 5 (1.7%) Private Practice Physiotherapist – 16 (5.3%)

8.3.1. Objectives 1 and 2 – ratings of leadership capabilities

Tables 8.2, 8.3, 8.4 and 8.5 display the ratings of the leadership capabilities. To make the tables easier to read the ratings of ‘Not at all important’, ‘Not very important’ and ‘Neutral’ have been pooled into one category, ‘Not important or neutral’. The full tables are displayed in Appendix XI (pg 485-488).

Table 8-2 Ratings of structural frame capabilities

Leadership capability	How important are these capabilities for physiotherapy management to demonstrate?			How effective is physiotherapy management in your workplace at demonstrating these capabilities?		
	Not important or neutral (%)	Important (%)	Very important (%)	Not effective or neutral (%)	Effective (%)	Very effective (%)
Co-ordination of operations						
Co-ordinate service; organise the work of the team and themselves	5.0	22.2	72.8	17.7	47.2	35.1
Appropriately delegate tasks to team-members	4.6	33.1	62.3	22.1	47.3	30.5
Monitor the work and results of team-members	6.3	37.7	56.0	28.9	41.9	29.2
Strategic planning and alignment						
Develop and implement appropriate strategic plans for the team	4.7	35.3	60.0	23.6	48.8	27.6
Set appropriate goals for individual team-members and the team	13.0	41.2	45.8	38.5	39.2	22.3
Ensure adherence to policy and procedure and clinical guidelines	5.3	34.0	60.7	17.3	46.5	36.2

Table 8-3 Ratings of human resource frame capabilities

Leadership capability	How important are these capabilities for physiotherapy management to demonstrate?			How effective is physiotherapy management in your workplace at demonstrating these capabilities?		
	Not important or neutral (%)	Important (%)	Very important (%)	Not effective or neutral (%)	Effective (%)	Very effective (%)
Professional development						
Assist individuals to identify and address gaps in their knowledge	8.6	42.9	48.5	39.7	40.3	20.0
Provide opportunities for the improvement of knowledge and skills	2.3	28.6	69.1	27.8	48.5	23.7
Provide emotional or practical support to team members	6.3	34.9	58.8	35.0	36.0	29.0
Communication						
Effectively exchange information and ideas	4.3	30.8	64.9	24.6	44.5	30.9
Listen to ideas, suggestions and opinions of team-members	2.0	23.2	74.8	24.8	42.1	33.1
Provide feedback on the work of the team and welcome feedback on their own performance	2.7	27.6	69.8	37.7	37.4	24.8

Table 8-4 Ratings of political frame capabilities

Leadership capability	How important are these capabilities for physiotherapy management to demonstrate?			How effective is physiotherapy management in your workplace at demonstrating these capabilities?		
	Not important or neutral (%)	Important (%)	Very important (%)	Not effective or neutral (%)	Effective (%)	Very effective (%)
Organisational interpersonal dynamics						
Influence development, process or behaviour in their organisation	5.3	35.2	59.5	26.3	47.3	26.3
Implement and drive change to improve practice	0.7	24.9	74.4	25.7	46.7	27.7
Demonstrate effective strategies for managing conflict	2.3	31.2	66.4	44.5	36.1	19.4
Collaboration						
Work with individuals outside of the physiotherapy team to develop links and look for opportunities	6.0	38.9	55.1	24.7	40.0	35.3
Network effectively with medical consultants or other managers	5.6	32.6	61.8	27.1	40.1	32.8
Ensure visibility and status of profession within the workplace/society	4.0	30.3	65.7	25.0	41.7	33.3

Table 8-5 Ratings of symbolic frame capabilities

Leadership capability	How important are these capabilities for physiotherapy management to demonstrate?			How effective is physiotherapy management in your workplace at demonstrating these capabilities?		
	Not important or neutral (%)	Important (%)	Very important (%)	Not effective or neutral (%)	Effective (%)	Very effective (%)
Ethos						
Foster a positive workplace culture	0.3	16.3	83.3	33.0	37.7	29.3
Demonstrate awareness of the atmosphere of the work environment	0.3	25.0	74.7	42.7	34.0	23.3
Initiate activities to encourage team bonding	9.3	31.3	59.3	51.8	31.8	16.4
Symbolic						
Communicate their vision for the future of the team	5.6	42.2	52.2	40.2	36.9	22.9
Provide mentorship/encourage team members to seek a mentor	6.6	39.5	53.8	39.9	36.9	23.3
Act as a role model for the team and lead by example	5.0	29.6	65.4	29.9	39.9	30.2

The top five most highly rated leadership capabilities for importance and for effectiveness are displayed in Table 8.6.

Table 8-6 Top five most highly rated leadership capabilities

Leadership capability	**% of respondents rated leadership capability as very important**
Foster a positive workplace culture (symbolic)	83.3
Listen to ideas, suggestions and opinions of team-members (human resource)	74.8
Demonstrate awareness of the atmosphere of the work environment (symbolic)	74.7
Implement and drive change to improve practice (political)	74.4
Co-ordinate service; organise the work of the team and themselves (structural)	72.8
Leadership capability	**% of respondents rated physiotherapy management as very effective**
Ensure adherence to policy and procedure and clinical guidelines (structural)	36.2
Work with individuals outside of the physiotherapy team to develop links and look for opportunities (political)	35.3
Co-ordinate service; organise the work of the team and themselves (structural)	35.1
Ensure visibility and status of profession within the workplace/society (political)	33.3
Listen to ideas, suggestions and opinions of team-members (human resource)	33.1

8.3.2. Objectives 3 and 4 – Comparison of ratings of leadership capabilities across frames

When comparing across the frames, the Friedman test demonstrated that there was a statistically significant difference in ratings of importance of the leadership capabilities between the four frames, ($X^2(3) = 9.362$, p=0.025). The mean ranks for the structural, human resource, political and symbolic frames on the Friedman test were 2.33, 2.54, 2.53, and 2.60, respectively. Post-hoc analysis using Wilcoxon signed ranks test with a Bonferroni correction applied demonstrated that there were no significant differences between the structural and human resource frames (z=-2.514, p=0.012), the human

resource and political frames (z=-0.334, p=0.739), the human resource and symbolic frames (z=-0.170, 0.865), or the political and symbolic frames (z=-0.543, 0.587). However, there was a statistically significant difference between ratings of importance of capabilities in the symbolic frame and the structural frame (z=-2.640, p=0.008), which indicated that the respondents rated capabilities on the symbolic frame as more important than capabilities on the structural frame. The difference between ratings of importance of capabilities in the political frame and structural frame was approaching significance (z=-2.617, p=0.009). These results are displayed in Table 8.7.

Table 8-7 Comparison of ratings of importance and effectiveness across the four frames

	Comparison of ratings of importance across the four frames		**Comparison of ratings of effectiveness on the four frames**	
Friedman Test	**Chi square**	**P value**	**Chi square**	**P value**
	9.362	0.025	78.022	<0.001
Mean rank*	Symbolic – 2.60 Human resource – 2.54 Political – 2.53 Structural – 2.33		Structural – 2.82 Political – 2.72 Human resource – 2.45 Symbolic – 2.01	
Wilcoxon signed ranks test	**Z score**	**P value**	**Z score**	**P value**
Structural vs Human resource	-2.514	0.012	-4.375	<0.001**
Structural vs Political	-2.617	0.009	-1.475	0.140
Structural vs Symbolic	-2.640	0.008**	-7.866	<0.001**
Human resource vs Political	-0.334	0.739	-2.866	0.004**
Human resource vs Symbolic	-0.170	0.865	-5.027	<0.001**
Political vs Symbolic	-0.543	0.587	-7.482	<0.001**

*A line joining frames indicates that there was no statistically significant difference between those frames for ratings of importance/ratings of effectiveness
** Statistically significant with significance level set at p<0.00833

When comparing ratings of effectiveness across the frames, the Friedman test demonstrated that there was a statistically significant difference between the four frames, ($X^2(3) = 78.022$, $p<0.001$). The mean ranks for the structural, human resource, political and symbolic frames on the Friedman test were 2.82, 2.45, 2.72, and 2.01, respectively. Post-hoc analysis using Wilcoxon signed ranks test with a Bonferroni correction applied demonstrated that there was no significant difference between ratings of effectiveness on capabilities in the structural and political frames ($z=-1.475$, $p=0.140$). However, statistically significant differences were found between the structural and human resource frames ($z=-4.375$, $p<0.001$), the structural and symbolic frames ($z=-7.866$, $p<0.001$), the human resource and political frames ($z=-2.866$, $p=0.004$), the human resource and symbolic frames ($z=-5.027$, $p<0.001$), and the political and symbolic frames ($z=-7.482$, $p<0.001$). The results indicated that the respondents rated their physiotherapy management as more effective on the structural frame than the human resource and symbolic frames, more effective on the political frame than the human resource and symbolic frames, and more effective on the human resource frame than the symbolic frame. These results are displayed in Table 8.7.

8.3.3. Objective 5 – Comparison of ratings of importance of leadership capabilities with ratings of effectiveness of physiotherapy management at demonstrating the leadership capabilities

Wilcoxon signed ranks tests demonstrated that there was a statistically significant difference between ratings of importance and ratings of effectiveness for each of the four frames. Wilcoxon signed ranks test indicated that ratings of importance were higher than ratings of effectiveness on the structural frame ($z=-10.767$, $p<0.001$), the human resource frame ($z=-12.666$, $p<0.001$), the political frame ($z=-12.434$, $p<0.001$), and the symbolic frame ($z=-13.465$, $p<0.001$). These results are displayed in Table 8.8.

The Friedman test demonstrated that there was a statistically significant difference between the frames for the differences observed in ratings of importance and effectiveness ($X^2(3) = 80.519$, $p<0.001$). The mean ranks for the structural, human resource, political and symbolic frames on the Friedman test were 2.08, 2.58, 2.37 and 2.97, respectively.

Post-hoc analysis using Wilcoxon signed ranks test with a Bonferroni correction applied demonstrated that there was no significant difference between the human resource and political frames for the difference observed between ratings of importance and

effectiveness (z=-1.923, p=0.055). However, statistically significant differences were found between the structural and human resource frames (z=-5.088, p<0.001), the structural and political frames (z=-3.215, p=0.001), the structural and symbolic frames (z=-8.606, p<0.001), the human resource and symbolic frames (z=-4.657, p<0.001), and the political and symbolic frames (z=-6.551, p<0.001). The results indicated that the difference observed between ratings of importance and ratings of effectiveness was significantly greater on the symbolic frame than the structural frame, human resource frame and political frame. The difference observed between ratings of importance and ratings of effectiveness was statistically significantly greater on the human resource frame than the structural frame, and statistically significantly greater on the political frame than the structural frame. These results are displayed in Table 8.8.

Table 8-8 Comparison between ratings of importance and ratings of effectiveness on the four leadership frames

Comparison between ratings of importance and ratings of effectiveness		
	Wilcoxon signed ranks test	
	Z score	**P value**
Structural	-10.767	<0.001
Human resource	-12.666	<0.001
Political	-12.434	<0.001
Symbolic	-13.465	<0.001
Comparison of the size of the difference observed between ratings of importance and ratings of effectiveness		
Friedman Test	**Chi square**	**P value**
	80.519	<0.001
Mean Rank*	Symbolic – 2.97 Human resource – 2.58 Political- 2.37 Structural – 2.08	
Pairwise comparison – Wilcoxon signed ranks test	**Z score**	**P value**
Structural vs HR	-5.088	<0.001**
Structural vs Political	-3.215	0.001**
Structural vs Symbolic	-8.606	<0.001**
HR vs Political	-1.923	0.055
HR vs Symbolic	-4.657	<0.001**
Political vs Symbolic	-6.551	<0.001**

*Line joining frames indicates that there was no statistically significant difference between those frames for size of difference observed between ratings of importance and ratings of effectiveness

** Statistically significant with significance level set at p<0.00833

8.3.4. Objective 6 – Leadership among different grades of physiotherapist

Respondents were asked to indicate the grade(s) of physiotherapist that they work with. The responses to this question are displayed in Table 8.9.

Table 8-9 The grades of physiotherapist that the respondents report working with

Grade of Physiotherapist	Report working with this physiotherapy grade (%)
Staff grade	Yes – 255 (85.9%) No – 42 (14.1%)
Senior	Yes – 276 (92.9%) No – 21 (7.1%)
Clinical specialist	Yes – 160 (53.9%) No – 137 (46.1%)
Advanced physiotherapy practitioner	Yes – 38 (12.8%) No – 259 (87.2%)
Manager	Yes – 235 (79.1%) No – 62 (20.9%)
Physiotherapy peer	Yes – 45 (15.2%) No – 252 (84.8%)

The percentages and frequency distributions for the grades of physiotherapist that the respondents reported to demonstrate leadership are displayed in Figure 8.1 and Table 8.10.

Figure 8-1 Percentage of respondents who report different grades of physiotherapist to demonstrate leadership

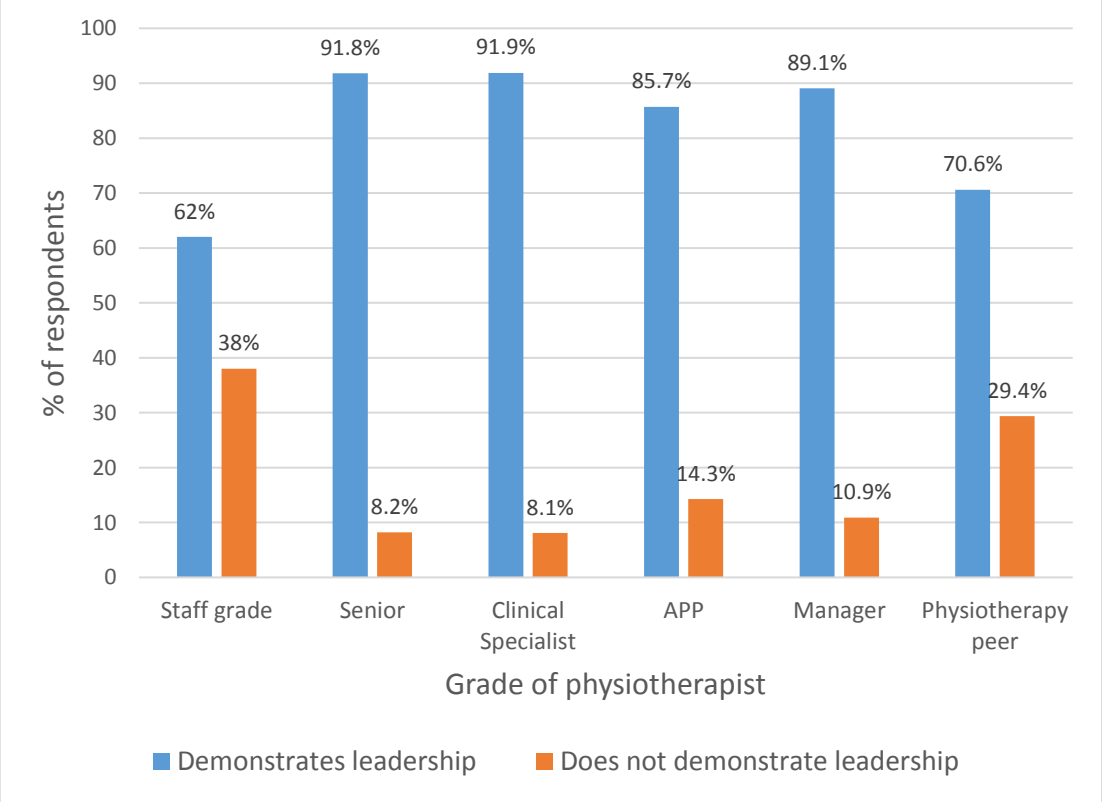


Table 8-10 Frequency distribution and percentages of grades of physiotherapist reported to demonstrate leadership

Grade of Physiotherapist	Perceive physiotherapists working at this level to demonstrate leadership (%)
Staff grade	Yes – 160 (62.0%) No – 98 (38.0%) N/a* – 39
Senior	Yes – 259 (91.8%) No – 23 (8.2%) N/a* - 15
Clinical specialist	Yes – 158 (91.9%) No – 14 (8.1%) N/a* - 125
Advanced physiotherapy practitioner	Yes – 36 (85.7%) No – 6 (14.3%) N/a* - 255
Manager	Yes – 230 (89.1%) No –28 (10.9%) N/a* - 39
Physiotherapy peer	Yes – 36 (70.6%) No – 15 (29.4%) N/a* - 246

*N/a – number who indicated that they did not work with this grade of physiotherapist

8.4. Discussion

The results of this survey suggest that there are both similarities and differences in the perceptions of leadership capabilities of physiotherapy managers and clinical specialists/APPs, and their clinical physiotherapist colleagues. The results from this survey are discussed below and compared with the results from Studies II and III.

8.4.1. Effectiveness at demonstrating leadership capabilities

The respondents to this survey rated physiotherapy management as most effective on the structural frame, followed by the political frame, and then the human resource frame. There was no significant difference, however, between the ratings of effectiveness on the political and structural frames. Physiotherapy management were rated as least effective on the symbolic frame leadership capabilities. In studies II and III, the physiotherapy managers and clinical specialists/APPs reported prevalent use of human resource and structural frame leadership capabilities. While the high ratings of effectiveness on leadership capabilities of the structural frame in this study concurred

with the results of the previous studies, the ratings on the human resource and political frames differed to the results of the earlier studies. The managers in Study II had spoken of difficulties working through the political frame and in the interviews with the clinical specialists/APPs there were few examples of some leadership capabilities associated with the political frame. Additionally, human resource frame leadership capabilities were prevalently used and perceived to be important by the participants in Studies II and III. In this survey, however, physiotherapy management was rated as more effective on leadership capabilities associated with the structural and political frames than the human resource frame. The reason for these differences is unknown but they suggest that the clinical physiotherapists do not perceive physiotherapy management to be as effective on human resource leadership capabilities as the participants in Studies II and III perceived themselves to be. They also suggest that the clinical physiotherapists perceive physiotherapy management to be more effective on political leadership capabilities than the managers and clinical specialists/APPs had perceived themselves to be. The lower ratings of effectiveness on the symbolic frame were in keeping with the results of the interviews conducted in studies II and III where the symbolic frame was found to be underused.

The top five rated capabilities for effectiveness included two capabilities from the structural frame, two from the political frame and one from the human resource frame. There was no capability from the symbolic frame in the top five which again reflects that the respondents did not perceive physiotherapy management to be as effective at capabilities associated with the symbolic frame. The leadership capability most highly rated for effectiveness was 'Ensuring adherence to policy and procedure and clinical guidelines'. This capability was from the structural frame and reflects an aspect of leadership associated with the management role but also an important component of clinical practice. The importance of clinical guidelines to the effectiveness of physiotherapy care has been recognised (Bernhardsson et al., 2014), as well as the need to encourage adherence to guidelines (Rutten et al., 2013). Participants in Studies II and III acknowledged the importance of policy and procedure and clinical guidelines and the clinical specialists/APPs had discussed developing these for their service.

The second most highly rated leadership capability for effectiveness was 'Working with individuals outside of the physiotherapy team to develop links and look for opportunities'. The clinical specialists/APPs in Study III discussed their affiliation with the specialist team they worked with outside of the physiotherapy team and of their working relationships with medical consultants. The importance of clinical specialists and APPs developing

and maintaining good working relationships with medical and other health professionals has been recognised (Moloney et al., 2009, Morris et al., 2014, O'Mahony and Blake, 2017). The physiotherapy managers in Study II also reported collaborating with other disciplines, managers and medical consultants. The third most highly rated capability for effectiveness was 'Co-ordinating service; organising the work of the team and themselves'. This was a prevalent subtheme in the interviews with the physiotherapy managers where they discussed the strategies and approaches they employed to ensure the smooth running of their practice/department. This subtheme was less prevalent among the clinical specialists/APPs, however, these participants did discuss the importance of time management and being organised.

The majority of respondents rated physiotherapy management as effective or very effective on all of the leadership capabilities except for one, 'Initiate activities to encourage team bonding' (symbolic). While 90.1% of respondents rated this leadership capability as 'important' or 'very important', only 48.2% of respondents rated physiotherapy management as 'effective' or 'very effective' at demonstrating it in their workplace. Physiotherapy leaders need to recognise the importance of team bonding activities and should not neglect this aspect of leadership. Team building is seen as essential in today's healthcare environment as it creates commitment, creativity, support and cohesiveness (Danna, 2009). In a study investigating the impact of a specific team enhancement and engagement intervention on a nursing team, Kalisch et al. (2007) found that there was a significant reduction in patient fall rate and lower staff turnover, as well as staff reports of improved teamwork. Bolman and Deal (2008) advocate the importance of creating team spirit and shared culture, stating "peak performance emerges as a team discovers its soul" (pg 290). Physiotherapy leaders should be aware of both simple activities that can be incorporated into the working day and larger team-building initiatives that can be employed to enhance team morale and promote team bonding.

8.4.2. Ratings of importance of leadership capabilities

The ratings of importance of the leadership capabilities were in the opposite order to the ratings of effectiveness. The capabilities associated with the symbolic frame were most highly rated for importance and the capabilities associated with the structural frame were least highly rated. It is important to note, however, that that there was only a significant difference between the ratings of importance of symbolic frame and structural frame

leadership capabilities. The top five rated capabilities for importance included two from the symbolic frame and one from the structural, human resource and political frames. Capabilities from all four frames were in the top five. These results suggest that the that the respondents recognise the importance of the four frames to effective leadership rather than mostly focusing on one particular frame or aspect of leadership. As described in Section 2.13, Bolman and Deal contend that while each frame is powerful on its own, all four frames contribute to effectiveness (Bolman and Deal, 1991, 1992a), and the ability to use multiple frames is associated with greater effectiveness for leaders (Bolman and Deal, 1991, 1992a, 2008).

The leadership capability that was most highly rated for importance was 'Foster a positive workplace culture' and the third most highly rated leadership capability was 'Demonstrate awareness of the atmosphere of the work environment'. Both capabilities are associated with the symbolic frame. Organisational culture encompasses the common perceptions, values and beliefs held by organisational members (Robbins and Coulter, 2002). The culture of an organisation is key to whether it is a positive environment in which to work and can influence the attitudes and behaviour of staff (Tsai, 2011). The need for a culture of learning, safety and transparency, and the important role of leadership in facilitating this, has been recognised by the NHS in the UK (Muls et al., 2015). Respondents to this survey place importance on the culture of their workplace and recognise the impact that leadership can have on this. Tsai (2011) found that factors of organisational culture were significantly, positively correlated with leadership behaviours and job satisfaction in a survey of nurses in Taiwan. The culture of an organisation can also impact patient care. Leaders who create positive, supportive environments for their team, facilitate their team to in turn create positive, supportive environments for patients and thus deliver higher quality care (West et al., 2014).

The atmosphere or climate of an organisation is related to an organisation's culture. It encompasses team members' feelings, emotional responses and subjective impression of their workplace (Aarons and Sawitzky, 2006). Organisational climate can be changed (Danna, 2009) and thus it is important that leaders are aware of the atmosphere of their workplace so that they can take steps to improve it if needed. Danna (2009) has suggested several activities that leaders can engage in to promote a positive workplace climate including: developing the organisation's mission and goals with input from the team, asking for feedback in meetings and through surveys, encouraging free expression of ideas and opinions, rewarding competence and productivity, and recognising

contributions to the organisation. These are approaches that could be employed by physiotherapy leaders to ensure a positive atmosphere in their workplaces.

The leadership capability with the second highest rating for importance was 'Listen to ideas, suggestions and opinions of team-members'. The importance of effective communication to leadership has been highlighted in each of the studies of this PhD thesis. In Study I, communication was the most highly rated leadership capability in the workplace, the healthcare system and society (see Section 4.3.4). Communication was also an important subtheme in the interviews conducted in Studies II and III. The physiotherapy managers and clinical specialists/APPs recognised the importance of effective communication, of listening to others and being open to their ideas and opinions (see Sections 6.4.2 and 7.4.2). The results of this survey demonstrate that clinical physiotherapists also value their leaders being able to demonstrate effective communication strategies. Collective leadership where there is a partnership approach between management and staff and everyone takes responsibility for the success of the organisation has been advocated as a leadership model to bring change to the NHS (West et al., 2014). This model encourages staff engagement and involvement in decision-making and requires high levels of dialogue and discussion. The results of this survey suggest that this may be a favoured leadership model for clinical physiotherapists.

The importance placed on leadership capabilities associated with the symbolic frame reflects the research of Bolman and Deal who found that the symbolic frame was highly associated with leadership effectiveness (Bolman and Deal, 1992a, 1992b). The symbolic frame offers insights into issues of meaning and belief and provides opportunities for bonding individuals into a cohesive team with a shared mission (Bolman and Deal, 2008). The lesser importance placed on leadership capabilities associated with the structural frame is also in keeping with the research of Bolman and Deal. Bolman and Deal (1991, 1992a) found that the structural frame was most associated with managerial effectiveness and only modestly related to effectiveness as a leader which may explain the results observed in this survey.

8.4.3. Comparison of ratings of importance and ratings of effectiveness

There was a statistically significant difference between ratings of importance and ratings of effectiveness on all four frames. On each frame the ratings of importance were statistically significantly higher than ratings of effectiveness. Further analyses

demonstrated that the size of the difference between ratings of importance and ratings of effectiveness were significantly different between the frames. The structural frame had the smallest difference between ratings of importance and ratings of effectiveness. The respondents indicated that physiotherapy management in their workplace were most effective on leadership capabilities associated the structural frame suggesting that they perceive them to be effective at managerial tasks. However, in keeping with Bolman and Deals' (1992a) findings, the leadership capabilities associated with the structural frame were rated as the least important to leadership.

The greatest difference between ratings of importance and ratings of effectiveness was found on the symbolic frame. This reflects that while the respondents rate leadership capabilities associated with the symbolic frame as most important, this is the frame that they perceive physiotherapy management to be least effective at demonstrating. The lower ratings of the leadership capabilities on this frame and the importance placed on them by the respondents suggest that this is something that the managers and clinical specialists/APPs should address. The managers and clinical specialists/APPs may benefit from training to improve their awareness of the importance of the symbolic frame and to enable them to develop symbolic frame leadership capabilities.

8.4.4. Grades of physiotherapist who demonstrate leadership

When investigating the grades of physiotherapist that the respondents perceived to demonstrate leadership, the results showed that a very high percentage of respondents perceived senior physiotherapists (91.8%), clinical specialists (91.9%) and physiotherapy managers (89.1%) to demonstrate leadership. A slightly smaller percentage of respondents (85.7%) reported that APPs demonstrated leadership. However, a much smaller number of respondents reported working with an APP (n=38) than with senior physiotherapists (n=276), clinical specialists (n=160) or physiotherapy managers (n=235), and this must be considered when interpreting this result. As noted in Chapter 7 (see Section 7.3.7), there is confusion in the terminology used in advanced practice roles in physiotherapy. No definitions were given for clinical specialist or APP in the survey and so the results reflect the respondents' perceptions of whether they worked with a clinical specialist or APP.

The percentage of respondents who perceived staff grade physiotherapists or physiotherapy peers to demonstrate leadership was lower, 62.0% and 70.6%

respectively, however these results did indicate that the majority of respondents perceived these grades of physiotherapist to demonstrate leadership. Again, the smaller number of respondents who indicated working with physiotherapy peers must be considered (n=45). These results suggest that the majority of respondents in this survey recognise that physiotherapists working at all levels in the health care system can, and do, demonstrate leadership. A higher percentage of respondents perceived physiotherapy grades with greater levels of responsibility and authority e.g. senior or clinical specialist, to demonstrate leadership. This result may reflect that leadership is required at senior, clinical specialist and managerial level, whereas it is not expected at staff grade level (HSE, 2008). This result was also in keeping with Wylie and Gallagher (2009) who found that allied health professionals working at higher levels of seniority reported significantly higher transformational leadership scores on the Multifactor Leadership Questionnaire than those in less senior positions. However, it must be remembered that these results only indicate that respondents had experience of physiotherapists working at the grade demonstrating leadership, and not that all physiotherapists working at that grade demonstrate leadership consistently. Wylie and Gallagher (2009) asserted that there needs to be a "Copernican revolution among traditional clinical grades in order for clinicians to begin to think of themselves as leaders" and advocated for graduates to be targeted with leadership development opportunities early in their careers to facilitate clinical leadership at all levels.

8.4.5. Limitations

The limitations of this survey include the response rate, the potential for self-selection bias, and the possibility of misunderstanding of terms. The response rate of 55% was comparable with other surveys of physiotherapists (French, 2007, Bishop et al., 2016), however there may still have been a non-response bias. Physiotherapists with an interest in leadership or who wanted to share their views on physiotherapy management in their workplace may have been more likely to respond to the survey and thus there may have been a self-selection bias (Eysenbach and Wyatt, 2002). Respondent representativeness can be used as an approach to gauge differences between responders and non-responders and thus check for non-response error (Roush et al., 2015). In this survey, respondent representation across the different workplaces was very close to the proportions of the different workplaces surveyed. Of the surveys distributed, 56.6% were sent to public hospital physiotherapists, 7.8% to private hospital physiotherapists, 8.6% to private practice physiotherapists, 22.8% to primary care

physiotherapists and 4.2% to workplaces classified as ‘other’. Correspondingly, of the respondents, 53.5% indicated working in a public hospital, 7.7% indicated working in a private hospital, 9.8% indicated working in a private practice, 22.2% indicated working in primary care and 6.7% indicated their workplace as ‘other’.

Another potential limitation when conducting surveys is misunderstanding of the wording of questions. With surveys, there is a risk of participants interpreting questions or terms differently. To mitigate for this the survey was piloted to ensure readability and clarity, and amended based on this feedback. Additionally, definitions of the terms in the questionnaire were provided on the front page of the survey. Despite this, some misunderstanding of the questions was evident in the last section of the survey. As described above, some respondents indicated that certain grades of physiotherapist demonstrate leadership in their experience despite not having indicated working with that grade of physiotherapist. There was also the potential for differences in interpretation of the grades clinical specialist and APP.

This survey was conducted with a purposive sample of physiotherapists and while physiotherapists working in different areas were represented the results may not be generalisable to the wider physiotherapy population in Ireland.

8.5. Conclusion

Physiotherapy management were rated as most effective on leadership capabilities associated with the structural frame and least effective on the symbolic frame which reflected the results of the previous studies. However, the respondents rated leadership capabilities associated with the symbolic frame as most important and capabilities associated with the structural frame as least important. Ratings of importance were significantly higher than ratings of effectiveness on all four frames and the largest difference between ratings of importance and ratings of effectiveness was found on the symbolic frame. While the respondents rate leadership capabilities associated with the symbolic frame as most important this is the frame that they perceive physiotherapy management to be least effective at demonstrating. Physiotherapy managers and clinical specialists/APPs may benefit from training to improve their awareness of and ability to demonstrate symbolic frame leadership capabilities. Investigation of the grades of physiotherapist perceived to demonstrate leadership found that a very high percentage of respondents perceived senior physiotherapists, physiotherapy clinical specialists,

APPs and physiotherapy managers to demonstrate leadership. The majority of respondents, however, also reported that staff grade physiotherapists and physiotherapy peers demonstrated leadership in their experience. The introduction of leadership development opportunities early in physiotherapists' careers may help to develop leadership capabilities among all physiotherapy grades.

9. Chapter 9 – Conclusion

The overall aim of this research was to explore perceptions of leadership capabilities among physiotherapists in Ireland and to identify the leadership challenges facing the physiotherapy profession. To this end, this PhD thesis included a scoping review of the leadership literature, surveys of physiotherapists and physiotherapy managers, and interviews with two cohorts of physiotherapists in leadership roles, physiotherapy managers and physiotherapy clinical specialists/APPs. This research was structured on the Warwick 6 C Leadership Framework (Hartley and Benington, 2010). The framework is composed of the concept, context, characteristics, capabilities, challenges and consequences of leadership. The concept of leadership used and the context within which this research is situated were described in the early sections of this report. Leadership characteristics and capabilities and the challenges facing physiotherapy leaders were investigated in the studies of this project. The consequences of leadership were beyond the scope of this PhD but it is anticipated that results from this research may aid the design of future studies that investigate this component. The main findings of this research are summarised and discussed below.

9.1. 9.1 Key findings of this PhD thesis

9.1.1. Recognition of the importance of leadership

The research was initiated with a scoping review of the literature on leadership in physiotherapy. This review demonstrated that leadership in physiotherapy is an under-researched phenomenon but interest and research in the field are growing. One of the themes from the literature review was 'Need for leadership' which discussed the importance of leadership and that it is needed in the physiotherapy profession. There was recognition in the literature of the importance of leadership to ensure excellence, advocate for the profession, meet healthcare challenges and facilitate change. Results from the studies in this research also reflected the importance placed on leadership. In Study I, one of the themes in the responses to the open comment box was leadership is important. The respondents recognised leadership as important both for individual physiotherapists and for the profession of physiotherapy. Leadership was perceived to be a key competence in physiotherapy and essential for future development. Also in Study I, 53% of respondents rated attainment of a leadership position to be very

important or extremely important to their overall sense of career success. This suggests that for many physiotherapists leadership is perceived to be important at a personal level. The high ratings of importance of the leadership capabilities in Study IV also demonstrated the importance that clinical physiotherapists place on physiotherapy management being able to demonstrate these capabilities.

9.1.2. Importance of leadership capabilities

Perceptions of leadership capabilities were investigated in all four studies in this thesis. In Study I, communication and professionalism were the most highly rated leadership capabilities in the workplace, the health care system and society. The importance of communication to effective leadership was also recognised in the other studies. The physiotherapy managers and clinical specialists/APPs in Studies II and III discussed communication strategies and recognised the importance of effective communication in their roles. Similarly, in Study IV the second most highly rated leadership capability was 'Listen to ideas, suggestions and opinions of team-members'. The importance of professionalism to leadership was also recognised in other studies. Professionalism was defined as 'align[ing] personal and organisational conduct with ethical and professional standards' in Study I. The managers in Study II emphasised the importance of policy and procedure in their workplace and the clinical specialists/APPs discussed developing and using clinical guidelines to ensure best practice and quality care in their service.

The clinical physiotherapists in Study IV recognised the importance of leadership capabilities from all four frames. There was no significant difference between ratings of importance of symbolic, human resource and political frame leadership capabilities or between human resource, political and structural frames. Additionally, there was a leadership capability from each of the four frames in the top five most highly rated leadership capabilities. A significant difference, however, was found between ratings of importance of symbolic frame capabilities and structural frame capabilities. The symbolic frame capabilities were rated as the most important and least importance was placed on the structural frame capabilities. Similarly, two symbolic frame capabilities, 'Foster a positive workplace culture' and 'Demonstrate awareness of the atmosphere of the work environment', were very highly rated as important by the participants.

9.1.3. Effectiveness at demonstrating leadership capabilities

In Study II, physiotherapy managers were found to predominantly use the structural and human resource frames. The Leadership Orientations Survey (LOI) demonstrated that the physiotherapy managers used the human resource frame most often followed by the structural frame. The political frame was least often used. The interviews with the physiotherapy managers provided more detail on the leadership capabilities of physiotherapy managers. Analysis of these interviews confirmed the survey results; the managers predominantly used human resource and structural frame capabilities. Symbolic frame capabilities were underused by the physiotherapy managers and there was variation in demonstrating political frame capabilities. There were similar findings in the interviews with the clinical specialists/APPs in Study III. The clinical specialists/APPs placed less emphasis on some aspects of the structural frame because of differences in their role to that of the physiotherapy managers. They also placed more emphasis on their teaching role and leading by example. Overall, however, the clinical specialists/APPs were also found to predominantly employ human resource capabilities and to underuse the political and symbolic frame capabilities.

Clinical physiotherapists' ratings of the effectiveness of physiotherapy management at demonstrating leadership capabilities demonstrated both similarities and differences to the results in Studies II and III. The clinical physiotherapists rated physiotherapy management as most effective on the structural and political frames and least effective on the symbolic frame. The high ratings of effectiveness on structural frame capabilities were in keeping with the results of the interviews with the managers and clinical specialists/APPs. The capability that physiotherapy management were rated as most effective at demonstrating was, 'Ensure adherence to policy and procedure and clinical guidelines'. This capability is similar to the professionalism capability that was highly rated as important by physiotherapists in Study I. Differences were noted, however, between the ratings of effectiveness on human resource and political frame capabilities and the perceptions of the managers and clinical specialists/APPs. While the managers and clinical specialists/APPs were found to report prevalent use of human resource frame capabilities and varied use of political frame capabilities, the clinical physiotherapists in Study IV rated physiotherapy management as more effective on political frame capabilities than human resource capabilities. These results suggest that the clinical physiotherapists perceive physiotherapy management to be more effective at demonstrating political frame capabilities than the physiotherapy managers and clinical specialists/APPs perceive themselves to be. However, the results also suggest that the

physiotherapy managers and clinical specialists/APPs may not be as effective as human resource capabilities as they perceive themselves to be.

9.1.4. Leadership as a role in physiotherapy

As well as investigating leadership capabilities and challenges, this research also aimed to investigate different leadership characteristics. The characteristics component of the Warwick 6C Leadership framework recognises that there are different types of leadership rather than assuming there is a generic form of leadership (Hartley and Benington, 2010). The physiotherapy managers in study II demonstrated formal leadership and some worked clinically while others were solely in a managerial position. The clinical specialists/APPs in study III demonstrated informal leadership and all had clinical roles. The results of Studies II and III demonstrated that the leadership capabilities demonstrated by the managers and clinical specialists/APPs were similar. This result echoed that of Desveaux et al. (2016) who found similar leadership strengths profiles between two cohorts of physiotherapists in leadership roles, academics and managers.

There were some differences noted, however, between the leadership capabilities of managers and clinical specialists/APPs in Studies II and III. In the structural theme, the clinical specialists/APPs placed less emphasis on co-ordinating the service, planning and people management. In contrast, waiting list management and developing new policies and protocols were more prevalent subthemes for the clinical specialists/APPs than the managers. In the human resource theme, there was more focus on teaching among the clinical specialists/APPs and on their own continual learning. For the clinical specialists/APPs, promoting the profession and research involvement were prevalent subthemes in the political theme, whereas there was less discussion of looking for opportunities than there had been for the physiotherapy managers. Also within the political theme, influence, autonomy and power were not as prevalent in the clinical specialist/APP interviews as they had been in the managers' interviews. And lastly, in the symbolic theme, leading by example and demonstrating passion were more prevalent subthemes for the clinical specialists/APPs than for the physiotherapy managers.

Leadership roles was also a theme in the literature review. Recognised leadership roles in the physiotherapy literature included clinical leadership, academic leadership, and formal and informal leadership. A high percentage of the respondents (74%) in Study I

perceived themselves to be a leader. This result suggests that the respondents recognise that you can be a leader without being in a named leadership role. Similarly, in Study IV, while higher percentages of respondents indicated that senior physiotherapists, physiotherapy managers, clinical specialists and APPs demonstrate leadership in their experience, the majority of respondents (62%) indicated that staff grade physiotherapists demonstrate leadership. In a study that compared the leadership strengths of physiotherapy leaders and non-leaders, Chan et al. (2015) found that there was substantial overlap between the leadership profiles of leaders and non-leaders. The authors suggested that this finding may be explained by the fact that because the physiotherapy role is a professional role in itself, physiotherapists are likely to display leadership strengths irrespective of position.

9.1.5. Leadership development training

The literature review found that there was recognition of the need for leadership development programmes but that there was little literature exploring the leadership development of physiotherapists. The review found that leadership training opportunities were being offered by physiotherapy professional organisations internationally but that the ISCP does not currently provide leadership training courses for its members in Ireland. In Study I, 24.7% of respondents had completed formal leadership training and 32.8% had completed informal leadership training. A significant association was found between having participated in leadership training and self-perception as a leader, and between having participated in leadership training and the importance placed on attaining a leadership position. The 'Education' theme found in the analysis of the responses to the open comment box in Study I encompassed comments about wanting to complete leadership training, the need for physiotherapists to develop skills in this area and different ways of developing leadership skills.

Most of the physiotherapy managers in Study II and the majority of the clinical specialists/APPs in Study III reported that they had completed some leadership training. Despite this, the physiotherapy managers and clinical specialists/APPs were found to underuse the symbolic frame and to have some difficulties demonstrating the political frame. Additionally, in Study IV the clinical physiotherapists rated the importance of the leadership capabilities significantly more highly than they rated the effectiveness of physiotherapy management at demonstrating them. These findings suggest that the

managers and clinical specialists/APPs may benefit from more targeted and specific leadership development programmes.

The leadership development activity most frequently reported by respondents to survey I was mentoring. Mentoring was also suggested as a leadership development opportunity in the open comment responses. Many of the physiotherapy managers in Study II and clinical specialists/APPs in Study III reported that they had a mentor or had had one in the past. In a study investigating why occupational therapists chose the path of leadership, Heard (2014) found that a fostering a culture of mentorship was integral to identifying and supporting developing occupational therapy leaders. The authors recommended that a mentorship approach should be taken to support developing occupational leaders. This recommendation may also be relevant to the physiotherapy profession and mentoring should be considered as a strategy to aid physiotherapists to develop leadership capabilities.

9.1.6. Impact of context on perceptions of leadership capabilities

There were some differences noted in perceptions of the leadership capabilities between contexts and workplaces. Participants in Study I rated the importance of leadership capabilities more highly in the workplace than in society. Also in Study I, physiotherapists who work in private practice were found to rate business acumen as more important in the workplace and society than physiotherapists who do not work in private practice. There were also differences noted between private practice managers in Study II and mangers in other contexts. Private practice managers perceived there to be a difference between their leadership role and that of managers in hospitals. In the structural frame, the private practice physiotherapy managers placed less emphasis on reporting relationships, hierarchy, and planning, and in the political frame they did not speak about influence, networking, collaborating or being on committees. These differences may have been because these managers worked in smaller organisations and did not have to report to a higher-level manager. Hospital managers, in contrast, must contend with more complex hierarchies, larger structures, and more complicated systems.

Public hospital and primary care managers were cognisant of the priorities of their organisation or the HSE in setting goals for their department. There was also a perception that working in the HSE can be restrictive; limiting autonomy and placing restrictions on recruitment processes. Similarly, the clinical specialists/APPs in Study III

working in public hospitals or primary care discussed the control the HSE has over their services.

Both physiotherapy managers and clinical specialists/APPs noted that there are differences in working in primary care than other settings. Primary care managers reported that holding people accountable for their work was more difficult in the primary care setting because of the domiciliary aspect of the work and the geographical spread of their team. The primary managers were also particularly affected by the challenge of changing structure.

9.1.7. Challenges facing the physiotherapy profession

The challenges facing physiotherapy leaders and the physiotherapy profession were an important theme in the interviews with the physiotherapy managers and the clinical specialists/APPs. Challenges identified in the interviews of both cohorts of physiotherapy leaders were time constraints, lack of resources, other professions and changing structure. Two additional subthemes were found in the interviews with the clinical specialists/APPs, ordering imaging and career structure. The physiotherapy career structure was also identified as a barrier to leadership in the analysis of the responses to the open comment box in Study I. The range of challenges identified further highlights the need for physiotherapy leaders to demonstrate a range of leadership capabilities so that they can adopt a comprehensive and effective approach when addressing these challenges.

9.2. Critical analysis of this work

The limitations of the studies in this thesis have been discussed in each of the chapters. These limitations include the response rates to the surveys and risk of a non-response bias, the risk of self-selection bias in that physiotherapists with an interest in leadership may have been more likely to volunteer to participate in the research, and the risk of social desirability bias where positive associations of being a leader or effectively demonstrating leadership may have influenced the results. In the first three studies, the participants' responses to whether they were a leader, the leadership capabilities they demonstrate and their effectiveness as a manager and leader were based on their self-perceptions, and thus the studies are subject to the accuracy and reliability of those self-perceptions. The limitations of self-ratings of leadership have been noted in the literature

(Atwater and Yammarino, 1992). The fourth study was added to this PhD thesis to explore the leadership capabilities of physiotherapy management from the perspective of their physiotherapy colleagues. This allowed cross-checking of the results as it enabled comparison of the physiotherapy managers' and clinical specialists'/APPs' perceptions of their leadership capabilities with the perceptions of the clinical physiotherapists with whom they work. To get a more comprehensive evaluation of the leadership capabilities of physiotherapy leaders, it may be beneficial to investigate the perceptions of other individuals that they work with, e.g. their superiors, other healthcare managers and medical consultants. It may also be useful to explore in more detail the perceptions of clinical physiotherapists of the leadership capabilities of physiotherapy management by using qualitative research methods. This would allow the clinical physiotherapists to expand upon the leadership capabilities they most value and to discuss the effectiveness of physiotherapy management in their workplace at demonstrating these leadership capabilities.

This research project was also limited in that it did not evaluate the consequences of leadership. Martin and Learmonth (2012) advocated the importance of investigating what leadership *does* instead of just focusing on what leadership *is*. As discussed in Section 3.4.1, the effects of leadership capabilities, or impact of leadership development training, on delivery of care, team-members, other healthcare professionals, or patients were beyond the scope of this thesis. These would be, however, important considerations for future research in this area.

The survey used in the final study of this thesis was developed by the PhD researcher. It was designed based on the results of Studies II and III and thus served the purposes of this research project in that it was used to check and triangulate the findings of these earlier studies. Future studies investigating the perceptions of clinical physiotherapists of leaders in their workplace may benefit from using a widely-used, validated measure of leadership. This would allow comparison with other healthcare professions.

9.3. Implications for the physiotherapy profession

The results of this research demonstrate that clinical physiotherapists recognise the importance of leadership capabilities from all four frames of Bolman and Deal's framework. They place most importance on symbolic frame capabilities, however, they perceive physiotherapy management in their workplace to be least effective at

demonstrating these capabilities. There was a significant difference between the clinical physiotherapists' ratings of the importance of leadership capabilities and their ratings of the effectiveness of physiotherapy management at demonstrating them. The largest difference between ratings of importance and ratings of effectiveness was found for the symbolic frame leadership capabilities. Analysis of interviews with physiotherapy managers and clinical specialists/APPs also found that the symbolic frame was underused. This discrepancy between the frames most effectively used by the physiotherapy leaders and the frame most valued by clinical physiotherapists needs to be addressed. Physiotherapy leaders need to adapt and develop their leadership capabilities so that they are more aligned to those that their team perceive to be important. By recognising and responding to expectations of their team the physiotherapy leaders will be better able to demonstrate leadership that will engage, motivate and inspire their team.

The shortfalls in leadership capabilities identified by this research highlight the need for appropriate leadership development programmes. These programmes will need to develop leadership capabilities from all four frames but particularly improve awareness of, and ability to demonstrate, symbolic frame leadership capabilities. Physiotherapy managers and clinical specialists/APPs should use rituals, ceremonies and team bonding activities to create a positive workplace culture. Leadership development programmes should convey the importance of these seemingly simple activities and the effect that they can have on the culture of their workplace. Organisational culture has repeatedly been identified as central to the effectiveness of health care organisations (West et al., 2014) and so physiotherapy leaders must understand their role in the development and maintenance of their organisation's culture.

In a review of leadership development programmes for physicians, Frich et al. (2015) found that programmes that take a multi-modal approach, incorporating different activities, can be effective at a systems level (i.e. they have an effect not only on the individual but also impact organisational outcomes). Therefore, leadership development programmes for physiotherapy leaders should include a range of components, such as seminars, group projects, reflective assignments, simulated role-playing and action learning sets.

Another symbolic frame construct, the leadership vision, should also be addressed in leadership development programmes. Physiotherapy leaders need to communicate their vision for the future to inspire their team. According to Bass' Model of Transformational

Leadership (1985), an inspiring vision of the team's mission and values encourages team members to invest and engage in the shared vision and work with a strong sense of purpose. In keeping with the collective leadership approach advocated in health care today (West et al., 2014), physiotherapy leaders should involve team members in the development of the vision. The shortfall between the physiotherapy leaders' reported human resource capabilities and the clinical physiotherapists' ratings of the effectiveness of physiotherapy management at demonstrating human resource capabilities suggests that physiotherapy leaders need to do more to include their teams in the development and implementation of a shared vision. Involving the team in the development and implementation of the vision will help to ensure their ownership and engagement with it (Warwick, 2011; Nielsen and Daniels, 2012).

Another important consideration in the design of leadership development programmes will be the context within which participants will aim to demonstrate leadership. Just as Bolman and Deal's framework acknowledges that a particular frame may be more applicable than others for addressing a specific situation or challenge, translational leadership is a leadership style that is context driven and allows leaders to fine-tune their approach to match demands as appropriate Translational leadership is a term adopted and modified from the medical field. Translational medicine is concerned with the translation of medical research to practice, linking the laboratory to the bedside and focusing on the development and application of new technologies in a patient-centred environment (Fusarelli et al., 2010). Similarly, translational leadership focuses on customising leadership to the contextual realities and localised culture of organisations. Translational leadership does not suggest any specific leadership approach as superior, but instead advocates the development of context-specific leadership that emerges from an understanding of the unique needs and contexts of an organisation (Fusarelli et al., 2010). Therefore, an important aspect of the leadership development programme will be for participants to perform a comprehensive assessment and evaluation of their workplace so that they can plan, design and implement appropriate change strategies to address their specific challenges.

As well as developing specific leadership capabilities, the development of self-awareness and self-evaluation strategies should be central to leadership development programmes. In Study II Phase 1 (see section 5.3), almost 62% of the physiotherapy managers rated themselves as being in the top 40% of managers for leadership effectiveness. Additionally, the participants in Studies II and III described demonstrating human resource capabilities and taking this approach in their work, yet the clinical

physiotherapists did not highly rate physiotherapy management's effectiveness at demonstrating human resource frame capabilities. These findings demonstrate the need for leadership development programmes to include components that will improve participants' self-awarenessand ability to evaluate their behaviours and performance. Structured reflection on their experiences during action learning sets, self-development activities and 360º reviews which provide feedback from colleagues, may be suitable components to aid the development of self-awareness (Frich et al., 2015).

This research has also highlighted the importance of effective communication to leadership in physiotherapy. Physiotherapy leaders appreciate that communication is key to leadership and recognise the need to listen to others, be open to their ideas and opinions, and to receive and give feedback. Physiotherapists rated communication as the most important leadership capability in Study I and rated highly rated the capability, 'Listen to ideas, suggestions and opinions of team-members', in Study IV. The development of effective communication strategies is important for all physiotherapists; for as well as being central to leadership, effective communication is also essential in clinical practice (Reynolds, 2005, WCPT, 2011c, HPC, 2013).

The physiotherapy profession in Ireland is facing many challenges. Bolman and Deal (1991, 1992a, 2008) contend that leaders who can draw upon multiple frames, and thus have more options available, are more effective than those who adopt a narrow view when approaching and dealing with challenges. By adopting multiframe thinking and developing leadership capabilities associated with all four leadership frames physiotherapy leaders may be more flexible and effective in meeting these challenges. However, as well as training programmes to develop the leadership capabilities of physiotherapists, there may also be a need for changes at an organisational level. In a review identifying enablers and barriers to advanced nurse practitioners enacting leadership, Elliott et al. (2016) found that the majority of enablers and barriers were found at organisational level rather than associated with building the leadership capabilities of individuals. Organisational level enablers and barriers included: networking opportunities, mentoring and support from senior management, opportunities to participate in organisational committees, defined position of accountability at organisational and strategic level, administration support and clinical caseload management. Elliott et al. (2016) advocated that for there to be any real progress there needs to be changes made at an organisational level to build leadership capacity, as well as at an individual level to develop leadership capability. This is an important

consideration for the physiotherapy profession if it is to enable physiotherapists to demonstrate leadership and address the challenges identified.

9.4. Future research

The results presented in this research demonstrate the potential for further research in this area. As noted above, further exploration of clinical physiotherapists' perceptions of the leadership capabilities of physiotherapy management using qualitative methods is warranted. Additionally, further triangulation of the data through investigating the perceptions of other individuals who work with physiotherapy management would also be beneficial.

The results of this research indicate the need for leadership training programmes to develop leadership capabilities, and particularly symbolic frame leadership capabilities, in physiotherapy leaders. There has been very little research investigating leadership development programmes in physiotherapy, however, studies investigating physiotherapy students' participation in experiential learning opportunities found that these learning experiences developed participants' leadership capabilities (Wilson and Collins, 2006, Black et al., 2013). Similarly, Thornton (2016) reported that current thinking suggests that leadership development is more effective where there are opportunities to learn from experience, collaborative activities to facilitate collective sense-making and structured reflection to promote self-awareness. An action research study investigating the impact of a leadership development programme could provide useful information to guide the development of leadership development programmes for physiotherapists. This study should objectively measure the leadership capabilities of the participants before and after the development programme. The perspectives of key stakeholders (e.g. physiotherapy team members, other healthcare professionals, patients) should also be explored before and after the programme to provide further information about any effects of the course.

This research has investigated the leadership capabilities of two cohorts of physiotherapists in leadership roles. There are other physiotherapists who could be considered leaders in the profession, including senior physiotherapists, physiotherapists in academic roles, physiotherapists who hold positions in professional organisations, and physiotherapists who have progressed to roles beyond the level of physiotherapy manager. The leadership capabilities of these cohorts of physiotherapists also warrant

investigation. Additionally, with growing recognition of the need for all physiotherapists to demonstrate leadership (Wylie and Gallagher, 2009, Desveaux and Verrier, 2014, Thornton, 2016), the leadership capabilities of physiotherapy students and physiotherapists who do not have official leadership roles should also be investigated. This may help to identify the learning needs of physiotherapists early in their career and guide the development of leadership programmes aimed at physiotherapy students and physiotherapy graduates. As well as exploring the leadership capabilities of other cohorts of physiotherapists, future research should also investigate the challenges that other cohorts of physiotherapists perceive the physiotherapy profession and themselves to be facing. Physiotherapists working in other roles may be aware of different challenges to those reported by physiotherapy managers and clinical specialists/APPs. Exploring the perceived challenges of these physiotherapists may provide further information to aid the development of appropriate leadership development programmes for physiotherapists.

9.5. Conclusion

In summary, this exploratory research has investigated physiotherapists' perceptions of leadership capabilities and leadership challenges. There is growing recognition of the importance of leadership to the physiotherapy profession and acknowledgement that physiotherapists in a range of roles can demonstrate leadership. This research has highlighted important shortfalls in the leadership capabilities of two cohorts of physiotherapy leaders in Ireland, physiotherapy managers and physiotherapy clinical specialists/APPs. There is a disconnect between the leadership frames most commonly employed by physiotherapy leaders and the frame that is most highly valued by clinical physiotherapists. While the physiotherapy leaders were found to predominantly demonstrate human resource and structural frame leadership capabilities, leadership capabilities associated with the symbolic frame are perceived to be the most important by their clinical colleagues. This discrepancy needs to be addressed to ensure that physiotherapy leaders demonstrate appropriate and effective leadership in their roles. To most effectively engage, motivate and lead their team, physiotherapy leaders need to demonstrate the leadership capabilities that their team members perceive to be important. Physiotherapy leaders may benefit from specific leadership development training to develop a comprehensive range of leadership capabilities, and symbolic frame leadership capabilities in particular. Further research to guide the development of effective leadership development programmes for physiotherapists is indicated.

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