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“Nursing by the Long Stretch of the Arm”: an exploration of community nursing middle managers’ experiences of role enactment within Community Health Partnerships in three regions of Scotland.

A thesis submitted in partial fulfilment of the requirements of

Robert Gordon University for the degree of Doctor of Philosophy

Elaine Allan

December 2014

To open my thesis I searched for a meaningful quote from a person I could relate to. Instead it found me via the gift of a beautiful Victorian postcard.

“Where There’s A Will There’s A Way”

“Should you see, afar off, that worth winning

Set on the journey with trust;

And ne’er heed if your path at the beginning

Should be among brambles or dust –

Though it is by footsteps ye do it,

And hardships may hinder and stay;

Walk with faith and be sure you’ll get through it;

For where there’s a will there’s a way”.

Eliza Cook (Miles 2011)

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Words cannot express how grateful I am to Robbie for being my rock, tolerating "the cuckoo in the nest" and giving me the space I needed to focus on my academic work.

This thesis is dedicated to the memory of my beloved Mum and Dad.

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ABBREVIATIONS, DEFINITIONS, ACRONYMS & GLOSSARY OF TERMS:

Abbreviations:

AfC	Agenda for Change
AHP	Allied Health Professional
CHN	Community Health Nurse
CHP	Community Health Partnership
CNMM	Community Nurse Middle Manager
GP	General Practitioner
HR	Human Resources
IPA	Interpretative Phenomenological Analysis
LHCC	Local Healthcare Co-operative
NHS	National Health Service
NMC	National Nursing and Midwifery Council
QNIS	Queen's Nursing Institute Scotland
RCN	Royal College of Nursing
RI	Reflexive interview
SE	Scottish Executive
SG	Scottish Government
SSSC	Scottish Social Services Council
ST	Superordinate Theme
TC	Theme Cluster
UK	United Kingdom
VAIC	Visible Accessible Integrated Care

Glossary: *Definition of key contextual terms:*

Primary Care*:* "Primary care" is normally the first point of contact with the NHS and refers to the services provided by health professionals in clinics, practices, service user's homes and communities e.g. schools. Primary care professionals are considered the "gatekeepers" to secondary and tertiary services. An estimated 90% of patient contact is handled at this level (Robson 2011).

Secondary Care: ***"***Secondary care" refers to hospital-based healthcare provision. "Annually, there are approximately 1.4m hospital episodes in Scotland and over 4.5m outpatients are seen at consultant clinics" (Robson 2011, P4). Staff employed within secondary care, are usually directly employed by the NHS (Robson 2011).

Abstract

Aim

This thesis aimed to explore community nursing middle manager role enactment in managing change within Community Health Partnerships (CHPs) in three regions of Scotland from 2008-2011.

Background

CHPs were established to play a key role in shifting care from the acute to the community setting. Within this context the community nursing workforce has been adapting roles in response to Scottish Government (SG) directives. However literature review demonstrated there has been very little research into the role of Community Nurse Middle Managers (CNMMs) in the midst of this change. This investigation sought to address this deficit in the literature.

Design and Methodology

The study was conducted in four distinct phases comprising of the reflexive, foundational, recursive and expansive. A total of 42 semi-structured interviews were conducted over the period of investigation. The investigation was qualitative and phenomenological in character. A hermeneutic approach was adopted, broadly based on Heideggerian philosophy. More specifically this study drew on the Interpretative Phenomenological Analysis (IPA) approach of Jonathan Smith (1996).

Main findings

In general CNMMs perceived that their jobs had become more complex, with the pace and intensity of work having increased. They held a wide range of responsibilities managing the challenges of driving change within a hierarchy and professional bureaucracy. Opportunities for education and learning were felt to have reduced. A small but significant proportion had left and some were considering leaving the NHS service. A primary motivation for CNMMs was maintaining an implicit connection with service users. They were proud to be members of the nursing profession and aligned their identity with their career history. This was perceived to influence their management and leadership style. In overcoming some of the personal challenges they faced they identified protective factors or “assets” to

counteract stress. The application of a salutogenic perspective emerged as important in supporting this.

Conclusion

The study has addressed a knowledge gap in literature. It contributes to understandings of NHS community nursing, middle management, role, change and Community Health Partnership literature. In particular it gives a voice to the perspectives of community nursing middle managers in Scotland. It suggests that much more attention needs to be paid to the needs, constitution and sustenance of middle managers in Scottish community nursing and that this has policy, practice, education and research implications.

Keywords

Community nursing; middle management; role; change; Community Health Partnerships; Scotland.

CHAPTER 1: INCEPTION OF THE THESIS – INTRODUCTION & BACKGROUND

1.1 Overview of chapter

This thesis considers the experiences and perceptions of Community Nursing Middle Managers (CNMMs) in enacting their role through change across three regions of Scotland. In this preliminary chapter an overview of the rationale for the research undertaken in the thesis will be presented. Before outlining the rationale in relation to relevant literature, it is important to make clear my personal and professional motivation for my choice of topic.

1.2 Personal and professional motivation for the research

This qualitative investigation arose from various strands of my professional nursing career in the community. My roles have included that of generic and specialist health visitor, development officer for early years in a social inclusion partnership, public health co-ordinator and more recently a nurse/mid-level service manager in a Community Health Partnership (CHP). Over recent years there has been a shift of care from the acute to the community setting which has gained pace since the advent of CHPs. Scottish Government (SG) priorities, targets, and activities aimed at reducing social exclusion are expected to be achieved by multi-agency professionals working in partnership (Scottish Executive 2007 a). As a consequence and in response, those responsible for community nursing practice and nurse management have been required to adapt to the above policy driven changes and accommodate re-structuring and redesign, within finite resources. In addition, new models of care to meet the needs of service users have resulted in the evolution of traditional community nursing roles adding to National Health Service (NHS) complexity (Scottish Executive 2006a). It is within these contexts that CNMMs are often tasked to oversee policy directives by translating government led policy into operational action. As a middle manager myself this stimulated my curiosity.

At the inception of my PhD studies in 2007, community nursing was in the midst of major planned reform driven from within the Scottish Government's Nursing Directorate. The main document steering the change was "Visible, Accessible and Integrated Care (VAIC), the Report of the Review of Nursing in the Community in Scotland" (Scottish Executive 2006a). The core of the document outlined proposals for the transformation of community nursing into a new service to be achieved by the amalgamation of health visitor, family health nurse, school nurse, and district nurse roles.

The idea of such a major redefining of nursing roles in practice added another element into the complexity of change described above about the experiences of CNMMs. In particular I was keen to find out more systematically about how they perceived their changing work world. This led me, during 2007, to seek out relevant published literature that might provide insight.

1.3 Initial search of the literature in 2007/2008

An in-depth exploration of the literature available at the commencement of the research in late 2007/early 2008 is presented in Chapter Two. My initial reconnaissance of relevant literature sources moved from the level of national policy to the level of regional management and practice. The main areas included: NHS policy and change in the United Kingdom (UK), and especially Scotland, as relevant to community nursing; Local Healthcare Co-operatives (LHCCs) and CHPs; and CNMMs experiences, principally in the UK with a focus on Scotland.

At that time a considerable amount of publications associated with policy and change influencing community nursing existed. For example, “Delivering for Health” outlined the strategies to take forward “Building a Health Service Fit for the Future” (Scottish Executive 2005) which presented the plan for the NHS in Scotland over the following 20 years. An action point from “Delivering for Health” (Scottish Executive 2005) was a proposed review of nursing in the community. This resulted in the publication of VAIC (Scottish Executive 2006a, Scottish Executive 2007 b) which proposed a national framework for service change in Scotland. Both documents are more fully outlined in Chapter Two.

Little literature was found that pertained to CHPs apart from public policy sources such as the white paper “Partnership for Care” (Scottish Executive 2003), which provided the background and impetus to the development of CHPs and the subsequent regulations outlining their legislative base in Scotland (SEHD 2007a). Indeed the “Better Health, Better Care” (SG 2007a) action plan put CHPs at the heart of the agenda in shifting the balance of care from the acute to the community setting. At this point in the published literature I could find no mention of the role of CNMMs in CHPs.

On the other hand a large corpus of literature about middle management outwith and within the NHS was found but it mainly concentrated on the acute sector e.g. Pappas et al (2004). Exceptions included the work of Traynor (1999) who examined the effect of new management strategies on nurses, their morale and the profession as a whole and McKenna et al (2004) who sought the views of community nurses,

General Practitioners (GPs), members of the public and policy makers on nursing leadership in primary care. Overall however, there was a dearth of literature that specifically focused on CNMMs and their work especially within CHPs in Scotland.

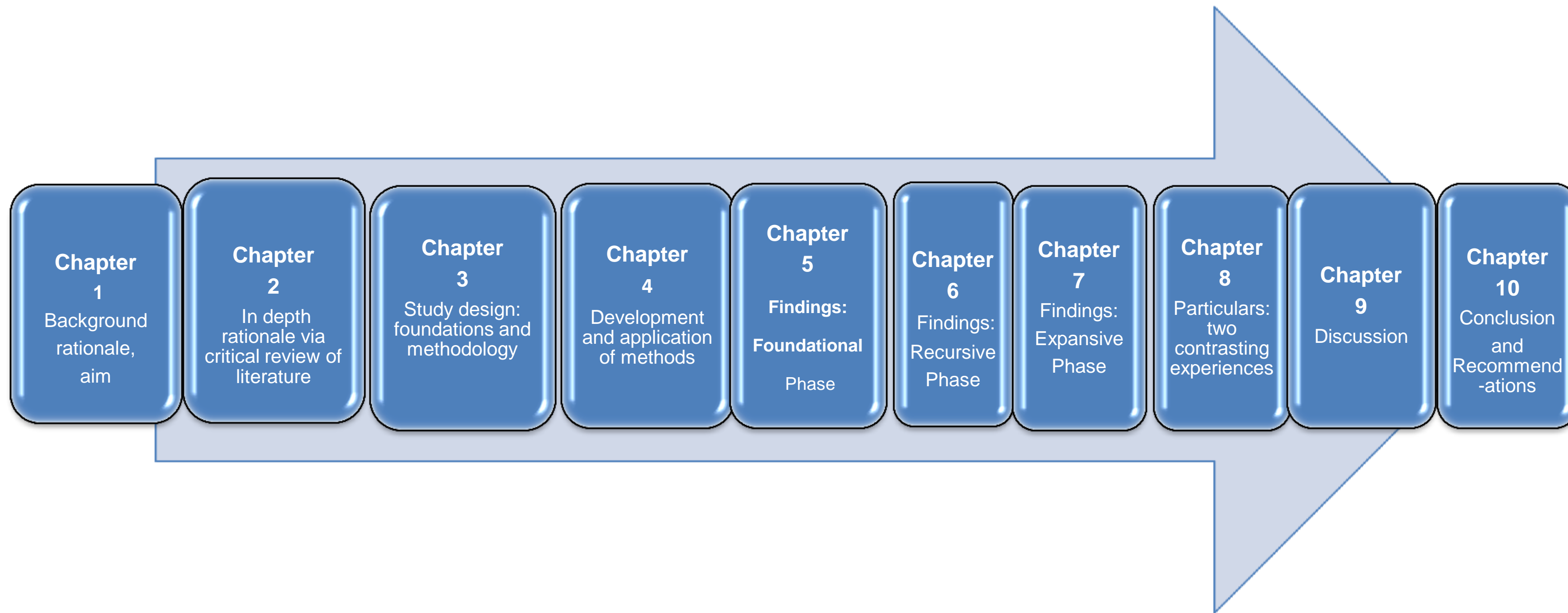
1.4 The research need and aim

Consequently there appeared to be a gap in knowledge and understanding of the experiences of CNMMs in contemporary Scottish healthcare. From subsequent discussions with colleagues active in relevant professional networks and local community nurse management there was a consensus of opinion that there was merit in exploring the literature gap further. Support for the study was gained from my NHS employers in terms of some time and funding. In addition the Queen's Nursing Institute Scotland assisted with doctoral fees. During the investigation I had the dual role of CHP CNMM and part-time PhD student. Both roles have influenced my research and work practice, and reflexive consideration of this is an integral part of the thesis.

The overall aim of the investigation was to redress this knowledge gap by exploring CNMMs experiences of role enactment through change. This concept was felt to be important in understanding how CNMMs interpreted and enacted their roles and used them to implement service change. This exploration sought to redress the gap by recording CNMMs perceptions of their work life and in doing so give them a voice that previously was hidden and seemed inaudible.

Figure 1 outlines the structure of the thesis (p.20).

Figure 1: Structure of thesis



1.5 The structure, main content and format of the thesis

Having introduced the background, rationale and general aim for the current research, the following section outlines the main content and format of the subsequent thesis chapters.

Chapter Two provides an in-depth rationale for the study through critically reviewing relevant and specific literature at the start of the exploration in 2007 and 2008. The literature review is structured using a framework which draws on the ideas of Pettigrew (1985a, 1988a), and Goes et al (2000) and Ferlie & Shortell (2001). It examines key contexts and concepts, moving from wider issues that frame the topic through to the focal issue of CNMMs role enactment in managing change. The literature review is congruent with hermeneutic methodology by providing context from the generic to the specific, and inviting the reader to share the thinking experiences of the author. The chapter concludes by identifying the main research questions for the study to be explored by the researcher. These are:

- What are CNMMs perceptions of their role within CHPs?
- What are CNMMs experiences and views of negotiating and managing change within CHPs?
- How do CNMMs understand the impact on themselves and others?
- What sense do they make of this?
- What does this mean in the context of wider understandings from the literature in Scotland and the UK?
- What implications are there for community nursing policy, practice, education and research?

Chapter Three explains the main ideas that underpin the design of the enquiry and justifies the choice of methodology employed during the research project. It begins by describing the challenges and advantages of my emic and etic position. My epistemological and ontological stand point and reflexive approach to the inquiry is then detailed. This is followed by outlining the rationale for the qualitative methodological design including the choice of phenomenological school. Explanation of Interpretative Phenomenological Analysis (IPA) and its design

principles follow including interviewing, sampling, and handling of the literature search. Finally justification for the expansion of the exploration during the course of the investigation is given followed by an overview of the study design and consideration of quality criteria.

Chapter Four provides detailed insight into how methods developed and were applied over the course of the inquiry through each phase. It commences with a description of the foundation and application of reflexivity, including the purpose and structure of the reflexive interview (RI). The feelings, findings and reflections the RI evoked are recorded, including outcomes of the RI and implications for conducting the preliminary interviews phase. The lessons learned from the preliminary processes are detailed and there is explanation of how these informed expansive interviews. The analysis processes are then detailed with specification of reading of the case and how initial appraisal and development of intra-case and inter-case themes were developed. Ethical considerations are then illustrated.

Chapter Five presents the findings from the foundational phase, opening with participant and CHP particulars across all phases. This provides some insight into the general characteristics of the CNMMs and CHPs involved in the study. The detail was collated across the foundational, recursive and expansive phases. The material includes overall role descriptors and the distribution of these across CHPs and regions over the three phases. Participant profile information is also included. The quotation system is then outlined with transcript quote codes presented. This is followed by an explanation of the foundational, recursive and expansive interview transcript codes, in turn. The foundational phase findings commence with graphically represented themes. A more detailed account of findings from interviews is then presented structured around the themes that emerged and using narrative extracts. (A similar structure flows through reporting of all phases i.e. in Chapters Six and Seven). The chapter finishes with a brief synthesis with initial referral to literature and conclusion section.

Chapter Six presents the findings from the recursive phase carried out two years following the foundational phase. It begins by outlining the recursive phase aim and objectives and provides insight into the characteristics of the CNMM population

studied over a timeline. The recursive phase findings commence with graphically represented themes. A more detailed account of findings from interviews is then presented, structured around the themes that emerged, using narrative extracts. It concludes with a brief synthesis of the findings informed by initial reference to the literature and conclusion section.

Chapter Seven presents the expansive phase which involved two Scottish regions and a further five CHPs broadening the study geographically. The expansive phase findings commence with graphically represented themes which are colour coded to aid overview of superordinate (ST) and theme cluster (TC) findings. A more detailed account of findings from interviews is then presented structured around the themes that emerged, using expansive participant narrative extracts. It concludes with synthesis of the findings informed by initial reference to the literature.

Moving from presentation of aggregated findings to more in depth acquaintance with particulars **Chapter Eight** presents two contrasting CNMM experiences. Two CNMM exemplars Mary and Laura are selected from different regions, CHPs and phases. Mary's experience from the foundational and recursive interviews is detailed. This is followed by Laura's life world experience from the expansive phase. Extensive narrative extracts from interviews detail these CNMMs experiences. Following discussion of each individual exemplar the chapter concludes with integrative analysis informed by initial reference to the literature.

Chapter Nine starts with reflection on the study's aims, research questions and parameters. It then critically examines literature published during the exploration, cohesively pulling together the strands of the empirical findings via different lenses. In-depth interpretation, analysis, and synthesis follow in order to bridge between the general understandings from healthcare literature, and empirical evidence from the thesis. Divergent CNMM experiences are highlighted, leading to consideration of the conditions within which the CNMM role can be best supported and empowered. In particular, the application of a salutogenic perspective emerges as important. The chapter finishes by highlighting a very recent study of middle managers in Scotland's social services which has much resonance with this study's findings.

Chapter Ten offers a conclusion from the findings, acknowledges the limitations of the research and suggests recommendations for NHS CHP organisations, SG, and NHS Education for Scotland.

The format of the thesis is mainly in words with extensive text from transcripts to represent participants' voices. Use of some diagrams, figures and tables compliment the manuscript wording to visually aid understanding for the reader.

CHAPTER 2: CRITICAL REVIEW OF RELEVANT LITERATURE

2.1. Overview of literature review in the thesis

During 2008 a formal foundational literature review was carried out in order to provide a basis for the enquiry in terms of coverage of the main relevant contexts and concepts. This chapter presents the structure, method and content of this review. Subsequent literature review was ongoing throughout the course of the thesis (2008-2014) drawing on a more hermeneutic approach as the study progressed (see section 2.3.2). The findings from the latter process are incorporated to some extent in subsequent chapters. A more formal overview of relevant contemporary literature between 2008 and 2013 is presented at the start of Chapter Nine as a basis for interpretation and discussion of the empirical findings. Literature on method is handled in the the methodology chapter.

2.2 Structure of the foundational review

Although research indicates that middle managers both experience change and have a critical role in facilitating it in healthcare, (Hill 2003, Iacono 2006, Ferguson and Day 2007) their own role is poorly understood (Hewison 2003 a, b). In this context it is important to start by trying to understand the environment in which this change takes place. The environment is not static and continually responds to the influences of UK and Scottish Governments which in turn affects healthcare structure and culture.

Change also takes place against a background of history, culture, politics and economics within and outwith the NHS. Change cannot be considered without acknowledging these contexts because change in itself is not an entity (Pettigrew 1987; 1990 a) but rather a process. Pettigrew (1985, 1988) also usefully distinguishes between outer contexts (e.g. societal, economic and macro political and business influences) that affect the NHS in particular (see Whipp et al1988) and inner contexts (e.g. structure, culture and politics) influencing change.

Within the scope of this thesis on CNMMs, the NHS itself forms part of the outer context, while the inner context is the world of the local healthcare team and the CNMMs themselves. Table 1 depicts the key contexts and concepts in the thesis, and the foundational literature review process is structured so as to move from the outer to the inner (i.e. more general to more specific). This structure also draws on Ferlie and Shortell's (2001) multi-level approach as outlined in Williams (2004). However Table 1 also depicts some key concepts in the thesis as cross cutting with relevance across all contexts, and these will be explained at the start of the foundational review.

Table 1: Key contexts and concepts that frame and focus the foundational literature review

<table>
<tr><th>Context (location)</th><th>Key contexts (structural)</th><th colspan="4">Key concepts (cross cutting)</th><th>Key concepts (focal)</th></tr>
<tr><td>Outer</td><td>UK healthcare structures and culture</td><td rowspan="5">CHANGE</td><td rowspan="5">MANAGEMENT</td><td rowspan="5">LEADERSHIP</td><td rowspan="5">ROLE</td><td>Primary care and community nursing</td></tr>
<tr><td>Outer</td><td>Scottish Government health and social care policy, and the NHS in Scotland</td><td>Primary care and community nursing</td></tr>
<tr><td>Outer /Inner</td><td>Health Boards, LHCCs and CHPs</td><td>Partnership working; community nursing management</td></tr>
<tr><td>Inner</td><td>Local healthcare teams</td><td>Team dynamics; role experiences, enactment and identity</td></tr>
<tr><td>Inner</td><td>CNMM role</td><td>Role enactment and identity; Experiences and perceptions</td></tr>
</table>

2.3 Literature search approach

2.3.1 Foundational literature searching

In conducting the literature review around the research topic, a variety of sources of information were drawn upon. Online academic databases were used to identify relevant journal papers and textbooks. Initially a wide search strategy was implemented for databases of journals, using the key concepts identified in Table 1 as the main search terms. These were selectively combined with the key contexts shown in Table 1 so as to make the search more specific and focal. In this way, for example, a search on “change management” was combined with the term “NHS”.

The main journal databases searched were: CINAHL, MEDLINE, OVID, SCIENCE DIRECT, EMERALD and BUSINESS SOURCE PREMIER. The main inclusion criteria used for this initial literature search were that the paper was published in English after 1990. The rationale was that by this time, following the Griffiths report of 1988, managerialism was being established in the NHS. Abstracts were read to assess relevance, and full text articles downloaded for papers of potential promise. Registration with several search engines produced email alerts which enabled access to lists of relevant literature topics published in my interest domain. Lists came with a hyperlink to the free full text when available e.g. Biomed library.

A broadly similar approach was taken to identifying books of relevance from library databases, but with more flexibility around publication date in order to capture older key texts. Often relevant books would include both theoretical and empirical perspectives.

The key concepts in Table 1 were also used to search for electronic theses and dissertations in institutional repositories (e.g. Open Air; RGU), national portals (e.g. Electronic Theses Online Service (ETHOS)), and international portals (e.g. Networked Digital Library of Electronic Theses and Dissertations (NDLTD)).

The SG and Department of Health websites provided access to relevant policy documentation, yielding NHS and wider health and social care material. Indeed, because of the multi-faceted nature of health and healthcare, review of the literature was not restricted to the NHS and included additional aspects of interest and relevance such as policy, sociology, psychology, and Human Resources (HR). Often these sources were identified through citations and followed up by seeking details through the world wide web e.g. through Google Scholar.

Finally those relevant to the subject of the study were searched for using portals and university institutional repositories. Several authors were contacted via email to gain agreement to access their work.

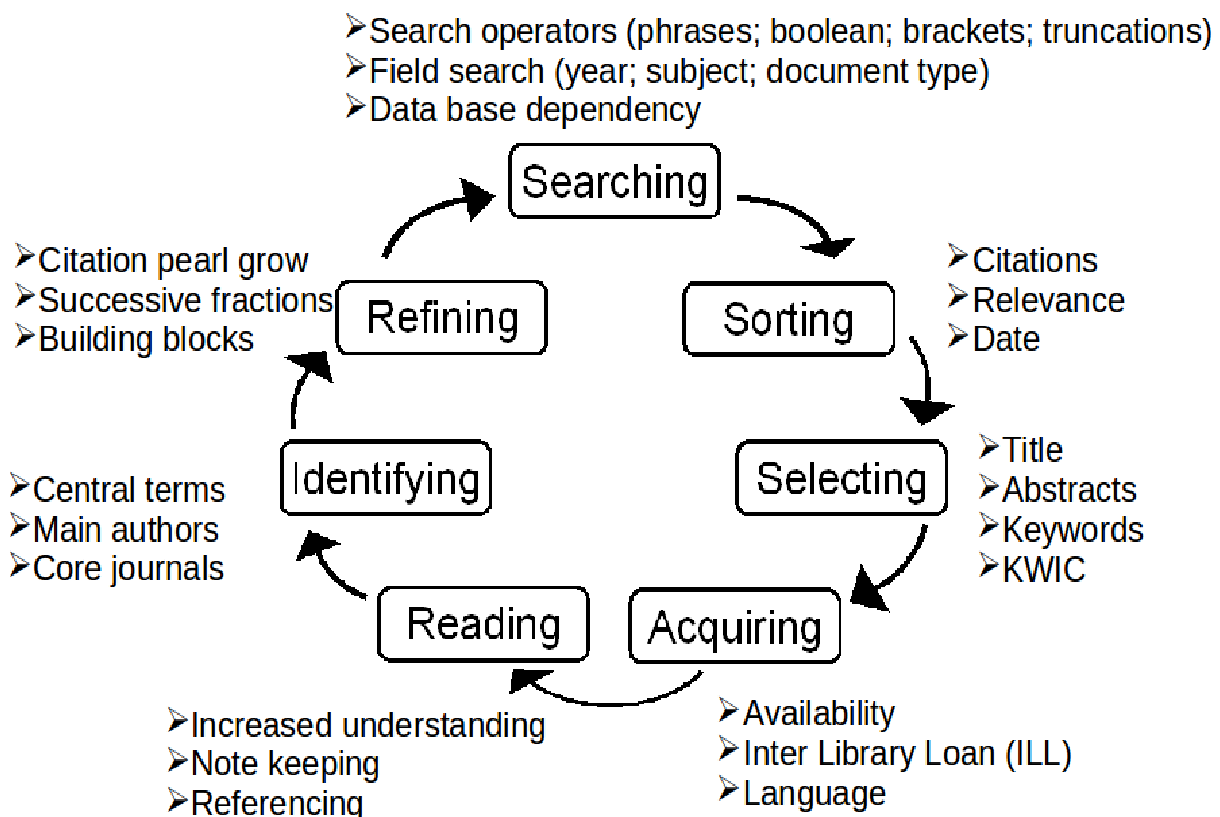
2.3.2 Ongoing literature search and review

The main literature search approach applied during the course of the whole thesis was broadly similar to that detailed previously. However, as the research progressed, the overall process of on-going search and review took on a more iterative character, in keeping with the hermeneutic approach used to guide the enquiry as a whole. The application of hermeneutic phenomenology to this exploration guides the review of the literature. According to Heidegger (1962) self-understanding and world understanding are inextricably linked and therefore influence every human experience to create interpretive understanding. Guided by this notion Sebastian et al (2010) argue that in reviewing literature the process of understanding is also open ended and circular in nature. It moves from the whole of all literature, to that which is relevant, moving to the particular and back again to the whole body of relevant literature to gain understanding through interpretation, which is considered the basis of hermeneutics.

My existing understandings came with me, drawing me towards particular research topics thus contributing to shaping the research questions. The understanding I accumulated guided my prioritisation of journals and authors so that the approach to the search was not totally random (Smythe and Spence 2012).

The process of the literature review for ongoing exploration therefore was to firstly recognise my existing knowledge, secondly to apply an iterative hermeneutic literature search framework which advocates targeted searches to identify pertinent documents and thirdly identify distinct but significant publications pertaining to the research questions. The aim of the review was to reach deeper understanding of the existing relevant general literature and also particular texts. Relevant texts were identified for meaning and for identification of further relevant literature. Using this approach enabled the successive encirclement/inclusion of relevant works. Because of my existing knowledge I was aware of relevant and reliable publications in "core" nursing and management journals and from that identified pertinent citations for follow up. Subsequent iterations of these steps were regularly repeated to gain increased understanding of the phenomena under study. Handling the literature in this way put an emphasis on gaining meaning before entering and leaving the hermeneutic circle to build on new knowledge (Heidegger 1962, Boell Cecez-kecmanovic 2010). Figure 2 draws from the work of Boell Cecez-kecmanovic, (2010) who illustrated the process.

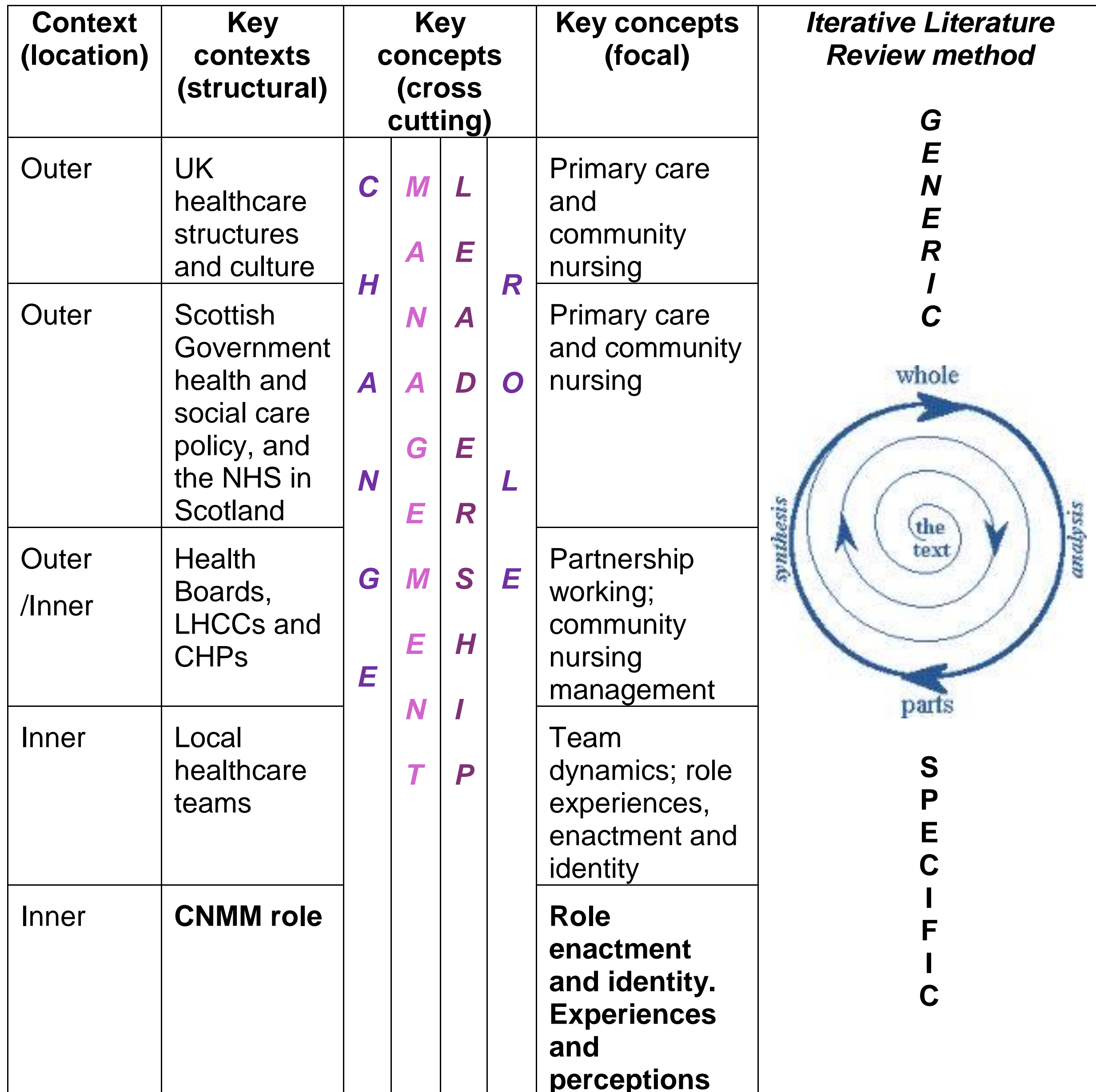
Figure 2: Iterative approach to ongoing literature review



As can be seen the detailed stages of the hermeneutic literature review technique are arranged in a circle with flowing arrows between each of them to represent the iterative process. Application of this technique was valuable in identifying and managing each specific stage of the circle which could be entered at any point. The outer detail indicates the anticipated outcomes from each stage of the process. This procedure facilitates continuous identification of relevant literature with new areas and related research fields identified.

This iterative approach was also suited to the longitudinal evolution of the study (Sebastian et al 2010). Table 2 integrates this method alongside the contexts and concepts.

Table 2: Application of iterative literature review method to key contexts and concepts that frame and focus the enquiry



Context (location)	Key contexts (structural)	Key concepts (cross cutting)	Key concepts (focal)	*Iterative Literature Review method*
Outer	UK healthcare structures and culture	*CHANGE* *MANAGEMENT* *LEADERSHIP* *ROLE*	Primary care and community nursing	***GENERIC***
Outer	Scottish Government health and social care policy, and the NHS in Scotland		Primary care and community nursing	whole / synthesis / the text / analysis / parts
Outer /Inner	Health Boards, LHCCs and CHPs		Partnership working; community nursing management	
Inner	Local healthcare teams		Team dynamics; role experiences, enactment and identity	**SPECIFIC**
Inner	**CNMM role**		**Role enactment and identity. Experiences and perceptions**	

2.4 Overview of key cross cutting concepts

Before presenting the review by structuring it around the specific key contexts and the main concepts identified in Tables 1 and 2, it is useful to provide a general introduction to the four concepts that cross cut the various parts of the thesis (and will be revisited as relevant within each of the specific contexts).

2.4.1 Change

Change means simply "to make or become different; alter" (English Collins Dictionary 2012), yet, paradoxically is a process that is perpetual at individual, group and organisational levels. Change at both operational and strategic level has been described as a key feature of organisational life (Burnes 2004) having been described as constant, (Iles and Sutherland 2001), continuous, (Hayes et al 2006) and pervasive (Grunberg et al 2008) in organisations such as the NHS. Change is constant in contemporary organisational life and is 'in the air that we breathe' (Amado and Ambrose 2001). Change is historical, contextual and processual; it is historical because it interconnects horizontally through past, present and future time, it is contextual because it interconnects vertically through different levels of society; and is processual because it interconnects process and action (Butler 2003, Melchor 2008). Bamford and Forrester (2003) distinguish between (i) planned change which is usually strategic and episodic aiming to transform the whole organisation (or a selected function, etc.), and (ii) emergent change which refers to unintentional actions and spontaneous changes that continuously happen as an organisation grows and develops. They assert that both commonly occur simultaneously.

Organisational change and redesign has meant that work and role enactment for staff have changed significantly over the past 25 years in particular in both private and public sectors, mainly due to the introduction of market systems and philosophies (Grunberg et al 2008). The multi-faceted dynamics that are involved in the change process have "human consequences" (The Office for Health Management 2003) evoking physical (Ferrie et al 1998), psychological (Bennet and Durkin 2000) and emotional responses for employees. Although these responses

may have positive aspects, the characteristic of uncertainty that change creates for staff, particularly when long standing and modernistic tasks are expected of them concurrently (Bennet and Durkin 2000), can be stressful and have an impact on staff commitment. In particular this can be the case when structural change affects organisational boundaries, distinct tasks, authorities and roles so that each of them becomes blurred (Borehinger 1999).

In the context of the NHS, management of organisational change is a highly desired managerial skill (Senior 2002). As outlined in Chapter One, my motivation for embarking on this enquiry stemmed from experience of the sort of change processes mentioned above, and curiosity about how other middle managers of community nurses in Scotland experience their roles.

2.4.2 Management

NHS organisations have become increasingly complex, maintained by complicated hierarchies. Multi-disciplinary teamwork underpins the delivery of services through networks and systems; therefore the NHS landscape is comprised of managers of various disciplines in specific areas at all levels of the organisation (The King's Fund 2011). Management involves the co-ordination and control of resources of different kinds in order to meet particular objectives (Huber 2010). To this end it may involve planning at strategic and/or operational levels. This thesis is concerned with the world of middle managers in particular. The middle manager is defined as "the coordinator between daily activities of the units and the strategic activities of the hierarchy" and the middle manager's role as "a link, a tie between top managers and operational workers" (Floyd and Wooldridge 1994 p.466). Middle managers have been referred to as the company engine (Freed and Dawson 2006), setting the pace for executing the strategic plan and focus on the organisation's priorities. Middle managers in particular have a critical role in interpreting and framing strategic objectives for front line staff (Balogun 2003, Huy 2002) because "as boundary spanners, middle managers mediate between the organisation, its customers and its suppliers" (Floyd and Wooldridge 1997 p.466).

This means that middle managers are integral to effective change management. Various studies have aimed to describe the roles middle managers play during the change process. Some authors suggest that middle management may have a negative impact in terms of resistance to change and slowing down decision making (Dopson and Neumann 1998). Others identify middle management in a more positive light as innovation implementers, key strategic actors and agents of change (Currie 2006), who are vital in contributing to organisational performance and change (Balogun and Johnston 2004, 2005; Currie and Proctor 2005). They suggest that middle managers sense making, through change occurs through lateral and informal processes, calling for more research to provide more understanding of the middle manager's role. In particular they highlight the neglect of research relating to the middle management role specifically around being both recipients and purveyors of change.

Again these considerations are very relevant to the overall goal of this enquiry being to explore CNMMs experiences of role enactment through change. One of the questions that quickly arises however, when considering middle managers and change, is the extent to which they are involved in influencing the direction and objectives inherent in the change process. This relates to the relationship between management and leadership.

2.4.3 Leadership

Leadership is key to the effectiveness of organisations (Yukl 1999). Several authors note the importance of leadership during change for example Luecke (2003) and Nadler and Tushman (1990). Mahoney (2001) describes effective leaders as having vision, strategies and plans with an intention to direct teams and services to a future goal. Literature on leadership in the private and public sectors is prolific. From this plethora it can be seen that a range of theories have evolved over time **(Table 3).**

Table 3: Timeline trends of leadership theories

Timeline trends of leadership theories	
Indication of the period and prominent theorists	**Prominent leadership theories**
1920s Carlyle, T. (1888)	The possession of innate traits to lead "Heroes"/"Great man theory"
1950s Ross, Murray G. and Charles E. Hendry (1957)	Demonstrating a style of behaviour that shows concern for task and people
1970s Stogdill *(*1974)	Demonstrating different styles depending on a range of contingent factors
1980/90s Kouzes, J., Posner, B. (1999)	Managing meaning to transforming organisations
2000s Alimo-Metcalfe, B. & Alban-Metcalfe, J. (2001)	Adapting to strategic challenges on a continuous basis with leadership dispersed throughout the organisation

Adapted from : Huczynski, A., and Buchanan, D., (2001).

The trends outlined in the table above indicate how the traditional concept of top down leadership has altered over time. Organisations have moved from ideas of more exclusive inherent personality traits such as "heroes" at the top to a more holistic approach throughout with the dispersal of leadership to others via an arrangement of roles including middle management (Hiller et al 2006). Therefore leadership would seem to be an important aspect of effective management although it is acknowledged that differentiating leadership and management can be difficult (Tappen et al 2004). Indeed an extensive study showed that the overlap between leadership and management is larger than previously believed (Jennings et al 2007 in Huber 2010). In addition, following examination of a range of public and private sector companies, the terms leader and manager were found to be used interchangeably (Alimo-Metcalfe 2001 in Williams 2004). In effect leadership can be a particular element in a management role, or management may be a particular element of a leadership role.

2.4.4 Role

The final cross-cutting concept that is useful to outline before going further is that of role. As the thesis focuses on CNMMs perceptions of role enactment through change it is important firstly to unpack the concept of role. In terms of role theory organisations are described as open systems made up of the "patterned activities of a number of individuals" (Katz and Kahn 1978 p.17). These activities contribute to how roles are enacted by individuals and include the perceived and expected responsibilities and obligations required of the job. Work roles are necessary in contributing to organisational effectiveness in the co-ordination and integration of employee behaviour (Hiller et al 2006). In addition role theory suggests that a role is the function or position that someone has or is expected to have in an organisation, in society, or in a relationship and involves interactions between individuals and organisations focusing on the roles they play. In a classic text, Goffman (1959) asserts that roles are fluid constructs that individuals can take on and off with relative ease. Role behaviour is influenced by role expectations and appropriate behaviour specific to that position, with changes in role behaviour occurring through an iterative process of role sending and role receiving (Thompson 2001). However, it should be noted that similar work roles may be interpreted and enacted in a variety of ways (Biddle 1979, Graen 1976).

As a concept role in particular is crucial to the understanding of the different components which constitute CNMM role enactment. This thesis is concerned with the aspects that make up role as outlined by Macduff (2007), i.e.:

- Role content (activities actually undertaken)
- Role form (professional domain(s))
- Role identity (and associated cultural meanings)
- Role set (the nature and scope of relations professionals and the associated expectations in regard to function, status and power)
- Role development (expansion or extension of content, form, and/or set as gauged by normative or ipsative criteria)

Studying these collective concepts of the CNMM role will be valuable in understanding their individual experiences and perceptions of managing change, how it impacts on them and others, and any related implications identified for community nursing practice, theory, education and research.

Having introduced key cross-cutting concepts that will recur across the thesis, the foundational literature review now focuses on explaining the key structural contexts and the related concepts that will later emerge as focal in the thesis.

2.5. Overview of key structural contexts and focal concepts

2.5.1 UK healthcare structures, culture and community nursing

Previous decades have seen many changes in the NHS including structures and cultures which have been politically driven. In 1997, the then UK Labour government pledged to abolish the “internal market” put in place by the previous Conservative government. By 2004 NHS Trusts had been abolished and CHPs created in Scotland. The Scottish Parliament in 2007 was a Labour/Liberal Democrat coalition which continued with this policy. The Kerr report (Delivering For Health, Scottish Executive 2005a) in particular was the main driving policy in Scotland at that time in “shifting the balance of care” closer to the community and away from acute services. “Primary care” was promoted as the first point of contact with the NHS and GPs, considered the “gatekeepers” to secondary and tertiary services. Primary care is provided by health professionals in clinics, practices, homes and schools with an estimated 90% of patient contact handled at this level (Robson 2011).

This shifting of the balance of care from the acute hospital (secondary care) to the community setting (primary care) is an international trend (Scottish Executive 2005, Scottish Government 2007 a, b) and a common policy aspiration across the four countries of the UK. However, the delivery of healthcare differs across the UK having been devolved in Scotland to the Scottish Parliament and through the Assemblies in Wales and Northern Ireland (Greer 2007). Each healthcare system is influenced by discrete political principles and the health needs of each country. Over the course of the study the SG supported a collaborative, integrated approach to healthcare delivery along with a commitment that “NHS Scotland remain firmly in the public sector – a public service delivered in partnership with the public” (Scottish Government 2007 p.3). Conversely the English healthcare system is increasingly driven by market forces and a commissioning process led by general practice consortia based on giving greater freedoms to the NHS. This has impacted on healthcare delivery in England with private companies being encouraged to compete to run healthcare services (The King’s Fund 2011).

Community nursing is characterised by the comprehensive span of duties they deliver in diverse situations within the UK and Scotland. These comprise service user homes, surgeries, schools, and small community hospitals. Community nurses deliver a range of health activities reflected by the populations served. For example, many community nurses in addition to being registered with the National Nursing and Midwifery Council (NMC) are in receipt of community specialist practitioner qualifications such as Health Visiting (under-5 age group and families), School Nursing (School-age children, young people and families, Public Health Nursing), District Nursing (mainly elderly people and those with complex care requirements) and Practice Nursing (all age groups). Community midwives also deliver care for women in the community from the antenatal period through to the post-natal period.

Community nursing is viewed as a well-established profession being the "cornerstone" of community care (Kennedy et al 2008), yet despite this assertion, it has been found to be politically marginalised (Mcintosh 2000). Community nursing has remained relatively under-researched compared to nursing work in acute care. This shortage of evidence contributes to the lack of understanding of: the processes and knowledge involved in community nursing assessment (Bryans & McIntosh 2000, Kennedy et al 2008, 2009); the role (Elliott et al 2012); effectiveness of practice; and how the discipline could inform both local and national decisions in terms of development and reform (Bryans 2004). This notion of lack of community nursing literature was further supported by Kennedy et al (2008) who were commissioned by the Scottish Executive (SE) to carry out a literature review. Notwithstanding an extensive search they concluded that adequately resourced research was necessary to strengthen the evidence base of community nursing.

Moreover the few studies in existence at the time of the foundational literature review relating to community nursing management and leadership in the UK concluded that it was neither very visible nor valued e.g. McKenna et al (2004). This may be partly due to the social culture and construction of community nursing and a management structure which has historically been affected by policy reform and which has radically affected present day nurse manager roles (Hewison 1999).

In 1974 nurse managers arguably equated with medical manager status. However the Griffiths report (1983) introduced general management and senior nurses became advisors which destabilised and weakened nursing hierarchy, authority, (Hewison 1999) and influence. This resulted in ambiguous and inconsistent community nurse titles, roles and responsibilities, and there was a greater focus on market forces in healthcare provision. The situation remained similar in 2014 in that whilst nurses are in general managed by nurses (although they may be managed by other disciplines), they are still advisors to and answerable to general managers who have overall responsibility in managing primary healthcare services via CHPs in Scotland (the evolution of CHPs is discussed 2.5.3).

The Cumberlege Report published in 1986 and influenced by market philosophy urged consideration of reforming community nursing by merging community nursing roles into one. Kelly and Symonds (2003) asserted that this rationalisation fuelled ideology and negatively impacted on the community nursing population. Since then developments have focused on community nurses substituting medical care (i.e. nurse practitioners) as opposed to focusing on and making explicit other community nursing roles. In spite of the push towards a more public health model of healthcare delivery by successive governments, district nursing, health visiting and school nursing roles arguably became somewhat eroded.

Literature relating to CNMM role enactment in the UK was found to be sparse, as was the case for the community nursing profession in general. However, using a two round Delphi technique with focus groups, postal questionnaires and semi-structured interviews, McKenna et al (2004) sought the views of community nurses, GPs, members of the public and senior policy makers on nursing leadership in primary care (60 in total). It was difficult to ascertain whether CNMMs as defined in this study were included in their sample. However their findings indicated that there was a need for strong leadership for the development of community nursing but there was confusion and disagreement over whether it existed. They concluded that the traditional subservient culture of community nursing was at fault for the perceived absence of nurturing strong leaders and recommendations were made for their development.

The development of community nursing has differed in England and Scotland. The English system favours privatisation whilst the Scottish system favours that of the health service remaining within the public sector. Community Matrons were introduced in England in 2005 to reduce unplanned hospital admissions of patients living with long-term conditions. However a literature review evaluating the role at a later date identified some confusion as to the difference between community matrons and case managers, and a lack of a shared vision across healthcare professionals concerning the community matrons care plan role and its goals (Lillyman et al 2009). Scotland took a different path embedding the delivery of community nursing healthcare firmly within the CHP structure and the philosophy of a multi-agency approach to improving health.

It is notable that despite NHS reforms resulting in a shift of the balance of care from the acute to the community setting and aligned responsibilities, the work community nurses carry out has been invisible and poorly understood (Hallett and Pateman 2000, Low and Hesketh 2002, Kennedy et al 2009). In addition, Dr Peter Carter, the Royal College of Nursing's (RCN) general secretary and chief executive suggests that whilst the acute sector is contracting the community sector is not expanding to "take up the slack". This is of concern as the community nursing workforce "will carry a major responsibility for delivering any change and growth in the Primary Care Sector" (RCN 2009 p.36.). This observation further supports the need to explore the subjects of this thesis.

2.5.2 Scottish Government health and social care policy, NHS Scotland and community nursing

The current organisation of the NHS in Scotland (Appendix 1) has become increasingly complex (McPhail 1997) in striving to meet service delivery demands. These include the demographic and social changes across populations with communities becoming more complex due to vulnerability, diversity, deprivation and social exclusion. In addition family compositions and dynamics have altered, as have lifestyles and care around mental health and learning disability (Scottish Executive 2006b, 2007a, 2007b, Scottish Government 2008b, World Health Organisation

2008). Moreover, there are rising numbers of children and adults in the community with complex needs (McIntosh and Runciman 2008) and complex chronic conditions due to the ageing population (Scottish Executive 2005, 2007 a). Furthermore, the cost of healthcare is increasing along with service user and government expectations of health services. Moreover new technology has been introduced to manage information (Scottish Executive 2006b). Current and future health service design in Scotland is and will continue to be complex.

However the Scottish position is one that is common in many other countries across the globe. It is important to note that, "not all of the factors driving change point in the same direction. However the implications are that 'more of the same' is not the solution, change is inevitable and planning for change is essential given the complexity of the drivers. New ways of working will be required, involving the whole healthcare system in the change process" (National Planning Team 2005).

This has influenced contemporary healthcare policy by stressing the importance of efficiency, effectiveness and accessibility (Scottish Government 2007). In an attempt to meet some of the challenges set by the changing context outlined above, models of service delivery have changed over recent years. Since devolution, the drive behind government policy in Scotland has been for public service to be delivered in partnership with the public, building on a "collaborative, integrated approach built on our traditional values" (Scottish Executive 2007 a, p.3).

Community nursing in Scotland was not immune to these pressures and changes. Indeed, at the beginning of the investigation Scotland was in the middle of a major review of community nursing which had commenced in 2006. The provision of high quality care was quoted as one of the drivers of SG NHS policies aimed to change how community nursing care was delivered (Scottish Government 2007a, 2008b). As already mentioned a key document at that time was The Kerr Report (2005) which outlined how the NHS in Scotland could deal with current and future challenges (e.g. Scotland's overall poor health, health inequalities, and ageing population) offering a new model of care. An action point from the document was that a review of community nursing should take place. In response to this, VAIC, the Report of the

Review of Nursing in the Community in Scotland, was published in 2006 (Scottish Executive).

The document outlined proposals for a new community nursing service amalgamating the health visitor, family health nurse, school nurse, and district nurse role. The new model was tested in four development sites over the following two years to allow an informed decision to be made about the future of the community nursing service. Key pieces of work in terms of literature review, evaluation, education, workforce and workload were commissioned and subsequently undertaken (e.g. Kennedy et al 2008).

This policy initiative and its early enactment drew mainly negative responses from the community nursing profession (Pollock 2007) over concerns of fragmentation. In response the RCN produced “A sustainable future: the RCN vision for community nursing in Scotland” (2009), following consultation with RCN members. An alternative vision was offered which contributed to influencing the SG to reconsider the way forward. Subsequently a new approach was adopted which focused on partnership working including relevant trade unions to influence the modernisation of community nursing. From this a National Community Nursing Board was established to modernise nursing in the community (Appendix 2). The new approach did not centre on the generic community nurse model.

Accordingly at the time this study commenced community nursing in Scotland was in a state of flux, with change very much in the air. The Community Health Nurse (CHN) development sites were based in CHPs within four of the 14 regional Health Boards in Scotland. As CHPs and their “parent” Health Boards were by this time the key organisational contexts for community nursing and its management in Scotland, it is important to look in some depth at how these evolved.

2.5.3 Health Boards, Local Healthcare Co-operatives and CHPs

CHPs are a committee of the Health Board which develops local community health services in partnership with their local authority partners. Collectively they aim to

ensure that health and social care services are integrated and seamless for service users (www.chp.scot.nhs.uk/index.php/about). The community nursing population are mainly employed by the NHS with some employed by GPs such as practice nurses. However all community nurses function and carry out their role within the current 36 CHPs (Robson 2011) across Scotland. There is a range of size and structures which vary from area to area to meet local need. Regional Health Boards are charged with implementing NHS policies and plan the delivery of local health services. The background and impetus to the development of CHPs in which CNMMs operate is contained in the white paper "Partnership for Care" (Scottish Executive 2003) and the NHS Reform (Scotland) Act 2004. CHP Regulations came into effect on 1st October 2004 forming their legislative base within the current organisation of the NHS in Scotland. The "Better Health Better Care" (Scottish Government 2007a) action plan put CHPs at the heart of the agenda in shifting the balance of care from the acute to the community setting.

The rationale and driver for this change has been successful financial performance (Scottish Government 2007a). In Scotland, the vast majority of healthcare is delivered by primary care through CHPs (Ball et al 2003). CHPs are guided by key interlinked SG frameworks and directives which identify priority areas including health improvement (Appendix 3). CHPs evolved from LHCCs. They were described as voluntary associations of primary healthcare and partner agencies (e.g. local authorities) that meet the needs of patients and local communities by considering and planning the delivery of health services in partnership (Ball et al 2003). Policies produced by successive governments in the late 1980s and 1990s **(Table 4)** and Hopton and Hill's (2001) positive evaluation of LHCCs supported the advancement of CHPs.

Table 4: Successive government policies

Successive government policies
A Fruitful Partnership: effective partnership working. London, Audit Commission. Audit Commission (1998)
Community Care: an Agenda/or Action. London: HMSO. Page V. Griffiths (1988)
Secretaries of State for Health, Social Security Wales, N. Ireland and Scotland (1989)
The National Health Service and Community Care Act. House of Commons (1990)
White Paper "Designed to Care" – Renewing the National Health Service in Scotland. (Scottish Executive 1999) The Scottish Office. Edinburgh
"Community Health Partnerships – Statutory Guidance" (Scottish Government 2004).

Reform strategies moved from one to multi-dimensional approaches (involving various public, private and voluntary sectors) to cope with complexity. Key thinking was that partnership and collaboration between integrated social care organisations would deliver improved healthcare outcomes. Since devolution in 1998, the SG has upheld this philosophy, basing the CHP role on the three policy areas of shifting the balance of care to local settings, reducing health inequalities and improving the health of local people concentrating on specific priority areas **(Table 5).**

Table 5: Specific CHP priority areas (SG 2007a)

Specific CHP priority areas
Better access to Primary Care Services
Taking a systematic approach to long term conditions
Anticipatory care
Supporting people at home
Preventing avoidable hospital admissions
More local diagnosis and treatment
Enabling discharge and rehabilitation
Improving specific health outcomes
Improving health and tackling inequalities

CHP Regulations came into effect on 1st October 2004 forming their legislative base within the current organisation of the NHS in Scotland**.** They became fully operational in April 2005 and were tasked to improve access, manage demand, reduce unnecessary referrals, reduce waiting times, and reduce health inequalities by working in partnership with other agencies and partners including service users. The guidance set out 12 key detailed outcomes defining the role and objectives of CHPs **(Table 6).**

Table 6: Role and objectives of CHPs (SG 2007a)

Role and objectives of CHPs
• Reduce waiting times for assessment, diagnosis, treatment and care in a systematic way across a range of services.
• Manage waiting times for inpatient and outpatient services more effectively by using their understanding of local demand to influence and adjust the supply of and/or the demand for services.
• Decrease the number of inappropriate hospital visits by improving the quality of referrals to consultants and increasing the skills of community practitioners.
• Reduce the number of people admitted to hospital in an emergency by improving the level and quality of chronic disease management, and increasing community based support.
• Reduce the numbers of delayed discharge from hospital by increased provision of rehabilitation services, rapid response teams and other similar interventions.
• Reduce the time taken to agree care packages by extending single shared assessments.
• Increase the quality of care by systemic implementation of more evidence based care and multi-disciplinary guidelines and protocols.
• Increase the number of single points of access for all community based services.
• Reduce inequalities in access to information by providing targeted and coherent health messages, aimed particularly at excluded and disadvantaged groups.
• Reduce the number of premature deaths by preventable diseases through local actions by key partners to improve health.
• Improve access to services by increasing the level of joint service provision and co-location of services.
• Implement jointly agreed care packages for young children.

The context outlined has created very substantial challenges for community health services in Scotland. Contributing factors have been higher expectations from both the public and politicians to improve public services, expansion of their overall geographical catchment areas, responsibility to provide local services, and increased

management responsibilities, due to the re-organisational shift from the acute to the community care setting. Consequently CHPs across Scotland became larger and more complex organisations. This is evidenced by the policy context that continued to evolve alongside the introduction of a plethora of key policies impacting on the role of CHPs in service planning and delivery.

Although there was a concentrated effort by the SG to deliver primary healthcare via CHPs and an expectation that community nursing would deliver these services, very little was known about their work world. However, there were a few extant studies generally relevant to community nursing in Scotland, e.g. Kennedy et al (2008), Macduff (2007) and studies on community nursing leadership and team working were being commissioned by the Queen's Nursing Institute Scotland (QNIS).

2.5.4 Local nursing teams in CHPs

For the purpose of the study the definition of team used is "a group of people with a mixture of skills who manage and maintain a common patient caseload and work effectively together" (Dawes and Handscomb 2005, p 11). Nurses who work in teams report increased and more cost effective use of specialist skills, more streamlined patient care and less duplication of services (Ross et al 2000). High performing boards and management teams have been shown to put patient experience and data at the heart of their work using individual complaints to highlight and fix system-wide weaknesses (Dawes and Handscomb 2005). However literature indicates that there is little in place to monitor team effectiveness in the NHS although they are increasingly measured against national set targets. Not only do community nurse teams mainly work in community settings where their work is invisible and unobserved (Hallett and Pateman 2000, McIntosh 2000), but this situation is exacerbated by four other factors. Firstly community nurse colleagues can be unaware of the working patterns of others within the team (Walshe and Gordon 2008), the second, third, and fourth factors are: the range of client groups community nurses provide services to; outcomes that can be difficult to quantify; and the lack of community nurse research.

Again at the time of the study's inception there were no completed research studies examining community nursing teams working within CHPs in Scotland.

2.5.5 Community Nurse Middle Managers (CNMMs)

Not surprisingly given the lack of research studies mentioned above, a dearth of knowledge about the experiences of the CNMMs within these CHPs was also evident.

Before going further it is useful to more closely define what is meant by CNMM.

CHP Community Nurse Middle Managers generally sit at Agenda for Change (AfC) Band 8 which is subdivided into 8 a-d (AfC is more fully explained in p,74).
CNMMs typically manage community nurses of various disciplines, e.g. district nurses, school nurses and health visitors who work together in teams. Some CNMMs have discipline-specific lead responsibilities or discipline roles. Several have responsibility for local areas whilst others have responsibility for a specific region. A few CNMMs manage professional disciplines other than nurses as part of their team; however this is the exception rather than the rule. All CNMMs collaborate with agencies outwith the NHS such as local councils and the voluntary sector. Working to a social model of care CNMMs contribute to the delivery of healthcare in partnership with multi-professional and multi-agency teams and disciplines.

In the absence of specific studies in Scotland it is useful to look more generally at the literature on healthcare middle managers in the UK, particularly those managing community nursing.

Although the healthcare setting has examined middle management, studies have mainly concentrated on the acute sector e.g. Pappas et al (2004). Linton and Farrell (2008) argue that healthcare organisations value the role of nurse managers and leaders. Hewison (2002) questioned this observation but his subsequent enquiry confirmed the existence and need for NHS middle manager function, supporting Wall's (1999) assertion that NHS organisations cannot do without them. In addition a

RCN publication (2009) reviewed the UK nursing labour market and highlighted that, due to the policy focus of shifting resource and care away from the acute to the primary care sector, development issues relating to this phenomenon have received insufficient attention. This has important implications for the management of change in community nursing and for middle managers in particular. Accordingly the CNMM role merits exposure and analysis. The literature reviewed demonstrated that whilst there has been interest in middle management per se, there has been little progress in the understanding of the CHP middle manager and CNMM role in particular.

Within large organisations it is often difficult to define where middle managers sit (Ainsworth et al 2009). In CHPs they link horizontally and vertically with NHS and partner agencies to collectively improve health. Middle managers often assume an enhanced role of change agent, by acting to produce directional change, and are critical to how change will be implemented and accepted within an organisation. Potentially they add value to organisations which has important implications for policy-makers (Balogun 2003). Middle management literature is somewhat polarised (Appendix 4). However, it would appear that they are the group who take orders from the high strategic level and translate them to the operational for staff who then implement the change.

The CNMM role, unlike some other middle managers in other sectors, typically has the added aspect of “duty of care”. The NMC states that nurses have a duty of care at all times and people must be able to trust nurses with their lives and health. Nurses are personally accountable for actions and omissions in their professional practice and must always be able to justify their decisions. They must always act lawfully, whether those laws relate to their professional practice or personal life.

Failure to comply with this Code of Conduct may bring nurses fitness to practise into question and endanger their registration. Many CNMMs have a clinical background with some having clinical duties. Causer and Exwothy (1999) in Hewison (2006) describe this status as “hybrid management”. Within the context of change Fitzgerald et al (2006) argue that this population holds an important and credible role in acting as a conduit between senior management and the community nursing profession as they understand the ethos, interests, and most importantly the language of both. This

can result in effective and knowledgeable leadership which is critical in delivering high-quality care, ensuring patient safety and facilitating positive staff development (Frankel 2008). High performing boards and management teams have been shown to put patient experience and data at the heart of their work using individual complaints to highlight and fix system-wide weaknesses (Dawes and Handscomb 2005).

However, nursing middle managers enact a semi-autonomous strategic role due to power differentials within organisations and government intervention, making managing change very difficult (Currie & Procter 2005). Linstead & Thomas (2002) focus on the lesser researched aspect of the benefits of fluid and flexible identities in fostering organisational adaptability. In the process they highlight “the neglect of ontology (as managers’ lived experience) and epistemology (in both academic and manager constructions of self-knowledge)” (Linstead & Thomas 2002 p.4). Again this thesis is concerned in addressing this gap.

Indeed, overall the literature review demonstrates a gap in literature. The investigation therefore can contribute to NHS change and management literature on three levels. First it introduces the CHP Community Nurse Middle Management perspective contributing to redressing the balance of NHS management literary work. Second, it explores a role not previously examined, to my knowledge. Third it adds to middle management literature in general and to CHP and CNMM literature in particular. In summary this review of the literature suggested that an in-depth exploration of CNMMs perceptions would be both necessary and novel.

2.6 Identification of research questions

Based on the gaps in the literature identified above, and following further consideration and discussion with my supervisory team, six research questions were formulated to guide the enquiry. These will be explicated in more depth in the subsequent chapter but comprise:

- What are CNMMs perceptions of their role within CHPs?
- What are CNMMs experiences and views of negotiating and managing change within CHPs?
- How do CNMMs understand the impact on themselves and others?
- What sense do they make of this?
- What does this mean in the context of wider understandings from the literature in Scotland and the UK
- What implications are there for community nursing policy, practice, education and research?

The next chapter of the thesis details the resultant design, methodology and methods that were adopted in order to address these questions.

CHAPTER 3: STUDY DESIGN: FOUNDATIONS AND METHODOLOGY

3.1 Overview of chapter

Chapter Three explains the main ideas that underpin the design of the enquiry in this thesis and justifies the choice of methodology employed during the research project.

This explorative study aimed to gain an understanding of the work world of CNMMs across three regions of Scotland. In order to explain how this was captured, Chapter Three begins by specifying the approach to the inquiry which is qualitative in nature. My underpinning epistemological and ontological stand point is then outlined and the challenges and advantages of conducting research in my place of employment are considered.

Explanation of the reflexive processes undertaken to determine the appropriate methodological approach to apply to the exploration follows (these are more fully detailed later in Chapter Four). The rationale for methodological design is then explained, including the choice of phenomenological school which is based on the interpretivist phenomenology of Heidegger and interpretative phenomenological analysis (IPA) in particular, the three pillars of which are phenomenology, hermeneutics and ideography (Smith et al 2009). To support the exploration of the problem studied, the design, its principles and practice are explained including handling of the literature search, interviewing and sampling to match the methodological approach.

Finally justification for the expansion of the exploration during the course of the investigation is given followed by an overview of the study design and consideration of quality criteria.

It is important at this point to highlight that the method was designed to achieve consistency and compatibility with my epistemological and ontological position which runs throughout the thesis.

3.2 Qualitative inquiry

As the research questions clearly indicate, the focus of this inquiry is on the understandings and meanings that individuals (CNMMs) attach to their social world, with particular reference to the concepts of role enactment in managing change within NHS CHPs. My supposition is that these are not objective phenomena with known properties or dimensions. Rather they are subjective making them un-measurable in the quantitative sense (Rowlands 2005). Qualitative research as a broad term can include a number of different approaches. However they share the same aim of understanding the social reality of individuals, groups and cultures by focusing on the way people interpret and make sense of their experiences and the world in which they live (Holloway 1997). This makes the phenomenon being explored more amenable to qualitative research.

At an early stage in thinking about the nature of the potential study, it was clear that it had the following characteristics:

- an unstructured issue (Checkland et al 2011) requiring exploration to present a detailed view of the topic
- an under-researched and neglected area of interest requiring a better understanding of the social processes involved (Cresswell et al 2007)
- a focus on participant's perspectives and their meaning (De Witt and Ploeg 2005)
- a view that the researcher would be the key instrument of data collection

All these aspects lend themselves to qualitative inquiry. However all of these also needed explored in more depth in order to make underlying assumptions as clear as possible.

3.3 Epistemology and ontology

My assumptions about the nature of knowledge (epistemology), and approach in studying the phenomenon (ontology) were considered. Taking as a starting point the idea that the world we live in is built and understood by people within the context of historical and social practices (Rowlands 2005), I recognised that as a researcher my frame of reference could influence the study methodology, design and interpretation of the results, a notion increasingly recognised in the literature. Hamill et al (2010) assert that being human beings, researchers will naturally bring preconceptions, personal experiences, beliefs and attitudes to the research they are conducting.

Moreover, I was mindful of the caveat that:

"there is no such thing as knowledge uncontaminated by any particular system of human purposes, beliefs, values and activities, the world and values … it is grounded in experiences and practices, in the efficacy of dialogue, negotiation and of action" (Howe and Berv, 2000 p.33).

Literature increasingly recognises that research is socially constructed (Koch & Harrington 1998). "The researcher as interpreter, (whilst recognising the potential pitfalls), does not totally disengage with their own subjectivity and in doing so builds on that knowledge to form new ideas" (Maggs-Rapport 2000 p.219).

Denzin (1989) argues that all research is about the researcher, however to be of worth it has to be a shift outside the researcher's circumstances. It was within this context that it became apparent that what may appear to be self-evident truths and individual taken for granted experiences to me would require to be constantly questioned throughout the study, and made transparent.

These reflections are consistent with interpretivism which rests primarily on the following principles:

- the researcher and the social world impact on each other
- facts and values are not distinct and findings are inevitability influenced by the researcher's perspective and values, thus making it impossible to conduct objective, value free research, although the researcher can declare and be transparent about his/her assumptions
- the methods of the natural sciences are not governed by law-like regularities but are mediated through meaning and human agency; consequently the social researcher is concerned to explore and understand the social world using both the participant's and researcher's understanding. (Ritchie and Lewis 2003 p.17)

3.4 The researcher’s position: the emic and etic

The principles outlined above highlighted a need to consider my position as researcher. I sought to conduct research *with* rather than *on* colleagues (Ellis 2007). Being an “insider” who is also employed in a CNMM role brings sensitivities and challenges, not least around trustworthiness and ethics. The term "emic" in qualitative research refers to a subjective or insider account rather than the “etic” outsider view (Akin & Palmer 2000). As an “insider” I had some knowledge about the area of enquiry through personal and professional experience. Accordingly, I sought methodology that acknowledges and embraces the “emic” or insider perspective. This had both advantages and disadvantages when undertaking the research. Several authors maintain that insiders undertake research more responsively and sensitively than outsiders. For example, Merriam et al (2001), advocate that it is easier for an insider to gain access and a more authentic understanding of a culture (in this case CNMMs) under study.

However there is a concurrent need for some distance in order to understand the particular world in a wider context. Therefore, it is acknowledged that a disadvantage can be that insufficient explanation or clarity may be sought by an insider researcher based on assumptions created by interviewer/interviewee shared experiences (Hammersley and Atkinson 1995). Stephenson and Greer (1981) refer to this tension as walking an 'interpersonal tightrope' with the researcher both an insider (peer) and outsider (researcher). Nevertheless Smythe and Spence (2012 p.13) assert that the researcher’s “present past and future are constitutively involved in the process of understanding”.

The advantages and disadvantages of the emic/etic position in interviewing peers were therefore considered in order to facilitate as balanced an approach as possible to these challenges. **(Table 7)**

Table 7: Advantages and disadvantages of interviewing peers

Adapted from McEvoy (2001)

Disadvantages	Advantages
Potential of being wary in asking probing questions (Platt 1981)	Generating new knowledge and insight into area of work (McEvoy 2001)
Potential for taking common experiences for granted and therefore may raise difficulties in questioning aspects of the social world that appear to be self-evident (Schuetz 1944)	The insider's unique perspective can contribute in providing a voice for the interview participants. (Hutchinson et al 1994)
Blurring of the distinction between overt and covert research (Grinyer 2001)	Shared experience may act as a catalyst that helps to deepen the enquiry as long as there is sensitivity to how colleagues may position themselves and is prepared to question self-evident truths. (McEvoy 2001)
Non-constraint of group membership may give greater freedom to ask dumb questions. (Horowitz 1986)	"Insiders and Outsiders in the domain of knowledge, unite. You have nothing to lose but your claims. You have a world of understanding to win" (Merton 1972 p.44)
Role conflict (Butler 2003)	Lessening of psychological consequences for participants or at least more easily identified and avoided. (Reed and Proctor 1995)
Maintaining control of the interview	Acquire rich descriptive narrative

3.5 Reflexivity

These considerations suggested a need for self-awareness and indeed self-knowledge. Sahd (2003) notes that reflective practice has been highly promoted in nursing and in professional education arenas over the past 12 years. In terms of reflection in and on research practice, Alvesson and Skoldberg (2009) see such "reflexivity" as having two basic characteristics, that of careful interpretation and reflection. In this context they state that:

"the first element requires awareness of the major determinants of interpretations which include theoretical assumptions, the importance of language and pre-understanding. In the second element of reflection, attention turns inwards towards the person of the researcher, the relevant research community, society as a whole, intellectual and cultural traditions, and the central importance, as well as the problematic nature of language and narrative (the form of presentation) in the research context" (Alvesson and Skoldberg 2009 p.8).

This suggests a need for critical reflection, and the considerations of epistemology, ontology and researcher position detailed above provide a starting point for this reflexivity. Such reflexivity should be ongoing, involving a "complex relationship between process of knowledge production and the various contexts of such processes, as well as the involvement of the knowledge producer" (Alvesson and Skoldberg 2009 p.8). As shall be seen, a reflexive approach runs through the thesis and this was an important factor in considering appropriate methodology.

3.6 Methodology

Various methodologies were examined to identify the most appropriate application for addressing the aim of the research and the research questions. At an early stage in particular I was drawn to feminist methodology with its principles of:

- bringing my own experience and history to my research
- being both an insider and outsider to the topic of exploration role
- removing the hierarchical relationship between the researcher and participant
- using the term "participant"
- viewing the participant as expert
- highlighting bias, that the source of human knowledge is male knowledge (Hawkesworth 1989).
- involving the participant at all levels of research

On reflection however my envisaged study would not have fully met feminist methodology. For example, limits on time and resources would have made it very difficult to involve participants at all levels of the process. In addition, the primary focus of this study was first on understanding the participants' perceptions and experiences in terms of what they themselves saw as being important, before explicitly applying any particular critical theoretical lens. Moreover factors other than gender were considered to play a more prominent role in studying the CNMM population. Nevertheless, I recognised my affinity with feminism and its potential relevance as CNMMs were typically (though not exclusively) female.

In contrast to feminist philosophy, hermeneutic philosophy assumes that human beings experience their world through language and that language provides both understanding and knowledge (Byrne 2001).

3.7 Phenomenology

The need to understand and interpret CNMMs perceptions of their lived experiences led me to consider phenomenology as a possible source of underpinning methodology. It is increasingly used in healthcare research, and fitting for small scale projects exploring complex phenomena (Bowling and Ebrahim 2005). Leading figures in phenomenological philosophy include Husserl, Heidegger, Merleau Ponty and Satre (Smith et al 2009). Coming from the humanistic disciplines, phenomenology captures the ideas and reasoning of the participants (Denscombe 2007). It is regarded primarily as a philosophy, or a mixture of unique related philosophies with approach and method considered as the secondary function (Dowling 2004). The roots of phenomenology have developed over time with dispute over a true version (Finlay 2011). Rather than a static entity it is viewed as a movement (Laverty 2003), due to Husserl's original ideas having been adapted by subsequent scholars, such as, but not confined to, Heiddeger, Gadamer & Ricoeur (De Witt and Ploeg 2005). This is a significant distinction as it indicates that understandings of phenomenology are dynamic, evolving and not stationary (Laverty 2003).

Consequently, adopting a phenomenological approach required consideration of its three main schools. These can be seen as: eidetic or descriptive phenomenology which was modelled on the work of Husserl and dependent on bracketing beliefs; hermeneutic or interpretive phenomenology guided by Heidegger with an emphasis on understanding; and the Dutch school which favours a combination of both descriptive and interpretive phenomenology (Dowling 2004). Although abundant, much of the literature on phenomenology appears conflicting. Several papers (e.g. Dowling 2007, Dowling 2004, and Lopez and Willis 2004) warn of confusion and misunderstanding around the underpinning philosophical issues of the different phenomenological schools, and their application of method.

Nevertheless it seems fair to say that Husserl's philosophical stance favours the importance of description as opposed to understanding. Pringle et al (2010) intimate that descriptive accounts provide a one dimensional approach, a notion supported by Braun and Clarke (2006) in Pringle et al (2010 pp 20-24), who suggest that the

“Husserlian researcher” “bears witness” to participant experiences without being actively involved in the analysis.” As I also had reservations about “bracketing” my beliefs as a sustainable strategy, I was drawn to consider the Heideggerian approach.

3.8 The interpretivist phenomenology of Heidegger

Founded on the ontological position that lived experience is an interpretive process, Heidegger viewed understanding as a reciprocal process. In illustrating this concept Heidegger offered the notion of the “hermeneutic circle” to espouse the mutuality of the process. However, Van Manen (1990) challenges Heideggarian philosophy suggesting that hermeneutics fits outside the limits of phenomenological research. Conversely others argue that without hermeneutics phenomenology can become shallow (Dowling 2007).

Interpretive phenomenology has become increasingly popular in nursing, (Preist 2004), which as an art and science appears to fit with its underpinning humanistic principles. The goal of interpretive phenomenology is increased understanding of the multiple interpretations of the meaning of human experience. As Lopez and Willis (2004, p. 730) observe, ‘there is no one true meaning’. This fits with the goal of this research to increase understanding of the many constructions of the meaning of human experience for CNMMs in enacting their role through change. Moreover it concerns itself with individual and collective subjective experiences of CNMMs to identify commonalities, and differences between their worlds. In the Heideggerian tradition, the assumption is that knowledge comes through shared meanings formed in social interactions i.e. social constructivism associated with Schutz North American phenomenology (Berger and Luckman 1966).

These meanings are constructed via language, and consciousness, creating a joint reality (Rowlands 2005) and inter-subjectivity to make sense of each other (Smith et al 2009). Indeed how we relate to our world is a fundamental component of our human make up (Smith et al 2009). The researcher is part of this process taking their pre-existing understandings with them.

In considering interpretative phenomenology, I was drawn to a particular approach called Interpretative Phenomenological Analysis (IPA) that has developed recently, primarily in the UK (Smith 1996b). This is considered in more depth in the following section.

3.9 Interpretative Phenomenological Analysis (IPA)

As a particular approach to enabling the researcher to make sense of personal accounts of experiences, Interpretive Phenomenological Analysis (IPA) was first presented by Smith in 1995 in the context of work in health psychology. Smith identifies phenomenology, hermeneutics, and idiography (Smith, et al 2009) as the theoretical underpinnings of the approach. More specifically, in their critical appraisal of rigor in interpretive phenomenological nursing research, De Witt and Ploeg (2005) see IPA as informed principally by the theories of philosophers such as Heidegger, Gadamar and Ricoeur. This suggests congruity with the inquiry outlined so far.

IPA is also theoretically rooted in critical realism (Smith et al 2009). Critical realism accepts that there are some stable and enduring features of reality existing independently of human conceptualisation. Differences in the meanings individuals attach to experiences are considered possible because they experience different parts of reality in different ways (Fade 2004). This allows congruity with the interpretivist approach at the heart of my inquiry.

Indeed the aim of IPA is to discover as much as possible what it is like to be that person who is central to the focus of inquiry. Typically this is achieved through individual interviews. IPA encourages interviewees to discuss any relevant information to support details and convey their experience (Smith et al 2009). The IPA researcher is seen as an active participant in the process. Importantly, IPA involves a two-stage interpretation process, the purpose of which is to (i) describe and interpret the perspective of the participant (Bogdan and Biklen 2007) and (ii) to interpret how the participants make sense of their experience (Pringle et al 2011). The first part of this process clearly relates to the first two research questions in my study, while the second part relates clearly to question 3.

In this way IPA is said to utilise a double hermeneutic (Smith and Osborn 2003). Exploration of how participants make sense of their personal and social world, and the meanings that particular experiences, events, or states have for them through their lived experiences is detailed. The researcher reflects upon their role in relation to the interpretative and collaborative nature of the IPA interview, and also in the

data analysis and publication. A defining characteristic of interpretive phenomenology is that the researcher's preconceptions, biases and assumptions are clarified and become an integral part of the study findings (Cohen and Omeroy 1994, Ray 1994).

As can be seen, IPA offers a methodology that tries to link theoretical underpinnings with practical method. Drawing primarily on the work of Smith et al (2009), some key principles relating to data generation are now outlined:

- ❖ IPA is an inductive approach (it is 'bottom up' rather than 'top down'). It does not test hypotheses, and prior assumptions about participants' experiences are avoided. IPA aims to capture and explore the meanings that participants assign to their experiences.
- ❖ Participants are recruited via purposive selection because this offers insight into a particular experience
- ❖ Participants are thus seen as experts on their own experiences and can offer researchers an understanding of their thoughts, commitments and feelings through telling their own stories, in their own words, and in as much detail as possible.
- ❖ Typically numbers of participants rather than interviews form the parameters of IPA studies in capturing longitudinal "before and after" phenomena (Smith et al 2009, p.52). Numbers are in general small depending on the form of study being undertaken. There is no prescriptive solution to IPA sample size (Smith et al 2009).

As the name suggests, IPA is also characterised by principles of analysis:

- ❖ Researchers reduce the complexity of experiential data through rigorous and systematic analysis. Analysis relies on the process of people making sense of the world and their experiences, firstly for the participant, and secondly for the analyst.
- ❖ Analyses usually maintain some level of focus on what is distinct (i.e. idiographic study of persons), but will also attempt to balance this against an account of what is shared (i.e. commonalities across a group of participants).

- ❖ A successful analysis is: interpretative (and thus subjective) so the results are not given the status of facts; transparent (grounded in example from the data), and plausible (to participants, co-analysts, supervisors, and general readers).
- ❖ Researchers should reflect upon their role in the interpretative and collaborative nature of the IPA interview, data analysis and any subsequent publication. (Smith et al 2009)

Consistent with phenomenological origins, IPA combines an empathic hermeneutics with a questioning hermeneutics. It is a dynamic process with an active role for the researcher in the process who tries to understand what it is like from the participants' point of view. As such, the researcher is aiming to assume an insider perspective by employing in depth qualitative analysis (Smith and Osborn 2003). It can also develop theories and models to understand human experience better.

Reid et al (2005) carried out a literature review to identify the use of IPA within 65 peer reviewed papers between the dates of 1996 and June 2004. In the first half of 2004, they found 11 papers adding to the corpus of IPA research, affirming the continued rise in use of this qualitative method. They helpfully identified areas where IPA is making an impact along with key IPA exemplar studies. **(Table 8)**

Table 8: IPA research exemplars

Taken from: Reid et al (2005)

Research area	Examples
New genetics	Genetic test results: failure to reassure (Michie et al 2003)
Health professionals/therapists	Nurses' theoretical models that shape their assessment of carers (Carradice et al 2002)
Dementia/degenerative disease	Exploration of the 'threat to self' in early stage Alzheimer's disease (Clare 2003)
Sexual identity and sexual health	Impact of new treatments on gay men and HIV testing (Flowers et al 2001)
Chronic illness	Chronic back pain (Osborn and Smith 1998)
Quality of life measurement	The meaning of 'quality of life' from those who have undergone bone marrow transplant (Holmes et al 1997)
Spirituality and bereavement	The role of spiritual and religious beliefs in the bereavement process and bereavement therapy (Golsworthy and Coyle 2001)
Palliative care	Cancer patients' and relatives' views on the role of specialist palliative care teams (Jarrett et al 1999)
Mental health/addiction/	The self-identity issues raised by recovering addicts involved in a 12-eating disorders step programme (Larkin and Griffiths 2000)
Reproductive decision-making	A man's experience following his partner's termination of pregnancy for fetal abnormality (Robson 2002)
Personal and cultural identity	The threat to cultural identity as told by immigrants to Britain (Timotigevic and Breakwell 2000)

It is notable that the research areas of management in general, and community nursing management in particular, are absent from Reid et al's (2005) literature review with no identified exemplars.

As with all methods IPA has strengths and weaknesses. Based on hermeneutic principles of research and in accordance with the applied reflexive methodology, the strengths and weaknesses of IPA were duly considered in order to balance the emergent design to reduce limitations. **(Table 9)**

Table 9: Strengths, weaknesses in balancing IPA design

Taken from: Lyons & Coyle (2007)

IPA Strengths	IPA Weaknesses	Balancing design to reduce limitations, based on hermeneutic principles of research
Emphasis on cognition is central	Connections are not always straightforward	Maintenance of a constantly questioning attitude to search for misunderstandings, incomplete understandings and deeper understandings (Addison 1992, Benner 1994)
Theoretical background of commitment to individuals as cognitive, affective, linguistic, physical beings assumes connection between talking thinking and emotional states	People may struggle to express what they are feeling and they may not wish to disclose	Drawing out what is hidden within the narrative accounts and interpretations based on background understandings of participants and researcher
IPA studies are particularly suited to explore topics within health, social and clinical settings	Any analytical account will be partial	Engagement in active participation with the participants in the research process (Plager 1994) e.g. via sharing graphic representation of initial findings with return and additional region participants to enter into active dialogue in terms of trustworthiness (Addison 1992)
IPA emphasises that research is a dynamic process and one that aims to understand what it is like from the person's point of view as far as possible	Never completely possible	View topics narrated by the participants as significant at some level to the participant and work with participants to see what points are salient
The question is often about identity as individual accounts of significant experiences or events almost always impact on social identity	We cannot ever imagine it could ever be the final word on the topic	Deem every account as having its own internal logic; whatever is brought to an interview is significant to its bearer

3.10 Design principles and practice

The foundational ideas already detailed suggested good potential to address the main questions of the inquiry. In particular, IPA seemed a promising approach for applied translation of principles into practice. The next sections of the chapter explain this further by presenting the main elements of the emergent research design.

3.10.1 Ongoing literature reviewing

Firstly, as alluded to in Chapter Two, it is important to acknowledge that I brought my existing understandings with me while carrying out the ongoing literature review as reader and interpreter. In this way the literature became a companion in my thinking so that there was “a dynamic reflexivity” (Smythe and Spence 2012 p.14). In hermeneutic terms, as described by Heidegger (1962) this had three aspects: fore-having, fore-sight and fore-conception. My fore-having brought my existing understanding that drew me to this particular research topic and contributed to shaping the research questions. My foresight brought an advanced understanding giving me a sense of what journals and authors to prioritise thus helping to shape the search. My fore-conception brought a sense of the “what” that the research may or may not uncover (Smythe and Spence 2012) so that new insights could emerge. “The process and outcome is a reflexively critical understanding (Grondin 1994) of pertinent literature” (Smythe and Spence 2012 p.14.) I argue that tackling the literature review in this way enabled entry into the hermeneutic circle (Sebastian et al 2010).

3.10.2 Interviewing

As explained above, the individual interview is a mainstay of IPA method. Qualitative interviewing seeks to capture complex experiences, understandings, behaviours, and attitudes. Unstructured and semi-structured are the two forms of technique that can be used in qualitative research interviews with their use depending on the aim of the study. Unstructured interviews do not utilise an interview guide being casual, flexible

and non-directional. At the beginning of each interview a single core question is asked with the interview depending completely on the how the participant responds (Smith et al 2009 p.69). The majority of published IPA studies utilise this data collection method (Birkbeck University of London 2010, Smith 2011). The strengths of unstructured interviews lie in their flexibility and lack of restrictions on questions. This can be useful when little is known about the topic under research. However it may be problematic in terms of deciding which data to collect, directing the interview and obtaining appropriate data to answer the research question. I heeded the advice of Smith et al (2009) who advise the use of the semi-structured style of working from a schedule for the newcomer to IPA such as I was.

Semi-structured interviews use a schedule that tends to be minimal and flexible with questions prepared ahead of time. A list of key themes, issues, and questions are used to guide the researcher the order of which can be changed depending on the direction of the interview. This “allows the interviewer to be prepared and appear competent during the interview”, (David & Sutton 2004 p.87) facilitating comfortable interaction with participants (Smith et al 2009) and allowing participants to express their views in their own terms (Kajornboon 2004). In this way semi-structured interviews can provide two way communication giving participants as experts the opportunity to inform the research (Beth 2005). In addition participant dialogues can be recorded during interviews and then transcribed so that the material can be held and retrieved. The advantages and disadvantages of using semi-structured interviews are summarised in Table 10**.**

Table 10: Advantages and disadvantages of using semi-structured interviews
Taken from: Cohen and Crabtree (2006)

Advantages	Disadvantages
Questions can be prepared ahead of time. This allows the interviewer to be prepared and appear competent during the interview (David & Sutton 2004 p.87).	Interviewing skills are required
Allow informants the freedom to express their views in their own terms (Kajornboon 2004 p.75)	Need to meet sufficient people in order to make general comparisons
Semi-structured interviews can provide reliable, comparable qualitative data (Cohen & Crabtree 2006)	Preparation must be carefully planned so as not to make the questions prescriptive or leading
Semi-structured interviews encourage two-way communication. Those being interviewed can ask questions of the interviewer. In this way it can also function as an extension tool (Gray 2004)	Skills to analyse the data can be a problem-risk of construing too much
Confirms what is already known but also provides the opportunity for learning. Often the information obtained from semi-structured interviews will provide not just answers, but the reasons for the answers	Time consuming and resource intensive
When individuals are interviewed they may more easily discuss sensitive issues	Managing sensitive issues which may elicit emotional responses

Semi-structured interviewing seemed suitable because it could allow participants freedom in expressing their views on their own terms within a framework that would address the main research questions. The evolution of the format and schedule used in the study are explained in detail in the following chapter.

3.10.3 Sampling

Considerable thought was given to the issue of sampling. A defining characteristic of middle manager literature in general, is the elusiveness of classifying the population

(Thomas and Linstead 2002) which has resulted in inexact definitions (Carroll and Levy 2008). Specifying the study population was found to be complicated by the variation of community nursing middle managerial roles within CHPs. Moreover hierarchies, titles and roles varied within these structures. In an attempt to provide a distinct definition for the particular population being explored, Agenda for Change (AfC), implemented in 2004, was used as a base for classifying the population. AfC is the uniform NHS pay and grading structure within the NHS:

“Staff are placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job rather than on the basis of their job title. The assessment of each post using the Job Evaluation Scheme (JES) determines the correct pay band for each post, and so the correct basic pay. Within each pay band, there are a number of pay points. As staff successfully develop their skills and knowledge, they will progress in annual increments up to the maximum of their pay band. At two defined "gateway points" on each pay band pay progression will be based on demonstration of the applied knowledge and skills needed for that job” (NHS Employers Factsheet Sept 2012).

CHP Community Nurse Middle Manages generally sit at Agenda for Change Band 8 which is subdivided into 8 a-d. Therefore for the purpose of this explorative study AFC Band 8 defines the collective population investigated.

Initially I considered that one Health Board (HB) would yield sufficient CNMM participants to explore a range of experiences, as the HB contained three CHPs of different size and geographical characteristics, and the participants were drawn from a range of contexts.

Another key consideration was the opportunity to study the group longitudinally – crucially to study CNMM experiences over time. In this way the idea of an initial set of “foundational” interviews was formulated with participants drawn from three CHPs. These participants were followed up around 24 months later with “recursive” interviews, by returning to the same population of self-selecting individuals. The notion behind recruiting around 20 participants in the foundational phase was two-

fold, firstly there would be sufficient initial breadth of participants and secondly it would allow for the likelihood of attrition at time of follow up.

There is no specific or correct solution to IPA sample size, although the total number recruited to the investigation is at the higher end of IPA study sampling (Smith et al 2009).

Purposive sampling technique seemed appropriate, selecting participants on the basis of their particular experience, characteristics, similar roles, and broadly speaking being a homogenous group (i.e. CNMMs at AfC Band 8). This would help ensure the research study would have meaning to them (Smith et al 2009) and more general relevance. Indeed Smith et al (2009) see purposive sampling as particularly suited to IPA in its provision of insight into the particular experiences under investigation.

3.10.4 Preparation

Interviewing peers can have complicated dynamics (Merton 1972), and (Naples 1996). Peers may not be instantly distinguishable as a vulnerable group, but the constraints of group membership may limit the interviewer from asking questions not only about well-established social mores but also about sensitive issues (McEvoy 2001). It was also recognised that there was potential for some tension between the emic and etic dimensions of my researcher role. Indeed as my researcher role included that of investigator, research instrument, and interpreter of experiences, it seemed important that I developed my understanding and skills before undertaking the main part of the study.

In keeping with the reflexive approach being taken, the first phase of my preparation involved a personal RI where I was interviewed using my own questions. Literature relating to this approach is sparse but this proved a very valuable experience. Further details of the process and outcome of this are given in the next chapter.

This informed a further preparatory phase whereby a set of six semi-structured "preliminary" interviews were carried outwith a small number of volunteer participants. This tested the format, the interview schedule and analysis processes as well as helping me to develop my skills. Again further details of the process and outcome of this are given in the next chapter.

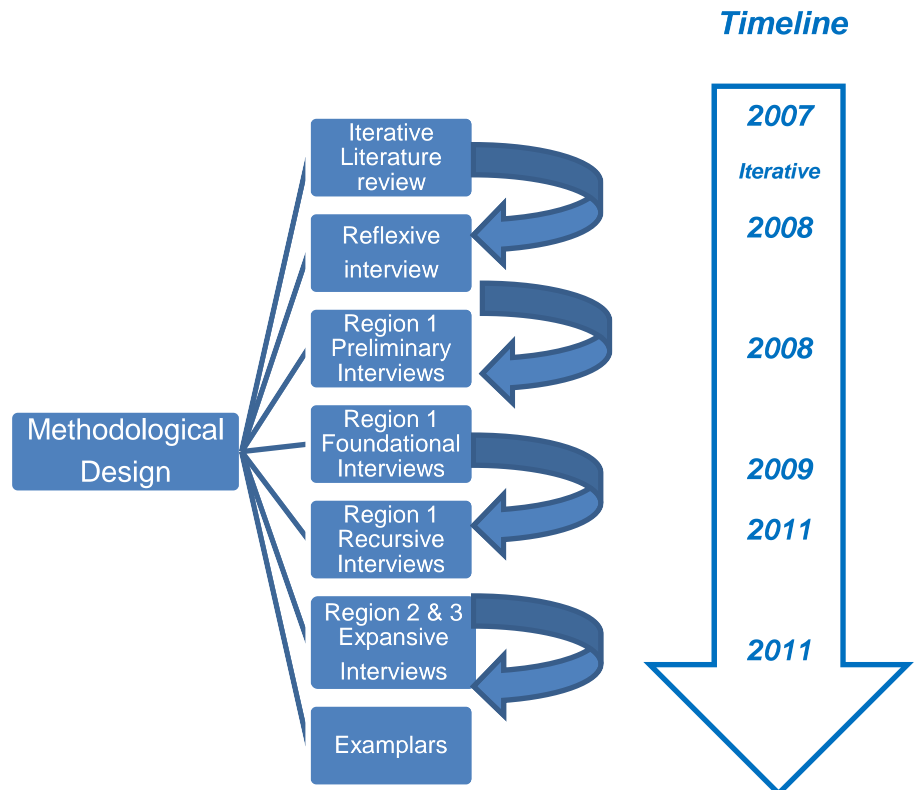
3.10.5 Expansion

To an extent the design of the study was open to development in the light of progress and findings. In the context of analysis of the foundational interviews, I decided not only to undertake the recursive interviews as planned, but also to expand the final phase of the study to access participants from a greater number of CHPs, in the process adding two additional regions of Scotland to the study. This facilitated exploration of the phenomenon under study from multiple perspectives obtaining "a more detailed and multi-faceted account of the phenomenon" (Smith et al 2009 p.52). Again further details of this process are given in the next chapter.

3.11 Overview of the study design

The final structure of the investigation and the related timeline is represented in Figure 3.

Figure 3: Methodological design



The multi-phased approach outlined above, was applied to the collection of data within the study, with data analysis following each distinct phase.

Overview of the composite interview total and rationale for interview each phase is given in Table 11. Data from these interviews were collected, analysed and interpreted contemporaneously over the period from March 2008-August 2011 as shown above.

Table 11: Overview of interviews undertaken

Type of Interview	Rationale	Numbers
Reflexive	Stimulates investigator reflexivity	1
Preliminary	Tests questions and method	6
Foundation	Gathers data	18
Recursive	Tests initial interpretation & gathers new more in-depth data	9
Expansive	Widens study, further tests interpretation & gathers new more in-depth data.	8
Total		**42**

3.12 Consideration of quality criteria

Finally, before giving detailed insights into the development and application of methods, it is proper to consider relevant criteria for quality. As already outlined Smith et al's (2009) criteria were applied. Analysis is interpretative, the results are not given the status of facts, they are grounded in examples from the data, and plausible.

Morrow's (2005) criteria for qualitative studies were also applied to the investigation. These included *disclosure* – for example via the RI, s*ituated description* – via aiming to give adequate description of the group of participants and context studied, e*xamples* – via aiming to ground the findings in examples that come directly from accounts provided by participants, c*redibility and coherence* – for example, via aiming to share initial findings from the foundational interviews with the participants from recursive and expansive interviews, in order to check reliability and resonance in terms of relationships among themes and categories, *fairness* – by aiming to provide accounts that represent a fair and balanced outline of participant experiences, *dependability* – via aiming to describe the systematic process utilised during the investigative process, and finally *triangulation and saturation* – by returning to the foundational cohort and by broadening and deepening the investigation to support saturation of thematic possibilities. More detailed examples of the application of these criteria are given in the next chapter.

CHAPTER 4: DEVELOPMENT AND APPLICATION OF METHODS

4.1 Overview of chapter

Chapter Four provides detailed insight into how methods developed and were applied over the course of the inquiry through each phase. It commences with a description of the foundation and application of reflexivity, including the purpose and structure of the RI. The feelings, findings and reflections the RI evoked are recorded, including outcomes of the RI and implications for conducting the preliminary interviews phase. The lessons learned from the preliminary processes are detailed including how recruitment was tested, interviews planned, organised and enacted, and procedures for analysis developed. Reflections on the design and methodology for the foundational interview phase follow, including the objectives, the revised interview schedule and how interviews were conducted.

A similar process is illustrated in turn for the recursive and expansive interview phases, again outlining objectives, recruitment to these phases, the revised interview schedules and how the recursive and expansive interviews were conducted having been informed by the preceding phases.

The analysis processes are then outlined with specification of reading of the case and how initial appraisal and development of intra-case and inter-case themes were developed. Triangulation and development of analyses are charted with an explanation of how the findings are presented.

Ethical considerations are then explained which include professional ethics, statutory codes and processes, and legislative frameworks. Conducting research in the researcher's employment context i.e. the challenges and advantages are considered. Finally protecting participants from harm via informed consent, sensitivity during the interviews and the maintenance of anonymity and confidentiality conclude the chapter.

4.2 Reflexivity: foundation and application

As alluded to in Chapter Three, reflexivity is a way of systematically approaching the enquiry and a means through which knowledge is constructed, especially considering the effect of the researcher, through every step of the research process (Cohen and Crabtree 2006). Koch and Harrington (1998) view such reflexivity as congruent with a hermeneutic and postmodern /post-structural method. This capacity to reflect upon one's personal actions and values during the research process can be a hallmark of researcher integrity (Brewer 1994, Seale 1999).

This is a particular issue for this thesis as I was studying members of a group of which I had membership and professional affiliation (Edwards 2002). Interpretive phenomenology's philosophy in particular acknowledges that people are inextricably situated in their worlds. Therefore the use of a "bracketing" or "suspension" interview (Koch and Harrington 1998) was considered prior to starting empirical data collection. However having given this consideration I found that I concurred with Maggs-Rapport (2000) who doubts the feasibility of putting aside all preconceived ideas. The Heideggarian School suggests that it is not possible to bracket pre-existing experience and understanding. Individuals live within a changing social and political context requiring reflection and challenge (Van Maanen 1990).

In short, researchers need to be aware of their beliefs to increase transparency (Brocki and Wearden 2006) and be aware of how they will impact on process and outcomes (Finlay 2008). From these considerations and discussions with the supervisory team, the notion of carrying out an initial RI evolved.

4.2.1 Reflexive interview: purpose and structure

The idea of the RI was that I would be interviewed by an experienced colleague using the schedule of questions that I intended to use in the study. This would be taped and transcribed as a basis for analysis by myself, my interviewing colleague (IC) and my principle supervisor. My experienced IC would share personal reflections on the process of the RI in order to further raise my awareness.

The initial interview schedule that I had prepared was designed to explore the main concepts of the study as envisaged at the time (i.e. managing change, role, leadership, teamwork) within the structure of a broad chronological framework (past, present and future). This schedule is presented below in Table 12.

Table 12: Initial interview schedule
Within your role as a Community Nurse Leader, can you share some of your past experiences of managing change? What team work related issues can you recall? What leadership related issues can you recall? Why did things happen in the way that they did? What did you learn from this?
In relation to the present situation can you share some of your experiences of managing change? What team work related issues can you recall? What leadership related issues can you recall? How do you communicate change? What are the present expectations of your role?
If you were to project your thoughts forwards, what change do you see happening over the next few years in relation to managing change? What are the implications for team work? What are the implications for leadership? What are the implications for your role and other Community Nurse Leaders in the region? What are the implications for education and practice development? Finally, is there anything you would like to add?

4.2.2 Reflexive interview: feelings and findings

At the inception of the interview I was conscious that the IC came to the interview from a different standpoint having a different background, experience and knowledge that might impact on the interview. In the early stages of the interview I was aware of how rapport was built and did not feel an imbalance of power. As I was being questioned I was at times conscious of the interview style, timing, and how there were few interruptions to my narrative, which facilitated my story-telling flow. This appeared to ensure that it was more about me (the participant) than the researcher. During the dialogue I occasionally wondered why questions had been asked that appeared to veer from my interview schedule, but later realised that the interviewer was mining for information which a semi-structured design allows for.

On reading the transcript afterwards, it emerged that the answers I had given to the questions usually provided the required information. They had been asked in a flexible way to capture my experiences and perceptions in what I felt, was a non-threatening way. I realised that it would be important to scrutinise interview transcripts to ensure that the questions from the schedule had been asked and answered to provide the required data.

One of the main themes that was prominent in the initial stage of the RI (where I was being asked about past experiences) was the significance to me of my background as a Public Health Co-ordinator. In talking about this I emphasised how I had learned about leadership skills in working with diverse groups. I described some specific project work involving negotiating, and how this felt like “walking a tightrope” at times.

Despite having designed the questions, there were occasions during the interview when I felt slightly ill at ease. I found the interview experience to be more than a cognitive process because it involved my emotions and feelings (Dewey 1933, Mezirow 1981, and Schön 1983). I hadn’t been wholly prepared for some of the emotions elicited in reliving and telling parts of my story specifically in relating a negative experience. The following excerpts illustrate a particularly vulnerable and unpleasant time:

Interviewer quotes are differentiated by the use of bold italics, for example ***"Interviewer"/***"Participant".*

"I do not appreciate people who want to win and see you lose, or who go into the game thinking you are going to lose whatever ... you know ... that, that just doesn't work, but there are people who will use their power, and maybe not in the most ethical of ways and so integrity comes into it as well, and I kind of despair at the way some people act sometimes". RI

*"**What has been your experience when you have been on the other end of a fait accompli?** Oh, indignation, complete indignation, lack of trust, because people didn't have the decency and the respect to share what is going on. Generally when you've got a fait accompli, for me, from my perception, it seems to be that those people want to be in complete control and they want to manage everything to suit themselves...". RI*

***"So change hasn't been positive, that's not a very positive, though it doesn't sound very positive** ... I went around with invisible armour **(laughs)**, you know ... like a helmet, you know, anything that was going to sort of ... I would say protect me". RI*

The interviewer then went on to ask:

***"Do you like being in control?** Em. It depends what you mean by control. I like to feel that I've contributed to something, I think that's important. I think people need to feel that they are being respected". RI*

My reactions, which I hadn't noted at the time, were described during the subsequent feedback from the interviewer as deflective. Although subconscious at the time, on reflection, I could see how the surfacing of uncomfortable emotional feelings had contributed to putting up a barrier by avoiding answering a question. I felt that I had had enough of that thread of exploration.

I reflected that even the most expert researcher may be unable to elicit participant knowledge (whether conscious or subconscious). From this I realised that there may be tension between the potential value of a timely probe and the risk of trying to dig too deep. In order to best manage this tension, I was reminded to be mindful of observing verbal and non-verbal cues during interviews to inform me whether any question needed to be reframed, pursued via an alternative avenue or let go.

One of the trends in my answers in the early part of the interview (pointed out by my supervisor) was a tendency to go into the second person when talking about myself and my role e.g.:

"You are neither one thing or another really, you know, because although I was leading the change to other people, somebody was sort of facilitating me to lead that change if you like, you know, so it was like, em ... you weren't actually going to be, well the change wasn't going to be ... happen to you ... although it was in a way, because you were actually changing your whole role, you were changing your perception of yourself..." RI

One of the aspects I said that I had learnt from the past was to temper my intuitive nature and passion with rationality and use of evidence.

The RI took place at a time when the VAIC development seemed likely to be rolled out across Scotland. It became clear that I was sceptical about the rationale and evidence base for VAIC. When pressed by the interviewer on what I'd do if VAIC was imposed locally, I acknowledged that there were times when imposed change had to be led and managed although I might not necessarily agree with it. I came across as favouring a democratic style of leadership and management. In responding to questions about the future I described nurses' capacity for responding to challenges and how I looked for a "win-win" balance for all parties. Indeed my supervisor pointed out my tendency to use managerial language and metaphors such as "juggling".

Table 13 presents a summary of my main pre-suppositions as elicited by the RI and subsequent feedback and discussion with my supervisory team.

Table 13: Main presuppositions

Main Presuppositions
Change is difficult to manage
Being in the middle is like walking a tightrope
Access to training is important for managing change
Scepticism about the proposals contained within VAIC
The power of politicians

4.2.3 Reflections on the reflexive interview

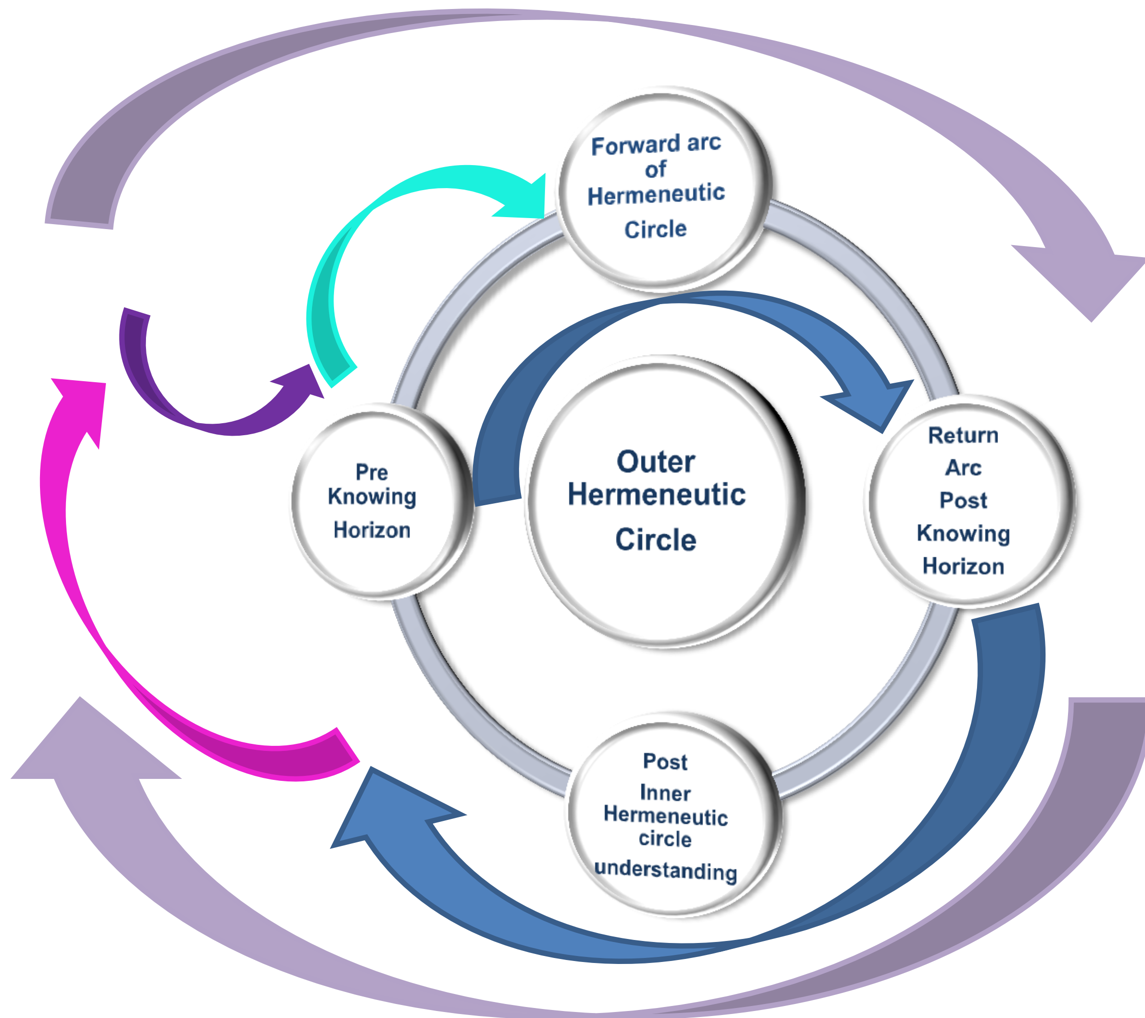
Brown (1996 p.20), asserts that, “awareness of one’s own biases, blind spots, deserves as high a priority as theoretical knowledge”. In a very practical way the RI enabled me to retrospectively reflect on my past experiences and current position by bringing these to the fore.

Literature pertaining to this method appears scarce, however Wertz (2005) supports the principle, and the process of reflection and review is seen as integral to IPA (Smith et al 2009). Brookfield’s (1995) four complementary lenses for reflection may be relevant here:

- The autobiographical, or self-reflection, is the foundation of critical reflection – this was applied to my autobiography as an “insider” researcher
- The students' eyes – this was applied to the participant’s eyes
- Our colleagues' experiences – this applied to interviewing peers
- Theoretical literature – this applied to the iterative literature search.

These lenses helped develop a framework that correlated with the critically reflective design of my research method to gain understanding of the subject being explored. Understanding is an important aspect in philosophical hermeneutics that is obtained by the personal involvement of the researcher and is “inextricably linked with one’s being in the world”: what Gadamer refers to as the hermeneutic circle (Pascoe 1996). Bliecher (1980 p.103) asserts that “the hermeneutic circle cannot be avoided; rather it is a matter of getting into it properly.” This initial stage in my research can be considered through this lens. Crist and Tanner (2003) describe this process as the forward arc of the “hermeneutic circle” and the interpretation as the return arc — the “movement of uncovering” of the circle. This process is illustrated diagrammatically in Figure 4.

Figure 4: Illustration of the iterative character of the Double Hermeneutic Circle and its application to thesis design:



Purple arrow illustrates entering the forward arc of the hermeneutic circle via the literature review.

Turquoise arrow illustrates the uncovering of my pre-knowing and pre-understanding via the reflexive interview, "surfing" the forward arc of the hermeneutic circle.

Deep blue Arrow Illustrates the return arc the "movement of uncovering" of the circle via interpretation.

Orchid pink arrow illustrates leaving hermeneutic circle with increased understanding.

Pale mauve arrow illustrates beginning of new cycle building on new understanding.

Application of the hermeneutic circle is represented as a spiral containing individual loops. As shown in Figure 4, each loop represents separate phases as distinct hermeneutic circles with their own forward and backward arcs (Ellis 1998). I entered the hermeneutic circle via the iterative literature review, then drew from my previous experience by “surfing” the forward projective arc via the RI. In hermeneutic terms this refers to pre-structure and pre-understandings. The backward arc represents my primary interpretation which was then evaluated along with my supervisor to identify differences, possible explanations and gaps from my first interpretation. In this way the backward arc facilitated more refined interpretation of what I had discovered. This process highlights how interpretation is at the heart of hermeneutics.

The four elements in reflective research are defined by Alvesson and Skoldberg (2009) as:

- Empirically oriented methods teach us to make contact with empirical material
- Hermeneutics raises awareness of the interpretative act
- Critical theory shows the importance of political, ideological contexts
- Postmodernism helps the reflexive researcher in handling the question of representation and authority.

They describe reflexivity as:

“interpreting one’s own interpretations, looking at one’s own perspectives from other perspectives, and turning a self-critical eye onto one’s own authority as interpreter and author” (Alvesson and Sköldberg 2000 p.vii).

Although the process of textual analysis by those involved in the RI was largely informal and exploratory, it made me conscious of the need to develop my analytic approach systematically, based on IPA principles.

4.2.4 Outcomes of the reflexive interview and implications for next stages

First and foremost, the RI enabled me to identify my pre-existing personal positions, perceptions and experiences before seeking to understand those of others. The

process was designed to raise my self-awareness and enable me to distinguish my personal experiences from those to be investigated. As noted previously, in IPA the participants are seen as the experts and the researcher the learner.

I suggest therefore, that the RI provided a robust methodological foundation, strengthened my reflective skills, and attended to the ethics of this particular area of research, congruent with the thinking of Van Maanen (1995). Indeed it can be argued that this approach suggested potential to diminish the risk of harmful effects on the participants (Clarkes 2006). From the RI, I was conscious that the interview experience itself had the potential to induce changes.

The opening up of life experience and related participant emotion could be powerful for interviewer and interviewee, potentially impacting on the way they may view each other in the future (Frank 2005, Goffman 2006). In turn I became aware of how the sharing of emotional experiences with peers had potential to both cloud or clarify understanding.

One of the main outcomes of the RI was to confirm the potential value of carrying out a number of preliminary interviews with health service managers who were not CNMMs. These would give valuable experience of research interviewing as I was a relative novice, and enabled me to incorporate some of the insights from being interviewed. To this end, only minimal changes to the interview schedule were envisaged for the preliminary phase. One was to ask the interviewee to describe their role at the start. Another was to try to ask the “why do you think that happened the way it did?” question more, to help build explanation.

4.3 The preliminary interviews phase

4.3.1 Rationale

Preliminary work in qualitative research is important in order to adapt to the situation in my area of interest, a notion supported by De Vaus (1993 p.54) who cautions, "Do not take the risk. Pilot test first." A variety of terms are used to describe the methodology of preliminary work as part of research studies. These include pilot, exploratory, or feasibility studies, stage or phase one (Kilanowski 2011). The advantages of conducting pilot studies include:

"developing and testing adequacy of research instruments; assessing the feasibility of a full-scale study; designing a research protocol; (…) collecting preliminary data; assessing the proposed data analysis techniques to uncover potential problems; developing a research question and a research plan; training a researcher in as many elements of the research process as possible" (van Teijlingen & Hundley 2001).

However, literature indicates that pilot studies such as this are under-discussed, underused, and underreported (Presscott and Sooeken 1989 in van Teijlingen & Hundley 2001).

In my own study I saw the potential for preliminary work to: establish the feasibility of recruitment and retention procedures, including testing protocols (such as gaining informed consent); determine how interviews were planned, organised, and carried out; hone my interviewing skills; develop and refine analysis procedures; and identify potential design and methodological problems more generally. In doing so I might also identify further training needs. Drawing from the work of van Teijlingen and Hundley (2001), these aspects are portrayed in Figure 5.

Figure 5: Learning outcomes of preliminary work

Modified from van Teijlingen & Hundley (2001)

4.3.2 Testing recruitment

As explained in Section 3.8.3, the plan for the main study (foundational and recursive interviews) was to seek to recruit around 20 CNMMs from one region (18 participants were recruited). For the preliminary interview phase it seemed logical to try to recruit a small purposive sample from a generally similar population of nurse managers within this Health Board, avoiding the target population to ensure that there would be an adequate pool to recruit for the following phases. Senior nurse managers were recruited by circulating an invitation on an internal senior Nurse network via the Director of Nursing. Six self-selected participants comprising middle-aged females

responded and agreed to participate. They had been sent explanatory information about the study along with a consent form. Ethical approval was obtained consistent with section 4.7 of this chapter.

4.3.3 Planning, organising and enacting interviews

Conducting semi-structured interviews requires thoughtful planning and organisation. The preliminary participants were middle managers with demanding roles and therefore not always easily available. Consequently, the location of each interview was determined by individual participants on an agreed date at a convenient time. The venue was organised on recommendation by the interviewee so that it was easy for them to travel to, familiar and comfortable in terms of safety, warmth and privacy and in a setting with the least possible distraction. Due consideration was given to the stages of rapport between the interviewer and the interviewee (Spradley 1979, Rubin and Rubin 2005) which include apprehension, exploration, co-operation and participation.

As indicated above, the schedule used in the RI was revisited to ascertain if it was adequate for the preliminary phase and no major changes were made. The interview guide provided a structure for the interviews, to stimulate participants to recount their experiences and perceptions. The aim was to conduct a conversation where the main focus was derived from the schedule (Denzin 1989). Questions were designed to be open-ended aiming to avoid yes/no or rehearsed answers and to stimulate focused, conversational, two-way communication (Fielding and Thomas 2001). To ensure coverage of the key areas and link topics (King 1994) the questions were structured to be asked in such a way as to capture these managers' experiences and perspectives to discover what it is like to be that person. This was congruent with the aim of IPA.

The participants and I appeared to be comfortable in each other's company and rapport appeared to be struck up fairly quickly. This may have been due to preliminary researcher preparation and having a similar role to the participants.

As with any conversation, twists and turns occurred and different paths were taken. In answering one question some participants were sometimes stimulated into lengthy dialogue, however in doing so answered consecutive and other questions contained in the interview schedule. In some instances a small minority of participants veered onto a completely different track and were encouraged to return to the topic in question. Some “lost their thread” and required to be reminded of what they had been saying.

I found this required a high degree of focus and concentration, and related to Arber’s (2006) observation of how emotionally tiring it is to maintain concentration during interviewing. Interviews on average lasted 1 hour and fifteen minutes and were audio recorded. Consequently, and in order to maintain an appropriate level of awareness, I recognised the wisdom of conducting a maximum of 2 interviews per day during the collection of data (Arber 2006).

Every preliminary interview “felt” different and individually and collectively provided a learning experience. The recordings became an aid to reflexivity. One preliminary interview in particular touched a participant’s raw emotions who had recently been through a challenging work experience. I found that her distress stimulated my empathy and decided that it was ethically sound to end the interview. It is suggested that researchers must consider and be prepared for the opening up and releasing of participant emotion and life experience, when distressing and painful memories can be brought up which can both cloud and clarify the account (Oppenheim 1996). The experience facilitated work on my own emotions and raised my awareness of the effects interviews may have on participants. This example was one of a challenging interview, but nevertheless one which I learnt most from. It alerted me to be mindful of the vulnerability of both the participant and researcher.

The interviews were transcribed providing the opportunity to decide whether typing the interviews by myself or by an audio transcriber was most time efficient. Comparison of the two methods is outlined below.

Table 14: Assessing efficient time management

Researcher (R)	Audio-typist (AT)	Most efficient time management
Adequate typing skills	Excellent typing skills	**AT**
Time Ineffective (four hours to write by hand, four plus hours to type per transcript)	Time effective (two plus hours per transcript)	**AT**
Familiar with text	Unfamiliar with text	**R**
Concentrated on typing rather than what was being said, tone etc.	Practiced listening and transcribing skills	**AT**
Less accurate transcripts requiring many corrections	Highly accurate transcripts requiring few corrections	**AT**

This rational approach was effective in contributing to my ability to more fully concentrate on the transcript content rather than the process of typing. Transcription of the preliminary interviews generated a substantial degree of preliminary data which was analysed. Differing and similar experiences of change were beginning to emerge.

By reading over the preliminary data I was able to check whether questions had been asked and answered adequately. This enabled consideration of interview questions to ascertain if they were fit for purpose for the main study. An approach to analysis of the fully transcribed text of each interview based on IPA principles was developed. As this was the basis for the data analysis approach adopted throughout the main study, details are given in a later section of this chapter (Section 4.6).

The main themes to emerge from the preliminary interviews and an example of an emerging theme are outlined Tables 15 and 16 respectively.

Table 15: Themes from preliminary interviews

Themes from preliminary interviews					
Preliminary participants	Change perceived as a challenge	Perceived large role and remit	Work across sectors	Conflict between shrinking budgets and providing quality services	Tension in work life balance
1	√	√	√	√	
2	√	√	√	√	√
3		√	√	√	
4	√	√	√	√	√
5	√	√	√		√
6	√	√	√	√	√

Table 16: Example of an emerging theme from preliminary data – change as a challenge

Preliminary Participants	Increased pace of change over past 5 years	Imposed, constant, govt led & short term	Perceived lack of evidence base for change	Structural change most difficult	Need to have good understanding of what the change entails
1	√	√			√
2	√	√		√	√
3	√		√		√
4	√	√	√	√	√
5	√	√		√	
6	√	√	√		√

4.3.4 Design and methodology reflections

Learning from preliminary work reduces risk and increases the likelihood of the success of an investigation (Turner 2005). By explicitly considering arising issues, an ethical obligation is also fulfilled (van Teijlingen 2000). Consideration of ethical aspects pertaining to the whole study is presented in the final part of this chapter.

Carrying out preliminary interviews with this generic group of managers provided general learning opportunities prior to the foundational phase. I found that recruitment and interviewing processes were feasible. I developed interviewing and analysis skills and a system for transcription. In addition the overall methodology seemed appropriate for eliciting the perceptions and experiences of the target population and interpreting them. Moreover it supported my idea of revisiting interviewees for a second interview in the recursive phase thus providing a helpful perspective on how change evolves and is managed by CNMMs.

I also found that the preliminary work identified how the interview schedule could be improved. For example, on the basis of the preliminary interviews, some questions were subsequently refined and the interview schedule modified accordingly for the ensuing phases of the study. The descriptions of preliminary participants' role facilitated further consideration of the nature of the relationship between management and leadership in nursing. In particular the descriptions suggested that the term "Community Nursing Middle Managers" was more useful and less presumptive than the term "Community Nurse Leaders" i.e. while leadership would often be an explicit expectation within this populations' roles, this would most often be couched within the wider remit of management. Indeed one of the lessons from the preliminary interviews was the importance of eliciting details of the interviewee's job title, role expectations, role set, and managerial span. Moreover, the preliminary interviews also highlighted a need to ask about any previous educational preparation for the role, such as management or leadership training. Furthermore the exercise informed the foundational interview schedule via the inclusion of an explicit range of prompts and probes to draw upon and guide questioning.

In this way both the reflexive and preliminary interview phases informed and underpinned the design and conduct of the main phases of data collection. These subsequent phases are now explained.

4.4 The foundational interview phase

4.4.1 Objectives

As explained in Chapter Three, a major part of the study was the foundational phase where CNMMs from three CHPs were interviewed. Based on the gap in the literature identified in Chapter Two and the overall research questions for the study, the specific objectives for the foundational interview phase were:

- To elicit CNMMs perspectives on their role and remit, and relevant past and present influences on this.
- To explore CNMMs experiences of change, focusing on how they manage change for themselves and others.
- To identify any related effects for CNMMs in terms of professional and personal experiences.
- To analyse commonalities and distinctions within their accounts and to interpret findings in the light of wider literature.

4.4.2 Recruitment

As explained in Section 3.10.5, the initial sampling logic centred on studying one group of CNMMs longitudinally to establish their perspectives on change over time. By purposively drawing participants from three different CHPs within one Health Board, a range of contexts could be included.

The aim was to interview up to 20 self-selecting CNMMs working at around AFC Grade 8 level from a total target population of 54.

To gain access to the target population the Health Board Director of Nursing was written to explaining the purpose of the investigation and the parameters of the target population i.e. Senior Nurses within the community at AFC Grade 8 level. The Health Board Director of Nursing agreed to act as a third party by forwarding a letter of

invitation to participate in the investigation to the aforementioned relevant population. This avoided a direct approach to colleague CNMMs, therefore minimising feelings of coercion.

4.4.3 Revised interview schedule

The interview schedule (Appendix 5) developed from the one utilised in the reflexive and preliminary phases. The core structure of past, present and future, was maintained. This was strengthened to emphasise identification of the nature and scope of current CNMM roles at the start of the interview along with the addition of a range of prompts and probes.

4.4.4 Conducting the interviews

The approach to conducting the interviews was very similar to that taken in the preliminary interviews. The interviews were recorded with the use of a digital audio recorder which was checked to ensure that it was working prior to commencing each interview. Interviews began with an informal introduction as a warm up (Robson 2002) and consent revisited prior to recording the interview. Establishing rapport is an essential component of the interview (Palmer 1928, Douglas 1985) involving showing respect for the interviewee and the information shared. In this respect sharing a similar role to the participants was advantageous for building trust and rapport. In turn this contributed to establishing a safe and comfortable environment which in turn facilitated the interviewee to share personal experiences and attitudes that may not have otherwise been voiced.

Having gained more experience and skills from the preliminary interviews, I was more relaxed about covering the questions in a way that could be modified depending on participant response (Smith et al 2009). The sequence of the questions varied depending on where the participant “roamed”. Varying levels of prompting and probing for information were used to elicit interesting topics that arose (Ritchie and Lewis 2003). This largely depended on each participant’s individual

account and was intended to enable them to include their own perspectives and agenda (Wengraf 2001). These questioning techniques were intended to encourage participants to communicate their underlying attitudes and beliefs and were central to the application of the method. I made frequent use of a technique of briefly repeating or paraphrasing what the respondent had said to indicate my interest in them and understanding of what had been communicated. This also provided an opportunity for the participant to correct any misunderstandings (Beth 2005).

For example (interviewer quotes are differentiated by the use of bold italics):

"From what you're saying I'm picking up that as a leader you've to influence some of that , *Yes, Yes (emphatic),* ***there's a feeling at least of some control and therefore in feeling that control, you feel that you can deal with it because you've got ... then you've got your chance to make the plans, is that what you're saying?"***

"Yes, I think, I think you have to implement changes that you have no control over, where you do have some control, you can either, on occasion, opt to implement it a bit in the future, or it may be that you have to do something there and then, or you miss the boat, so I suppose that's the influencing bit, ***yeah,*** *you might not necessarily want to do it at that time but you feel you have to." Rosie, F., S.M., CHP 1.*

The 18 foundational interviews that were carried out each typically lasted between 50-90 minutes. A substantial amount of data was generated and analysed, and a number of important themes and sub-themes were identified.

4.5 The recursive and expansive interview phases

4.5.1 Objectives

As explained in Sections 4.2.1- 4.5.7, the aim of these phases was to deepen and broaden the investigation. This entailed: revisiting self-selecting foundational participants around two years after their original interview to share collated findings and to explore subsequent change over time (recursive interviews); and interviewing a small self-selecting sample of CNMMs from two additional regions in Scotland to capture a broader perspective (expansive interviews). The objectives for these phases were:

- To share outcomes of the foundational phase findings as a basis to examine points of resonance and dissonance
- To explore perceptions of change over time in terms of the CHP and their role within it
- To examine in more depth CNMMs perspectives on their professional identity and how this is negotiated within the CHP context
- To identify what CHP CNMMs perceive as the necessary skills, sustenance and support to effectively enact their roles in managing change
- To identify CNMMs perceived developmental needs and to propose requisite strategies to address these

4.5.2 Recruitment to the recursive phase

At the time of recruitment consent was requested and gained from all the participants for their participation in both the foundational and recursive phases of the investigation. The Health Board Director of Nursing facilitated recruitment of participants via the Senior Nurse Network. This comprised of the investigation being an item at one of the Senior Nurse regular meetings. I followed this up with an email, with an attachment of the original letter and consent form to the foundational phase cohort. The email requested that foundational phase participants contact me direct if

they were willing to contribute to the recursive phase. Numbers depended on those who self-identified.

Of the original foundational phase participants, nine indicated their willingness to participate in the recursive phase. These participants were sent a copy of the main themes that had emerged from the foundational phase and interviews arranged to suit participants.

4.5.3 Revised interview schedule for the recursive phase

The interview schedule for the recursive interviews (Appendix 6) was substantially altered following the foundational phase. This involved ascertaining if there had been any change or influence in how CNMMs enacted their role during the past two years. Participants then explored their reaction to the list of themes sent to them prior to the interview by working through their potential to identify or otherwise with the foundational themes. This was followed by further exploration of professional identity, especially within context of their experiences within CHPs. Their perspectives on skills and support they felt were necessary for the role, and any learning needs were then examined. Finally they were encouraged to look to the future of the CNMM position.

4.5.4 Conducting the recursive interviews

The process of conducting the recursive interviews was almost identical to that of the foundational phase. An advantage of the recursive phase was that the original rapport made between participants was built upon. In addition sharing of the foundational themes as a prompt for discussion facilitated deeper and richer exploration at interview. It felt that this process stimulated participants to recount their individual experiences and perceptions clearly having had the opportunity to reflect on themes prior to interview.

4.5.5 Sampling and recruitment to the expansive phase

As described in Section 3.10.5, reflection on the emergent findings from the foundational and recursive interviews led to a decision to broaden the investigation to target a further small sample of CNMMs from two other regions. Within the limits of what was deemed feasible for the nature and scope of a PhD project, it was felt that around five to ten more interviews would give a useful range of insights. Further ethical approvals were obtained for this phase.

To raise awareness of the investigation and stimulate interest with a potential to access a pool of additional participants, foundational phase findings were presented at the Annual QNIS Conference "Promoting Excellence in Community Care" in March 2011 where Health Board representatives from different areas of Scotland were in attendance. Following the presentation several Directors of Nursing registered interest and requested further written information explaining the purpose of the second stage of the investigation. This resulted in those who responded being sent a letter offering them the possibility to act as intermediaries for recruitment to this phase (in the same way as the Director of Nursing had done in the Health Board (HB) where the foundational interviews were held).

The CNMMs from these HBs who subsequently expressed interest were provided with the information sheet and consent form. A total of eight participants agreed to take part and the interviews were conducted at a place and time of mutual convenience in a similar way to the previous phases.

4.5.6 Revised interview schedule for the expansive phase

The interview schedule used for the expansive phase was essentially the same as that used for the recursive interviews. However there was a particular need to clearly elicit details of each interviewee's role, given that this was a first meeting.

4.5.7 Conducting the expansive interviews

The process of conducting the expansive interviews was broadly similar to that of the recursive phase. Like the recursive phase, I found that by sharing the foundational themes as a prompt for discussion, deeper and richer exploration at interview was facilitated. This process also appeared to facilitate rapport having stimulated participants to consider their individual experiences and perceptions prior to interview.

Organisation of this phase was more challenging due to the practicalities of travelling to additional Scottish Health Boards. However participants agreed to be interviewed in specific central locations that suited them and reduced extensive travel for all parties. This required a degree of co-ordination, and negotiation made more manageable by the co-operation of the CNMMs in the cohort. A timetable for interviews was agreed upon to maximise time efficiency. Timing of interviews depended on the need of each participant.

4.6 Analysis processes

The principles underpinning the approach to analysis were explained in Section 3.9. The use of IPA essentially involved a two-stage interpretation process, the purpose of which was to describe and interpret the perspective of the participant (Bogdan and Biklen 2007) and then interpret how the participants made sense of their experience (Pringle et al 2011). In other words, I was the analyst and interpreter, being effectively twice removed from that person's experience. Being concerned with a dynamic relationship between the part and the whole, IPA analysis usually reveals something about participants' meaning-making processes & how an event or state impacts on identity (Smith and Osborn 2003).

Reid et al (2005) provide an overall outline of the key elements of IPA, the seven steps:

1. Reading and re-reading the interviews
2. Initial noting
3. Developing emergent themes
4. Searching for connections across emergent themes
5. Moving to the next case
6. Looking for patterns across cases
7. Writing the analysis

Although this overview is useful it provides limited perspective on the process of interpretation and analysis in IPA, which is dynamic and iterative, moving back and forth between the data, with the meaning of the text being made at a number of different levels. This naturally involves a dynamic relationship between the part and the whole.

After consideration of a number of authors' approaches to IPA analysis, I formulated my own approach as summarised in Table 14. This is based predominantly on the work of Smith and Osborn (2003), and adapted from Kempster and Cope (2011) with slight modification (see blue text). The process summarised in this table is now explained in more detail in the next sub-section.

Table 17: Levels of interpretative phenomenological analysis (Adapted from Kempster 2010 and Cope 2011)

Process of analysis	Level of analysis	Description of analysis
Familiarisation/ gaining insight	*Reading of the case*	Reading and re-reading the transcribed interview whilst listening to the recording to gain an appreciation of the whole story and recall of the interview at both a cognitive and affective level, thereby becoming 'intimate' with the account (Senior et al 2002). Memos were written to note initial issues (Patton 1990).
Immersion and sense-making	*Initial appraisal of the case*	During this process of immersion and sense-making, a 'free textual analysis' (Smith and Osborn 2008) was performed, where potentially significant excerpts of text were highlighted. Building out from Hycner's (1985) technique, exploratory notes were made beside these excerpts.
Categorisation	*Developing intra-case themes*	Based on the process above, units of meaning were identified in relation to each of these significant excerpts and these were colour coded throughout the transcript. These units of meaning were formulated as relatively concise phrases such as "maintaining underpinning nursing values". These comprised the emergent themes for each interview and were compiled on a 'master-theme list' (Smith et al,1999) for each transcript. A brief summative narrative analysis was also made for each transcript.
Association/pattern recognition	*Developing inter-case themes*	With stages 1-3 completed for all interviewees, a meta-level analysis across the cases was conducted. This was done separately for the foundational, recursive and expansive interviews respectively. The master-theme lists were compared to identify and explain similarities and differences, thereby creating 'links' between accounts. This involved looking for shared aspects of experience, creating categories that aggregated themes from across the accounts (Smith et al 1999)**.** The most inductively derived categories were deemed "Theme Clusters". In turn these were organised under higher level overarching categories informed by both the emergent findings and the main study questions. These were deemed "Superordinate Themes".
Interpretation/ Representation	*Writing up*	This stage of analysis involved a formal process of writing up a 'narrative account of the interplay between the interpretative activity of the researcher and the participant's account of her experience in her own words' (Smith and Eatough 2006 p.338). This approach is evident in the presentation of findings in Chapters 5-7. To maintain an inductive, phenomenological approach at this stage findings were written up from the data without the use of any relevant academic literature, to some extent allowing the data to 'speak for itself' (Cope 2005b). Although the emphasis was on conveying shared experience, the process in Chapters 5-7 also allows some of the unique nature of participant experiences to re-emerge (Smith et al,1999). This is further developed in Chapter 8 where two individuals' experiences are presented in order to give contrasting insights.
Explanation and abstraction	*Enfolding literature*	During the analytical discussion of the data (Chapter 9) the theory-building process of 'enfolding literature' was conducted, which is required to produce a theoretical explanation at a higher level of abstraction (Eisenhardt 1989). Hence, the research was phenomenologically grounded but also interpretative and hermeneutic (Berglund 2007 and Seymour 2006). This involved an iterative and comparative process of tacking back and forth between existing theory and the data (Yanow 2004), whilst remaining sensitive to the unique situated experiences of the participants.

4.6.1 Reading of the case

The starting point for analysis was full transcription from each audio recording. This took place as soon as possible after each interview, although inevitably there was some backlog dependent on other concurrent commitments. Each transcript was read as a whole to check for accuracy, then re-read and listened to at the same time on two occasions (Groenwald 2004). This provided immersion in the data that helped recall of observations such as non-verbal language that were part of the interview process.

4.6.2 Initial appraisal and developing intra-case themes

Analysis of data took place as soon as possible after each interview. As an IPA researcher I was an active participant in the process bringing meanings into the light (Pringle et al 2010) by analysing themes and interpreting the data (Flowerday & Schraw 2000). The process of analysing the transcripts began with a free textual analysis (Smith and Osborn 2008), identifying potentially significant excerpts of text which were highlighted. Building on Hycner's (1985) technique, exploratory notes were made on the right hand side of the page adjacent to transcript text.

Units of meaning (created through relatively concise phrases) were identified in relation to each of the excerpts and then colour coded throughout the transcript. These comprised the emergent themes for each interview and were noted in a margin at the left of the transcript (Smith et al 2009). Appendix 7 provides an example of this process in relation to one of the foundational interviews where the emergent themes in these excerpts often reflected particular nursing values. Explanatory notes were part of the process. These emergent themes were then compiled on a ‘master-theme list’ (Smith et al 1999) for each transcript. Based on these themes, a brief narrative summary of each interview was produced in order to try to capture how each individual made sense of the world and their experiences (i.e. focusing on the idiographic). These summaries inform the more expansive accounts of two particular cases presented in Chapter Eight.

4.6.3 Developing inter-case themes

Although generalisation is not the function of IPA (Malim et al 1992) commonalities across accounts provide useful insights (Reid et al 2005). A cross case analysis was undertaken for each of the sets of interviews respectively (i.e. foundational, recursive and expansive). Graphic representations of the outcomes of these analyses (i.e. maps of cross case themes) are given at the start of Chapters Five, Six and Seven respectively.

Firstly the themes listed in the margins of each interview analysis were compiled, colour coded, referenced and transposed onto spreadsheets, enabling the identification of emergent TCs across the interviews undertaken in each phase. Returning to the original transcripts to verify understandings also facilitated further collective interpretation (Smith et al 2009). "Putting like with like" (Smith et al 2009 p.114) helped the distillation of the main TCs. An example of the outcome of this process was that the emergent themes from one interview, shown in Appendix 8, ended up informing the creation of a TC for the foundational and recursive interviews labelled "Integrating nursing values" (see also Diagram 2, Chapter Five). Appendix 9 gives insight into the contribution of the recursive interviews in inter-case construction.

This process evidences the hermeneutic circle of "constantly and dynamically moving between the part and the whole" (Smith et al 2009 p.116). The approach shares similarities with other well recognised qualitative techniques such as discourse analysis (Burman and Parker 1993, Potter and Wetherell 1987, Willig 2003) and narrative analysis (Murray 2003, Riessman 1993).

As a rule of thumb, the emerging TCs were chosen as representative of the whole group if they were present and recurrent in at least a third to a half of the interviews (Smith et al 2009 p.107) in each phase.

Appendix 10 shows the TC called "Role Complexity" which was formed from a number of different interviewees (and CHPs) during the recursive phase.

The TCs were inductively derived across interviews. In turn these were organised under higher level overarching categories informed by both the emergent findings and the main study questions. These were deemed Superordinate Themes (STs). Again examples of these are evident in Figures 2, 3 and 4 respectively (theme maps).

As analysis took place over time and over the three main phases of the empirical study, sometimes what was considered a TC in one was deemed a ST in another. Appendix 10 shows how role complexity was such a prevalent and strong theme across the expansive interviews that it came to be a ST.

4.6.4 Triangulation and development of analyses

To reprise: the foundational phase of the study focused on participants from one region within Scotland in 2009. The expansive phase included two additional regions of Scotland in order to capture a wider perspective of the CNMM experience. The recursive and expansive phases were conducted two years following the foundational phase, commencing in 2011. This provided the opportunity to investigate the same phenomenon and compare different data sources via triangulation and enhanced rigour by the sampling and inclusion of CNMMs from different locations (Gray et al 2011).

As detailed above, the collection of data on more than one occasion over a specified period of time, along with the introduction of new participants, fulfilled triangulation characteristics (Molloy et al 2002). This added to the strength of the design as it provided opportunity to collect “atypical data or the potential of identifying similar patterns, thus increasing confidence in the findings” (Thurmond 2001). Three types of data sources are time, space, and person (Denzin 1989) and the method included all three.

Similarly, the analysis was not a linear process, being recursive moving back and forth throughout the phases over the timespan of the study (Ely et al 1997, b). However, forward momentum was maintained. Themes were carried forward from

the first participant account, built on and added to (Smith et al 2009) and enhanced by subsequent accounts in different phases. As already mentioned, graphic representation of the findings from the foundational phase (see Figure 7, Chapter Five) were shared with participants in the recursive and expansive phases. The aim was to ascertain if the recursive and expansive phase participants perceived the foundational phase themes to be meaningful and coherent with their perceived experiences in order to further obtain deeper understanding of the phenomenon. Sharing foundational findings with participants in this way illustrates transparent and flexible working between interviewer and participants (Smith et al 2009) in identifying and interpreting relevant shared meanings to make sense of the topic (Reid et al 2005). STs and TCs were further interpreted and developed in subsequent phases, with the foundational phase ST, & TCs being utilised as a yardstick to aid deeper analysis across time and different Scottish regions. The construction and naming of these themes required considerable interaction with the data to reflect the context of participant's narratives, often reflecting specific words, phrases or metaphors found in the data.

4.6.5 Presenting the findings

The four findings chapters give insights into these themes via transcript excerpts. In some cases the extracts were chosen as being typical of perceptions and experiences reflecting the identified theme. Others were chosen due to the rich use of language, emotion or metaphor to capture concepts. Illustrative extracts which were complex and contradictory were also identified and included. To avoid being overdrawn from a small cluster of participants these exemplifications were evenly drawn from across each cohort as much as possible (Smith et al 2009).

The analysis was interpretative not just descriptive, and some interpretative commentary is woven through the presentation of findings. This reflects engagement in the double hermeneutic i.e. trying to make sense of the participant trying to make sense of their experience. However explicit use of relevant literature for integrative sense-making is reserved for the discussion chapter.

The investigation was carried out over a four year period, producing breadth and depth of participants' insights, experiences and perceptions. The accepted principle of altering minor details in maintaining participants' anonymity and confidentiality was upheld. In keeping with the IPA method the findings are presented in a structured way, commencing with generalisation, followed by contrasting accounts of two individuals at the same point in their respective careers. The aggregated findings capture CNMM participants' "lifeworld" (Halling 1999) from shared features of their accounts of role enactment through change within CHPs. Many accounts were characterised by use of metaphorical expressions embedded in the narratives. Metaphors are useful tools for communicating and sharing experiences in reflecting perceived reality (Goodman 2001) and contributed to my understanding of the participants' world. Therefore a number of textual extracts feature use of metaphor.

By presenting the findings in this way we can move from the general to describe intrinsically interesting specifics, with the purpose of demonstrating existence not incidence (Smith et al 2009). The overall findings from the foundational, recursive, and expansive phase are each presented separately. Then, following the presentation of the two contrasting exemplar accounts, an integrative discussion chapter provides in-depth analysis and synthesis.

Ethical considerations as applied to the investigation are now discussed.

4.7 Ethical considerations

Practising research ethically entails a dynamic process that requires “sustained reflection and review” (Smith et al 2009 p.53). Ethical considerations not only shape and contribute to the study design, they are also evidenced later in the study findings where practitioner participants apply them to manage value-conflicts and resolve ethical dilemmas. Ethical codes are vital for professions in that they provide underpinning principles that guide behaviours to protect the public. The main aspects of ethics that applied to the study were: professional ethics of nursing, statutory codes and processes, legislative frameworks, the researcher/participant relationship when conducting research in the researcher’s employment context, protecting participants from harm/informed consent, sensitivity during the interviews, and maintaining anonymity and confidentiality. These are now elucidated further.

4.7.1 Professional ethics

Many professions including nursing employ ethical codes in terms of codes of practice and general sets of governing principles describing the type of behaviours expected. They are specific rather than the generic “do no harm” (Ellis 2007) principles and include:

- considering what is right in any given situation
- being able to recognise ethical issues in practice situations
- being able to resolve ethical dilemmas
- applying reflective ethical practice
- upholding the qualities of respect for others, their dignity and values, personal integrity and responsibility to others (Lester 2010).

4.7.2 Statutory codes and processes

The researcher/participant relationship in undertaking this investigation is set within context of the North of Scotland Research Ethics Committee and Robert Gordon

University ethical codes; and the NMC Code of Conduct. In addition the Data Protection Act (1998) has been taken into account regarding security of the data. Data has been treated to ensure that individuals cannot be identified. These collective perspectives on ethics, accountability and data protection matters were central to the study. NHS local ethics and RGU ethics committees were consulted to gain independent advice and approval on the proposal for this exploration to ensure that it met recognised ethical standards. The process involved submission of the research protocol, participant information sheet, and consent form, investigator and principle supervisor's Curriculum Vitae and attendance at a committee meeting to gain approval.

The Declaration of Helsinki explicitly requires disclosure of sources of funding to the research subjects (Williams 2008). Cohen et al (2000) propose that the responsibility of ethics lies with the individual researcher and needs to be addressed at the beginning of the research process. Although professional codes provide guidance, the responsibility for upholding them ultimately lies with the researcher. Therefore the participants were informed of the NHS and QNIS sponsors via the letter of invitation to participate. The researcher also attended a recommended training course which gave a thorough overview of the ethics approval process and Good Clinical Practice (GCP) applicable to all research on human subjects conducted in the NHS.

4.7.3 Legislative frameworks

Two main pieces of legislation are relevant to the study, The Human Rights Act 1998 and The Data Protection Act 1998. The Human Rights Act, Article 8 of the European Convention on Human Rights, (now part of the Human Rights Act Department for constitutional affairs 1998) states that, "everyone has the right to respect for his private and family life, his home and his correspondence." In addition, the Information Commissioner has also issued a code of practice, "The Employment Practices Data Protection Code", which is intended to assist employers in complying with the 1998 Data Protection Act and to establish good practice for handling personal data in the workplace. These therefore were applied to the handling of data

in terms of confidentiality by storing data in locked cabinets in secure premises and via encryption. The project was subject to a NHS Research and Development audit during its enactment.

As an NHS employee, researcher and a CNMM peer of the population under study I had “insider status” (Styles 1979). Although identified as an established position in carrying out qualitative research (Lieblich 1996), it required reflection on and consideration of the challenges and advantages of conducting research in my workplace.

4.7.4 Conducting research in the researcher’s employment context – challenges and advantages

As explained previously the approach to conducting this investigation was that of the researcher as “insider” in terms of being a CMNN, an employee of NHS Scotland, and conducting research within it. Literary work suggests that there are challenges and advantages in conducting research in your context of employment with polarisation of emic and etic perspectives common. McEvoy (2001) advises that it may be overly simplistic to portray the two positions as absolutes, citing the difficulties in classifying clear cut group membership. Limitations of an insider perspective were identified as including researcher objectivity in terms of shared experiences that may be taken for granted, the potential difficulties in questioning the characteristics of that “shared world”, difficulty for me distancing myself as researcher, and the potential for my group membership to limit me asking sensitive and probing questions (McEvoy 2001). However being conscious of such limitations alerted me to the aforementioned possibilities.

There were several practical advantages of conducting research within the workplace, including: the identification of research questions which arose from practice, convenience of time and location, recruitment of participants, need for evidence based community nursing management practice, and building research capacity.

I was also mindful of the advantages and disadvantages of interviewing colleagues. The advantages included gaining insight into a context that otherwise may not have been possible for outsiders, and enhanced understanding and interpretation of data due to shared experiences that could collectively contribute to gaining new insights. The disadvantages considered were: difficulties that there may be interrogating and probing colleagues in order to reveal implied understandings, questioning what may be perceived as established social practices and the potential that any truthfulness shared by participants may compromise future working relationships.

In defending the value of the insider's emic angle I argue that by virtue of the insight gained from being a member of a similar social world it was possible to read between the lines, attach meanings, and interpret participants' accounts that may not be so readily achievable from an etic position. Previous/insider knowledge and preconceptions do not necessarily invalidate a study as long as they are handled as transparently as possible. This is justified by the reflexive steps undertaken within the thesis, e.g. the RI.

4.7.5 Protecting participants from harm: informed consent

The preliminary and foundational phases of the study focused on CNMMs within one region of Scotland. The target population comprised all Health Board CNMMs with experience of the phenomenon under investigation (Groenwald 2004). Volunteers were sought via the Directors of Nursing acting as intermediaries. They forwarded a hard copy and email letter of invitation and explanation of the purpose of the study, consent process & form to the target population, contributing to the reduction of undue influence and vulnerability. The information letter also specified to potential participants what was required of them, how long their involvement would last, how the data would be used, and that their participation was voluntary with a proviso that they may withdraw from the study without giving a reason at any time during the investigation. Details and background of the researcher and supervisor were also shared. In addition to this information, the funders of the study were specified. This information was included with the consent form which the participant and the

researcher signed, dated and retained. Further approvals for the expansive phase were obtained from RGU and NHS Research Ethics.

The recruitment approach comprised purposive selection of an identified target population (Groenwald 2004), and subsequent voluntary self-selection. Taken together, the above processes ensured a basis for informed consent. In addition intermediaries had no knowledge of who contacted me and agreed to participate in the study.

4.7.6 Protecting participants from harm: sensitivity during the interviews

However, I was mindful that in obtaining consent from colleagues there was the possibility of participants being vulnerable due to perceived influence, or feeling obliged to participate, despite any reassurances given. I was also mindful that:

"Interviews can have a certain seductive quality. Participants may appear comfortable and may disclose information apparently willingly during an interview, but may later regret having been so open. They may also be left with feelings and thoughts stirred up by the interview long after the researcher has moved on" (Lewis 2003 p.68).

I was alert to identifying any discomfort an interviewee might show and occasionally the interview was paused, but a counselling role was not adopted.

4.7.7 Maintaining anonymity and confidentiality

Within this context, as with all research, it was important to maintain the anonymity and confidentiality of the participants. Participant anonymity and confidentiality was maintained by using only information pertinent to the research. Anonymity was achieved by the alteration of participants' names, and exclusion of CHP and Health Board names to overcome recognition by colleagues, friends or family. Confidentiality refers to information that is provided by the participant that should not

be disclosed. In addition, during interview, if the participant specified that there were certain comments that they did not wish to be included in the final transcripts, their decision was respected. Participants were provided with my contact number and that of my supervisor so that he/she could contact either at any time after the interview.

In presenting the findings in the next chapters, first authenticity is offered by letting the participants speak for themselves, they then becomes descriptive, followed up with preliminary interpretation, this process flows through each phase. Interpretation builds through literature as shown in Chapters Five, Six, and Seven, through to the nuances and particulars outlined in Chapter Eight via the exemplars with the collective interpretation presented in the discussions (Chapter Nine).

This iterative presentation style builds the “onion skins” based on Smith et al who offer a sequence of writing up that is not prescriptive (1996 p.114), and commences with Chapter Five.

CHAPTER 5: FOUNDATIONAL PHASE FINDINGS

5.1 Overview of chapter

Chapter Five presents the findings from the foundational phase, opening with participant and CHP particulars across all phases. This provides some insight into the general characteristics of the CNMMs and CHPs involved in the study. The detail was collated across the foundational, recursive and expansive phases. The material includes overall role descriptors and the distribution of these across CHPs and regions over the three phases. Participant profile information is also included such as where participants were recruited from, their gender, average age, number of years in post, main reasons for taking up the role and the qualifications they held at the time of interview.

The quotation system is then outlined with transcript quote codes presented. This is followed by an explanation of the foundational, recursive and expansive interview transcript codes in turn.

The foundational phase findings commence with graphically represented themes which are colour coded to aid overview of ST and TC findings. A more detailed account of findings from interviews is then presented structured around the themes that emerged and using narrative extracts. (A similar structure flows through reporting of all phases i.e. in Chapters Six and Seven).

The chapter finishes with a brief synthesis with initial referral to literature and conclusion section.

5.2 Role type in foundational, recursive and expansive phases

CNMM titles and role types were relatively diverse. A total of six broadly distinguishable roles were identified. They fell into the following types: Lead Nurse, Region Wide Manager, Service Manager, Generic Manager, Wide Generic Manager, and Nurse Consultant. More information is given about the first three of these types in the current chapter, while the other three are explained in context in Chapter Seven (reporting of expansive phase findings). The distribution is outlined below.

Table 18: Distribution of participant role types, foundational, recursive and expansive phases

Role	Abbreviation	Numbers of Participants Foundational Phase (CHPs 1-3)	Numbers of Participants Recursive (Return) Phase (CHPs 1-3)	Numbers of Participants Expansive Phase (CHPs 4-6)	Total Participant Interviews
Lead Nurse	L.N.	4	1		5
Region Wide Manager	R.W.M.	3	1		4
Service Manager	S.M.	11	7		18
Generic Manager	G.M.			4	4
Wide Generic Manager	W.G.M.			1	1
(Nurse)Consultant/ Lead	N.C			3	3
Total Interviews		**18**	**9**	**8**	**35**
Total Participants		**18**		**8**	**26**

5.2.1 Participant profile information

All participants were recruited to their posts from within the NHS. It is noteworthy that only one individual from the total study cohort had worked outwith the NHS, having been employed in the private sector for a short spell during their career. Likewise only one participant did not have a nursing or allied health professional background. The vast majority of participants were female, two were male and the majority were middle-aged. The number of years CNMM participants had been in post varied between three and 22 years with the majority fitting into the 10-15 year bracket. One was carrying out the role on a temporary basis at the time. The main reasons for taking up the role and level of qualifications also varied across the phases **(Tables 19 & 20)**.

Table 19: Main reasons for taking up CNMM role

Main reasons for taking up CNMM Role	Foundational Phase (CHPs 1-3)	Recursive Phase (CHPs 1-3)	Expansive Phase (CHPs 4-6)
"Fell" into role	8	5	0
Planned career progression	2	1	1
Encouraged by manager	2	0	1
Role taken up following restructuring	5	3	1
Succession planning	1	0	5

Findings from the foundational and recursive phases suggest that an ad hoc approach to CNMM career development and progression had been applied to CNMM recruitment, with minimal succession planning. However it could be interpreted from the expansive phase finding that a more planned approach had been applied to the recruitment of CNMMs within this cohort.

Table 20: Qualification variation

Qualification variation	Foundational Phase – 19 participants	Recursive Phase – 9 participants	Expansive Phase – 8 participants
Basic registration	**18**	**9**	**8**
Diploma	10	2	0
BA	5	5	1
BA Hons	2	1	2
Masters	1	1	5
PhD	0	0	0

It can be seen that the proportion of CNMMs interviewed in the foundational and recursive phases with higher level qualifications such as honours or masters degrees was relatively lower than the proportion of CNMMs interviewed with higher degrees in the expansive phase.

5.2.2. Description of sites, regions and CHP characteristics

As already mentioned in Chapter Two, section 2.5.3, CHPs were introduced across Scotland to manage a wide range of local health services. There are 14 regional Health Boards, 34 CHPs and 32 regional councils in Scotland. Of the total CHPs in Scotland, eight (23.5%) were included in this investigation. They collectively served a population of 1,525,495, with 225 GP practices or health centres. The Scottish Government Community Health Partnerships Statutory Guidance (Scottish Government 2004) stated that partnerships would evolve according to local circumstances, and the healthcare needs of the population. In other words there was no one statutory model that CHPs were required to follow.

Many of the CHPs worked conterminously with local councils i.e. sharing geographical boundaries. Most had responsibility for community hospitals, with some having the regional lead responsibility for a specific service. Two CHPs were situated

in urban areas, the others were mixed representing medium/small towns and rural areas. CHPs were found to be diverse with differing structures and service delivery to fit local healthcare needs. These characteristics are covered in my sample of the participating CHPs within the three regions of Scotland and across all phases.

A general explanation of graphic representations of findings and transcript quote codes for all phases of the study now follows.

5.3 Presentation of transcript quotes codes

The text of this thesis is recorded in Arial 12 font. Participant quotes are differentiated from the main text by the use of italics within inverted commas. Interviewer quotes are differentiated by the use of bold italics e.g.:

"Participant"

"Interviewer"

Significant auxiliary communication such as laughter is bracketed and recorded in bold Arial 12 font e.g.:**(laughter)**

The quote system, which differs to identify distinct phrases, is outlined below:

Foundational Phase Interview transcript codes:

Participant Cypher, Phase Code, Role Descriptor, Community Health Partnership Code, e.g. Emma, F., L.N., CHP 3.

Explanation of Recursive and Expansive Interview transcript codes:

Participant Cypher, Phase Code, Role Descriptor, Community Health Partnership Code, e.g. Amy, R., (or E) S.M., CHP 1.

R.W. - Refers to a Region Wide Role.

5.4 Foundational phase findings: Superordinate Themes and Theme Clusters

The foundational phase involved exploring CNMM experiences and perceptions of role enactment through change in 2008 within one region of Scotland and involved three CHPs. In doing so it sought to capture the meanings attributed to their experiences of role enactment through processes of change within the CHP context at that point in time. The foundational phase comprised 18 interviews.

The foundational phase themes are graphically represented in the following page (Figure 7) and subsequently by a more detailed account of findings via narrative excerpts.

Figure 6: Colour code descriptors - foundational phase:

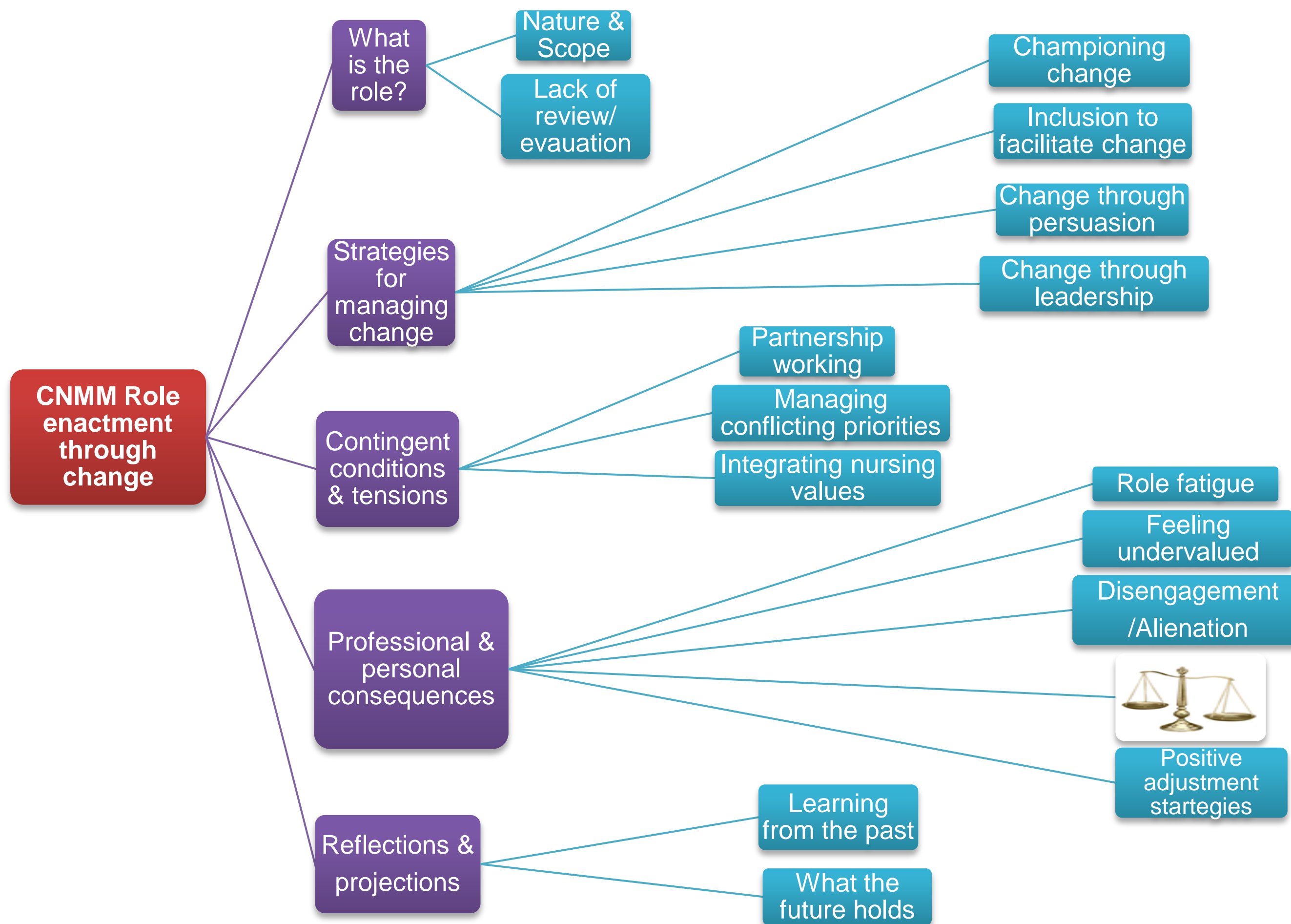


Figure 7: Graphic representation of foundational phase findings

As can be seen themes emerged from the transcripts, with STs and TCs identified. Five STs and fifteen TCs were identified relating to CNMMs perceptions of how they enacted and experienced the role. ST 1 identified what the role was. TCs included the nature and scope of the role. ST 2 indicates strategies used to manage change and related TCs include championing change, inclusion to facilitate change, change through persuasion, and change through leadership. ST 3 comprised of contingent conditions and tensions CNMMs experienced whilst enacting their role, with TCs of partnership working, managing conflicting priorities, and integrating nursing values (Appendix 15 gives an example of an analysis).

These tensions were perceived to contribute to professional and personal consequences including role fatigue, and feelings of being undervalued, which had led to feelings of disengagement and alienation in some instances. CNMMs indicated that they used positive adjustment strategies to balance role challenges. Finally CNMMs reflected on what they had learnt from the past and predicted what they perceived the future might hold for the role, CHPs and the NHS.

5.5 What is the role?

5.5.1 Nature and scope of role

The Lead Nurse:

Lead Nurses described having a wide professional leadership role across community nursing disciplines, including the acute setting in the community i.e. community hospitals. A leadership role with some management responsibility were felt to be the main components of the role:

"Er, em, I'm Lead Nurse for an area covering Acute and Primary Care, so it's all nursing within the area and em ... I have within that, I, eh have professional lead for the whole CHP. So anything associated with nursing, it comes to me. So, there's' strategic responsibilities as well as operational. I do line manage as well, certain members of staff and I also have a portfolio within that includes taking a lead for child health, child protection as a whole, so I've got a portfolio as well as a clear strategic role..." Isla, F., L.N., CHP 3.

The Service Manager:

Service managers comprised the majority of the foundational phase participants managing varied groups of community nurses. Compared to the lead nurse role, the converse appeared true of Service Managers whose management responsibility rather than professional lead was the main feature of their role, although some also had a profession specific lead role within some CHPs:

"Emmmm ... Just that I am managing ... quite a lot of different services ... and they can be across many service departments, so they can be within hospital services, community hospital, they can be community nursing and midwifery, they can be children's service and I manage services across all of these in a community health partnership area and ... emm ... that can be quite complex". Helen, F., S.M., CHP 2.

The Regional Manager:

The regional manager had a wide regional role identifiable to an explicit speciality that included training nurses, mainly within the community, and some within acute

and partner agency settings. They managed small teams that included administrative support to deliver the particular speciality:

"Lead the development of clinical specialists, specialist clinics. Working closely with physiotherapist, specialisms, you know? Development of guidelines, policies, making sure they are, with any research, kept up to date, We are also involved in procurement as well, looking at the products that come into NHS, so we can show we have got value for money the products that they use are effective do the job and there is not an increase in infection rates because of what we are using. That's nationally for Scotland as well." Marie, F., R.W.

5.5.2. Lack of review/evaluation

In addition to the above there was a feeling that as CNMM roles and remits had grown there had been little or no review of their nature and scope:

"... I think that's maybe part of the thing we need to look at, is to re-evaluate the roles, because, you know, that hasn't happened since we started and, eh, just, add on and add on. I don't just do things for the CHP, I'm involved in regional-wide groups and initiatives as well... ". Alice, F., S.M., CHP 2.

Another CNMM perceived lack of review of size and scope of the role centred around not being included in the decisions made about role expansion, with implication of a control/command style employed and no genuine engagement by line management:

"... again this is where I think they need to consult they need to they need to consult with everybody find out how people really feel ***mmm,*** *it's not again to sit in the ivory tower saying this is the way it'll be* ***mmm*** *but to remember there is people doing the work and they have to be consulted and say yes or no and they have to be listened to when they say yes and no". Emma, F., S.M., CHP 1.*

Moreover there was an element of role unpredictability that had to be accommodated:

"I mean historically, they haven't dropped anything off of the end, emm ... I think just we keep absorbing and taking on more roles. I mean, you just never know what else is going to come in from the left side" Anne, F., L.N., CHP 2.

Many CNMMs viewed the role as becoming unmanageable due to lack of review, time constraints, financial pressures, the demands of meeting targets within unrealistic timescales and the increasing pace of change. They felt that increased responsibility had contributed to workplace stress:

"I think the pace of change is *accelerating, I don't know that it could accelerate much more actually, because when you look at all the work that's going on, it's very hard to pinpoint an area that's not going through some sort of change, so I don't know that the pace of change could speed up much further ... and I'm not alone in that feeling, from speaking to colleagues in management, team leaders within the team."*
Rosie, F., S.M., CHP 1.

"It is unwieldy, totally unwieldy, and some things you can change very successfully and very quickly, other things , it's a drip, drip, effect that you might have your, with me at the moment there's not so much time constraints as there once was because there's not the finance , I know that. Em, if you've got targets or time targets rather than any other targets that's harder coz there is a pressure on, as the leader of that project, to get it going and then it does come probably even more unwieldy, it gets more out of control". Matt, F., S.M., CHP 2.

The situation was captured by another CNMMs use of metaphor of role enactment through change and the perceived consequence:

"Senior managers and politicians have to remember that if you put too much food on a plate or too many books on a bookshelf, things are bound to fall off, it's the risk that that creates." Rosie, F., S.M., CHP 1.

Common across participants from all role types was the feeling that the widening role had led to CNMMs working additional hours above their contractual agreement:

" I do work more hours than I'm contracted to, and I think most managers do and you know people will say you are never away from this place." Mary, F., S.M., CHP 1.

"I know I am paid for 37.5 hours but probably 42 to 45 hours a week is the average" Matt, F., S.M., CHP 2.

The following excerpt represents a widespread view of a lack of support from CNMM line management:

"… when sometimes you see people getting clinical supervision in other areas, you think that would be quite a nice thing to have here for us, and we don't have. We teach everybody, you know, you should do this, you should get clinical supervision in place, you should debrief professions, stressful events, we don't do any of that, you know, so there isn't that same level of support..." Liz, F., S.M., CHP 2.

However this CNMMs experience was different:

"I've got a good line manager, em, she's very supportive, she's on the end of the phone, you can email her, em nothing's too much bother, she's a very good leader, she's em somebody to aspire to and I hope that I would aspire to staff that I'm managing but she's somebody to aspire to, em, listens, I hope I listen as well". Angela, F., R.W.

5.6 Strategies for managing change

5.6.1 Championing change

Individual and group sense making as a concept was outlined by many CNMMs as a process they used to implement deliberate strategy. They felt it facilitated understanding and adaptability within teams even if the policy being implemented was not congruent with their own beliefs. The majority of CNMMs implied that they enacted their role by first making sense of SG/CHP directives followed by interpreting and identifying their perception of what it meant. They then synthesised the information, shared and communicated it to teams to raise awareness of relevant key elements of policy. They felt that this aided understanding and contributed towards trust:

"*I think it's communication, it's influence ...* ***Yeah*** *... and it's getting them to believe and trust in you and what the benefits of this will be". Isla, F., S.M., CHP 3.*

Another highlighted the tension of change that was felt to be incongruent with personal beliefs:

"... it's not always you agree with it, but you still have to, manage change through that". Jessica, F., S.M., CHP 1.

Strategic government documents driving change were seen by several CNMMs to create communication obstacles for operational staff:

"I find that jargon is the one thing that will put folk off, some of these policy documents are easy to understand and read whereas the strategic documents coming out from wherever can be a minefield". Isla, F., L.N., CHP.

5.6.2 Inclusion to facilitate change

Many CNMMs portrayed themselves as consultative & participative. Inclusion to facilitate change was seen to be an important factor in managing change along with

coaching & leadership. There was reference to the way that CNMMs encouraged members of the team to contribute to managing SG strategic change and was indicative of management and leadership skills:

"I might arrange to meet with a group of key people that the change would affect, and, as I said to you earlier, I would discuss the change that we proposed and see what they thought, whether they thought it was a good idea." Emma, F., S.M.,CHP 1.

"... get everyone involved at the outset, and don't exclude anyone, coz I think certain people have been excluded from this process." Joyce, F., S.M., CHP 2.

The reverse was believed to be true by this CNMM who recounted her experience of applying a non-participative approach:

"I was told to make this change, so I made the change, but I didn't take anybody with me, I didn't do the negotiation, I didn't explain it ... eh ... it was just implemented, emm ,and as you can imagine ***(laughter)*** *... It didn't go very well!" Sam, F., L.N., CHP 2.*

5.6.3 Change through persuasion

Many CNMMs perceived that they applied skills of persuasion by focusing on quality to manage change:

"I think with any change process as well that's within nursing, with any change process, you've got to focus on quality, patient safety, You've got to focus on key, em, benefits of whatever you're trying to do here, you know if you're looking at a dressing, community nursing, you know, if we haven't got enough nurses or this that and the next thing, but people don't engage well with that, they don't see that as their issue, it's your problem. But if you're focusing around quality of patient care, then that's when you'll get peoples' attention". Iona, F., S.M., CHP 2.

This involved the targeting of key individuals open to change:

"... selling it to the folk that actually will see the benefit of the change, rather than just to everybody, maybe it is just to specific people that you'll say this change will actually benefit you, and the people around you, but further along it will benefit him, him and him. So, I think if you sell it locally to the people it effects first, then that feeds out, I suppose, into other avenues and up the chain, it goes up as well." Jeff, F., S.M., CHP 3

Timing was seen by many CNMMs as an important element in role enactment to manage change:

"Because change is so big, and so rapid you sometimes don't get much opportunity to say, 'Right, I'll put that change on the backburner for six months and instead I'll concentrate on another change', because if you do that you almost miss the boat." Laura, F., S.M., CHP 1.

5.6.4 Change through leadership

The majority of CNMMs claimed that they used management & leadership behaviours & skills concurrently to move teams forward. They revealed that both functions blur & overlap. In addition an engaging management style was implied by several CNMMs in their descriptions of their utilisation of an open manner to generate a collective vision:

"I think there's no point in inflicting change on people – you've got to take them with you, I think you have to have a very clear vision of where we're going ... ***yeah, yeah*** *... I think that's the big thing about change". Helen, F., S.M., CHP 2.*

Inclusivity was part of the collective vision, as evidenced by this analogy:

"... it's like a house you start with the foundation you work up, you don't start at the roof and work down. So if you start from the ground and you start asking the right questions you're going to build a really strong house, and you'll get something from there and it doesn't need to be one house it can be one house

with many rooms and in that room everybody's got their own right but they still, as a family, they're altogether in one, one house and that's, that's one way of looking at it". Emma, F., S.M., CHP 1.

Another CNMM conveyed an image of summoning, rallying and encouraging teams and individuals to advance the vision:

"... try to identify when these things come up, give them a shout, get them to go forward, support them if they want help with their application, you know, whatever they need to do to take that step, emm, and I give them opportunities to go that way." Helen, F., L.N., CHP 2.

5.7 Contingent conditions and tensions (professional/personal)

5.7.1 Partnership working

These transcript excerpts outlined CNMMs work with and across inter-professions, departments, and partner agencies, to collectively contribute to government targets. This demonstrated a linking or spanning function. Challenges of, and misunderstandings about partnership working, were often outlined:

"We're now involved in community planning and also expected to work with councillors and attending all planning meetings, em ... and also develop new services, manage existing services and obviously trouble-shoot daily operational issues." Alice, F., S.M., CHP 2.

"We have to look at stake-holders and we've got to look at the public and how we actually em, sell change and ask their opinion about change, so I've been involved quite a lot in public participation. You just can't make something happen – you really need to work in partnership – you need to work in partnership with everybody that's involved and I don't think that sometimes people understand that". Laura, F., S.M., CHP 1.

The use of idioms by this CNMM gave the impression of being in a vulnerable position when there is a notable amount of threat through political scrutiny:

"I was trying to change this ... I started to get letters from MSPs, ***mmhh,*** *saying that ... you know ... there was great concern about this ... I'd no right to move it ... So you had a fight with ... well not a fight ... they're watching us like hawks, and very close association with MSPs, Politicians and Councillors and anything you change ... So, you know, I think, to walk into it is really like walking into a lion's den when you are faced with a room with, you know, some of the public consultations we did, and hecklers ... you know, really, we weren't treated very civilly in some areas" Alice, F., S.M., CHP 2.*

5.7.2 Managing competing/conflicting priorities

Typically, differing priorities and agendas were seen to create tension for these CMNNs:

"there is too many competing priorities I really think, that's the thing that drags away people's energy ... there is just so much, there is just so much at any given time... " Claire, F., S.M., CHP 1.

"I am getting pressurised to make sure we hit the target around KSF [Knowledge and Skills Framework] ... *I am having to pressurise my staff to do that, and that's very hard given that's not the only thing we are asking them to do at the moment ... we are asking them to do new things all the time ... and we don't have the resources". Joyce, F., S.M., CHP 2.*

"... it is trying to kind of please everyone". Marie, F., R.W.

Again, the use of metaphor was prominent to explain the challenges involved:

"It's like juggling all your balls all the time, you just have to make sure that you don't drop one, or if you do it's a deliberate drop emm ... so that you can absorb something else that is coming in". Iona, F., L.N., CHP 2.

5.7.3 Integrating nursing values

Many CNMMs suggested that they enacted a type of crossbreed management role, as manager, leader and professionally. They felt that they were working within two opposing sets of values, those of caring and monetarism. This engendered tensions between service provision to individuals and families, corporate concerns, and CNMMs professional and personal values:

"It can get very difficult because we've been in efficiency savings for so many years and we keep having to save another 1% another 1% and another 2 and you find,

now, where do you stop, where do you go from here, I mean if you want the quality of service that we hope for? " Isla, F., S.M., CHP 3.

"I think that making sure they (teams) are not ... .overburdened it, is, close to my heart and I think that's because I was a nurse". Matt, F., S.M., CHP 2.

5.8 Professional & personal consequences

5.8.1 Role fatigue

As CNMM roles continued to expand, perceived internal conflicts & tensions emerged as a consequence:

"… what I'm feeling is that, within the NHS, I don't have time to plan and execute things in as detailed a way as I would like and land up really ... what I've described almost becomes aspirational, and what you land up doing is skimming the surface, ***mmhh,*** *and doing just enough to get you by, and move on to the next phase." Helen, F., L.N., CHP 2.*

"... if you are really busy, how do you take time to get your mind round working in a different way, when you are fire-fighting, and that's actually what's happening in a lot of cases. People out there are crisis managing, and fire-fighting, and so they are unable to stand back". Claire, F., S.M., CHP 1.

"You get burnout, you get staff going off with stress, and you just think we're meant to be a supportive caring organisation and we're not supporting or caring for our staff". Alice, F., S.M., CHP 2.

5.8.2 Feeling undervalued

These CNMMs reported feeling underrated and lacking visibility and leadership which had led to discouragement:

"I think, you know, it's also, when you work in the NHS ... we're fed up of it actually, ***(laughs)****, em, and with successive governments, maybe with a government that we've had for a long time, and you just feel that you are meeting the targets, you know, you are doing everything you possibly can, and they change goal posts and I think there is a lot of despondency about that now". Jeff, F., S.M., CHP 3.*

“I was at a health board meeting a couple of months ago, and I came away just depressed because they had these really good people. I knew they were really good they were leaders, innovators, and because they weren’t being led themselves they were just being squashed. And you could see them just getting so demoralised, I ... just found it heart breaking, because they were all people who had the service user at the heart of what they wanted to do.” Marie, F., R.W.

5.8.3 Disengagement/alienation

This perceived negative atmosphere resulted in several CNMMs reporting that they or their colleagues were considering or deciding to retire early:

“... this is actually making them think about, “I think I just want to end my career now”. So the anxiety for some has been awful and almost unmanageable for some people uhuh.” Laura, F., S.M., CHP.

“I am leaving at the end of the year I am sort of disengaged from that ... I think ... .if I am being honest”. Mary, F., S. M., CHP 1.

5.8.4 Positive adjustment strategies

In order to survive other CNMMs felt that they applied coping strategies such as acknowledging emotions, use of humour and focusing on positives with some disengaging. However it was of note that little explicit reference was made to support mechanisms such as organisational structures, supervision, training and autonomy:

“... sometimes you have to laugh about, and sometimes we have been in tears, because it really has affected us, because we are here to do a good job trying to maintain a high standard of care”. Marie, F., R.W.

“You reflect back on the good bits and take that with you because if just take the negative bits there’s no point in going on, there’s no point in leading and managing, there’s no point of trying to get on in this organisation ***(laughter)”.*** *Angela, F., R.W.*

5.9 Reflections and projections

5.9.1 Learning from the past

CNMMs reflected on what their perceived learning from their past experiences in enacting the role and what the future may hold:

"I think that's the big thing about change – have a clear vision – have a timetable, ***yeah,*** *and act on that timetable. As soon as things start getting waffly, you lose it. The anxiety grows for everybody, and you get nowhere, and then it grows arms and legs, and it doesn't work". Jessica, F., S.M., CHP 1.*

"What did I learn? Em, I think tolerance." Angela, F., R.W.

5.9.2 What the future holds

Participant predictions of the future varied, but there was a majority view that the CNMM role would continue to be demanding requiring support:

"... you do, want to deliver a gold standard service but you are forced to recognise that at times you can only deliver bronze. Well it is hard and it's going to become even harder, I'm sure of that in the coming years". Rosie, F., S.M., CHP 1.

"I think it will continue to be very, very challenging ... I think we need to get better about succession planning. I think we need to build into our structures the ability for people to come, and work alongside, and shadow each other, so that they get a better picture of what's going on, because you can look at an organisation, and think, now top heavy with management, but there are often cases I don't think they are, em ... I think we've got to give people the opportunity to see what it's like."
Emma, F., S.M., CHP 1.

Many CNMMs acknowledged that whatever the future holds, NHS funded comprehensive education would be a requirement to ensure that the role will be fit for purpose:

"I actually think it should be a prerequisite for nurses at the end of their training to do a shared module, community nurses, a shared module with social workers, and police there should be a shared module between them all that they do at the university, to show them that they can work together". Anne, F., S.M., CHP 2.

The hermeneutic inter-subjective approach of making sense of how participants made sense of their experiences is now outlined via a short synthesis of the foundational phase findings supported by initial reference to literature. This method provided a means of identifying the main points of my initial interpretation which in turn influenced and contributed to a preliminary conclusion. Carrying out the method in this way identified how the investigation could further progress.

5.10 Foundational phase: synthesis of findings with initial reference to literature

The theme concepts in this phase provided a foundation to build on over the course of the investigation. The themes are provided below in table form for ease of reference, followed by discussion of findings in greater detail.

Table 21: Foundational phase Superordinate Themes and Theme Clusters

Superordinate themes	**Theme clusters**
What is the role?	Nature and scope, Lack of review/evaluation
Strategies for managing change	Championing change, Inclusion to facilitate change, Change through persuasion, Change through leadership
Conditions and tensions	Partnership working, Managing conflicting priorities,
Professional and personal consequences	Role fatigue, Feeling undervalued, Disengagement /alienation, Positive adjustment strategies
Reflections and projections	Learning from the past, What the future holds

The CNMM role type varied as outlined in section 5.2. Individual CHP type was felt to have influenced the assortment of CNMM role and responsibilities. CHP structures were viewed as changing frequently in response to organisational modification for example restructuring in response to SG directives, which had consequently moulded CNMM roles and role enactment.

Although the individual roles of the study population varied, from the analysis it was found that in enacting change, the majority of CNMMs applied a project approach to role enactment through change (Bate et al 2004). Many CNMMs viewed their role as expanding, fluid & flexible to benefit the organisation (Linstead and Thomas 2002). All reported having experienced additional aspects added to their role and remit but

felt that this was inadequately reviewed in terms of manageability. CNMMs perceived their workloads were continually increasing creating feelings of overload. Concerns were expressed regarding accompanying risks such as employing a reactive management style described by many as “fire-fighting”, with some indicating that they were feeling role fatigue. CNMMs implied that these risks were due to working additional unpaid hours, perceived work overload and some feeling that they weren’t coping, describing experiencing stress and disengagement.

All CNMMs perceived that role enactment was driven by translating government, board & CHP decisions into team actions. Conversely CNMMs perceived that they were without real power in terms of influencing change, alluding to the role being semi-autonomous as a consequence. The majority attested that they championed change by persuasion through sense making. Most felt that enacting the role in this way facilitated adaptability in teams to implement deliberate high level government strategy. In addition several CNMM accounts suggested that they were acting as “change intermediaries” (Balogun 2003). There was indication that in order to initiate and maintain good team working relationships, SG directives and information were synthesised by CNMMs and communicated in forms which they believed aided understanding for teams and individuals. Some implied that teams had little time for this because of team workload, implying that they understood their colleagues/NHS employees work circumstances. In enacting their role, the majority of foundational phase CNMMs cited that team inclusion along with coaching & leading change was important. The vast majority portrayed themselves as consultative & participative through change processes, which is consistent with Stoker (2006). Alongside this, many CNMMs implied that they worked in partnership across inter-professional, inter-departmental, and partner agencies, to collectively contribute to government targets. Several CNMMs intimated that they bridged multi-agency boundaries, similar to Floyd and Woolridge’s (1997) description of middle managers as “boundary spanners”.

Leadership skills such as influence, communication, and motivation appeared to have been applied by CNMMs in facilitating change, along with emotional & relational integrity, described as emotional intelligence (Huber 2010). This indicates

overlapping of management & leadership skills to accomplish set goals. Several CNMMs felt undervalued.

CNMMs experienced role expansion in what was perceived as a contracting but exacting environment, with more to be done with less. Many felt internal conflicts and tensions emerging citing the demands of competing priorities as an issue. In addition, some perceived that there were conflicting partner agency agendas along with SG competing policies & targets. Such tensions appear to be inherent in the middle of organisational structures (Currie 1999 and Ainsworth et al 2009). Furthermore, all suggested that a target and financially driven NHS caused pressures which were felt to compromise value systems and quality patient care. Participants were trying to work within two sets of opposing values which had led to strain between service and corporate concerns and personal values, additionally CNMMs experienced being crossbreed managers. This is described as "hybrid management" (Hewison 2002).

Many CNMMs seemed to experience tension between their core humanistic values of the nursing profession and the adoption of private sector values perceived as driving current government policy.

Nevertheless in order to survive all CNMMs felt they used coping strategies such as the use of humour, focusing on positives, with a small number planning to leave the NHS as their way of coping. It is of note that little explicit reference was made to support mechanisms such as organisational leadership, structures, supervision, training and autonomy or the use of occupational health or HR departments for support.

5.11 Foundational phase: conclusion

The majority of participants in the foundational phase perceived they were operating within such constraining financial limits that they felt that role enactment through change was becoming more challenging.

These findings identified the need to further examine the complexities of the CNMM role and function to gain more critical purchase on how, as a population, they may be supported and developed (Meinhardt & Metelmann 2009) in order to reduce stress and add value to NHS CHP organisations and ultimately care delivery.

This reinforced the value of the idea to return to participants over a timespan (the recursive phase). My rationale was that change is historical, contextual and processual. It is historical because it interconnects horizontally through past, present and future time. T.S Elliot eloquently captured this notion:

“Time present and time past
Are both perhaps present in time future
And time future contained in time past”
(T.S. Elliot 1967).

Indeed as already explained, the methodology was designed to reflect this by returning to the foundational participants in the recursive phase, the findings of which are presented in the following chapter.

CHAPTER 6 RECURSIVE INTERVIEW FINDINGS

6.1 Overview of chapter

Chapter Six presents the findings from the recursive phase carried out two years following the foundational phase. It begins by outlining the recursive phase aim and objectives and provides insight into the characteristics of the CNMM population studied over a timeline. The recursive phase findings commence with graphically represented themes which are colour coded to aid overview of ST and TC findings. A more detailed account of findings from interviews is then presented structured around the themes that emerged, using narrative extracts. It concludes with synthesis of the findings informed by initial reference to the literature. The aim and objectives of the recursive phase are now outlined.

6.2 Recursive phase aim and objectives

The aim was to amalgamate recursive phase findings with foundational phase concepts in a double interpretative process in order to chart CNMM role enactment through change over a timeline. This phase involved returning to a group of self-identified foundational phase participants broadening the exploration and introducing the use of serial interviews over a time line. This kind of interviewing has advantages over the usual one-off, snapshot interviews (Murray et al 2009).

Objectives were designed to expand the scope longitudinally and are now outlined:

- To share outcomes of the foundational phase findings as a basis to examine points of resonance and dissonance
- To explore perceptions of change over time in terms of the CHP and their role within it
- To examine in more depth CNMMs perspectives on their professional identity and how this is negotiated within the CHP context
- To identify what CHP CNMMs perceive as the necessary skills, sustenance and support to effectively enact their roles in managing change
- To identify CNMMs perceived developmental needs and to propose requisite strategies to address these.

6.3 Recursive phase: Superordinate Themes and Theme Clusters

A graphic representation of the recursive phase interview findings is now presented. It appeared that the preliminary ST held meaning for the participants being broadly the same and therefore retained. The recursive interviews did however provide enhanced insights and nuances at TC level which is reflected in some discrete nomenclature as shown **(Figure 9).** The recursive phase comprised nine interviews. The colour keys below indicate the category descriptors of the recursive phase.

Figure 8: Colour code descriptors - recursive phase

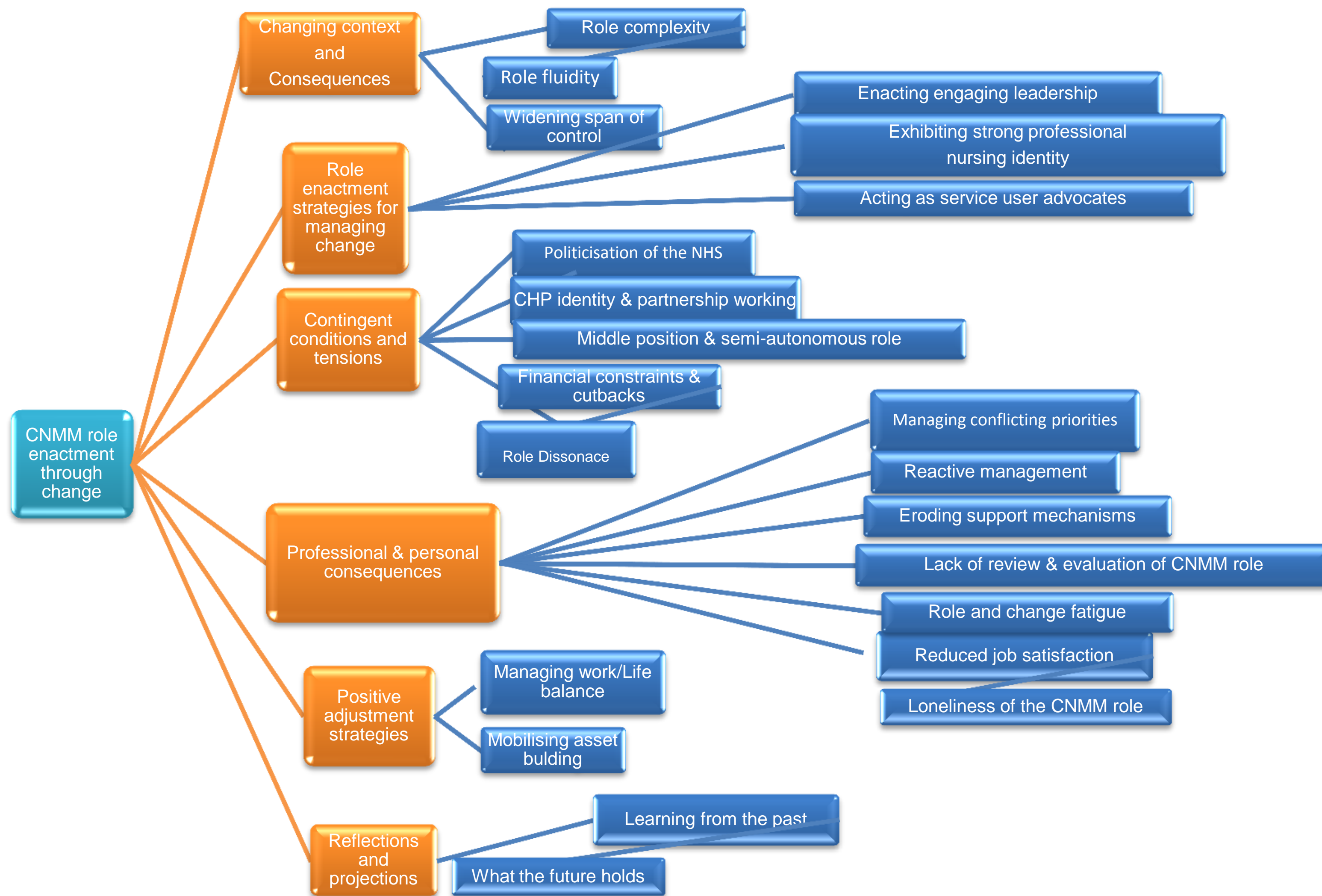


Figure 9: Graphic representation of recursive phase interview findings

6.4 Changing context and consequences

These interviews were carried out around two years following the foundational interviews. The foundational phase of the investigation identified a variety of distinguishable CNMM roles, categories or descriptor types which had not changed in the recursive phase. Overall CNMM roles and responsibilities continued to be influenced and to a large degree moulded by the direction and evolution of individual CHPs. CHP organisations appeared to be continually translating SG directives and policies relating to change and applying them to CHP structures. This involved consequent alteration of CNMM role enactment to meet the needs of structures. CNMMs felt that they had to accommodate new and changing roles and remits to meet the needs of the evolving CHP organisation.

Over that time change had continued to be a major feature of the NHS environment which many CNMMs felt was increasing. The UK and global financial climate had worsened over the two year period of the exploration resulting in even tighter fiscal spending. This had been felt to impact negatively on the CNMM role which was perceived as having exponentially expanded. These circumstances were felt to have resulted in continuing changes to the CNMM role with further increasing responsibilities.

Many CNMMs cited lack of involvement in change processes and decision making about how their role would alter which was seen to create negative experiences as evidenced in the following transcript excerpts:

"It's been a process of change, there's always been mention of review. This time last year it was discussed that I would come out of my area of expertise and role, and have a more management role around child health. But my manager ... after me leaving the ... role ... em presentations and everything, em ... a week later, my manager told me that that probably wasn't the best idea because I needed a clinical role to protect myself for the incoming changes. So I went back to my post, quite embarrassed and humiliated as you can imagine..." Isla, R., L.N., CHP 3.

"It was all decided and I do not know what discussion or negotiation went on behind, and maybe they did try and pick up on what they (thought) were our strengths, because sometimes ... we were not included. No, we went along those lines and yes, I think probably it could have been allocated differently." Marie, R., R.W.

6.4.1 Role complexity

Recursive phase participants indicated that CNMM role enactment was performed within CHPs which had continued to expand. CNMMs indicated that they experienced role and environmental complexity due to several factors.

"*Em, I was heavily involved with GIRFEC, but that role has now been taken over by another role. Em, inequality is the latest thing that em I'm involved in, and how that links into accessing services, and that was the link that I got involved with there. That's new; I don't know how much work it's going to generate at the moment."*
Isla, R., L.N., CHP 3.

6.4.2 Role fluidity

As role expectations increased role fluidity and lack of role definition was seen as problematic for many CNMMs, their managers and teams. The role was felt to have become hazy and misunderstood. For this particular CNMM it became difficult to make sense of and internalise the role, leading to confusion and a feeling of loss:

"My personal identity has disappeared. Em, sometimes, sometimes I'll say to my manager "I don't know what I am or who I am anymore". And it's been eroded; while I've been given other tasks that are very fulfilling, I don't know what my identity is within the CHP anymore." Isla, R., L.N., CHP 3.

Again metaphor was used to make sense of the experience:

"... because I've got so many hats people are totally confused about what I do, because I haven't even got a title that reflects my role". Isla, R., L.N., CHP 3.

In common with the findings of the foundational phase, many CNMMs from the recursive phase were experiencing complexity and uncertainty in enacting multiple roles. They felt that they were operating within indeterminate boundaries since job descriptions were fluid and flexible providing only a guide to often unplanned variation and modification:

"I mean what is the role? ... Well, again in my introduction, I said it was difficult because, I don't know what my role ... my future role is going to be. I don't know when that will happen, that does leave you, not lacking in enthusiasm but hesitant about progressing certain things that you've got in your head and that's frustrating. And it's a bit worrying". Liz, R., S.M., CHP 2.

Precise articulation of role for this CNMM proved to be difficult:

"... I think it's a role that evolves all the time without your realising, formally realising it's changed. ***How do you mean then?*** *Well if I look back my job probably is slightly different this year than what it was last year. I mean if you looked at my job description I'm quite sure it doesn't really accurately describe what I do. Because of the changes, because of the drivers; you just have to adapt to what you're doing..." Emma, R., S.M., CHP 1.*

6.4.3 Widening span of control

Recursive CNMMs perceived themselves to be doing more with shrinking resources (e.g. taking on additional responsibilities on top of their previous role). The growth of the CHP functions, financial restraints, and reduction in the number of middle managers were seen as causal factors.

"The CHP was becoming ever bigger and more complex and the management structure within the CHP wasn't growing because of financial constraints. So that

resulted in managers and nursing staff, and very possibly wider staff too, although I can't speak for them, but with regard to nurses and managers, yes it did result far more work coming all of our way." Mary, R., S.M., CHP 1.

"... you take on a greater workload, your responsibilities have extended because we have a reduced management structure, or certainly have been ... nursing ... our work ... numbers have reduced". Rosie, R., S.M., CHP 1.

The impact of the aforementioned collective changes within CHPs and on CNMM role enactment were seen to weaken and devalue nursing leadership and the CNMM role. This was a strong theme in the recursive phase interviews but was particularly evident in one specific CHP:

"... I'm not convinced that eh, that our roles are particularly well recognised to be honest, even though we're the biggest employees, within the NHS let alone the CHP, and I think people forget that if it wasn't for nursing staff – and give them their due we're still nurses. Yes, I actually don't think that people appreciate what we do and what our skills and knowledge is..." Emma, R., S.M., CHP 1.

The experience of reduced leadership was also outlined by others:

"... I still firmly believe that there should be nursing leadership. Um, and I know that they've subsumed us into different posts. But without a leader again, for nursing it doesn't send out the best signals for nursing. Um, you know, I'm sure that there's another ... a doctor or a medical person that they would replace that person because a medical doctor would seem important". Marie, R., R. W.

This perceived lack of understanding and/or appreciation of the CNMM role was felt to include colleagues from within nursing teams:

"I don't know if they (teams) would see it very ... as a very important job, I think they would see it very much as we're sitting in an office". Emma, R., S.M. CHP 1.

However some CNMMs had a different experience in terms of team support:

"I probably didn't feel valued, probably didn't feel confident at that level but I did at a local level." Liz, R., S.M., CHP 2.

"it's the little things that make a difference and I think my manager, he does recognise what I do and I think he does now and again send an email saying 'good piece of work". Iona, R., S.M., CHP 2.

Most CNMMs viewed themselves as supportive to teams through change, however conversely there were varied perceptions of organisational support for some CNMMs:

"... I've repeatedly said there's not enough Nursing Managers, but here we are reduced further than expected, and asked to take on more, and how can you? You know what? Something I fight for my staff all the time, saying they can't keep, we can do things differently em, but something will have to give, you know? But it doesn't seem to apply to middle managers. It doesn't seem to apply does it?" Rosie, R., S.M., CHP1.

6.5 Role enactment strategies for managing change

In the recursive phase CNMMs perceived that they led team change processes by the use of strategies and frameworks to manage colleagues and manage themselves. They implied that they identified their personal leadership philosophy based on their culture, rules, behaviours and values (as was shown in the foundational phase) to guide their leadership style.

6.5.1 Enacting engaging leadership

"... really listen and take note and ah negotiate that change right at the beginning. Often the staff right at the ground ... if they are very busy they do not want change because change usually means more work, and so it is much easier just to keep your head down and get on ... and it is quite difficult sometimes, to get frontline staff to engage with us at a conversation around that. But often when you do get that part right then they will sit back and they can come up with better suggestions." Mary, R., S.M., CHP 1.

"It's their workplace, it's their team, they're the ones that look after the patients so I think if you've got a dictatorial approach you'll just get resistance and folk won't work with you but I think if ... you give them autonomy and the recognition that they know the job better than you do." Anne, R., S.M., CHP 2.

Another CNMM reflected on why this sort of approach was used:

"I guess it is about when folk have forced me to change and I haven't felt included and that's not the way that I would do that, I mean, I am not saying that the way I do it is right but I mean, I always say to my staff if you have got a problem with it, and I would say the same about that, if they don't know why it has to be changed and why they are going to have to". Mary. R., S.M., CHP 1.

In addition most CNMMs implied the use of genuine compassion towards teams in terms of concern for their wellbeing acknowledging the additional pressures change creates for employees. This was found to be a collective feature across both phases. The following narrative is a typical example of this in the way networking, mediating and negotiating change was perceived as being enacted:

"I think the way I manage change is to work with people. Change is often not negotiable, it's how you deliver it and how you sell it and how you support it that's important to get buy in and I think if you leave it to staff without that support it's the old Chinese whispers and you end up with an ants nest of problems that cause you even more time and more stress. People going off sick and things like that, so that's what you want to avoid at all costs". Anne, R., S.M., CHP 2.

Another CNMM perceived resistance to be part of the change process and framed it in a positive way, however it is notable that this was not a widespread notion:

"... there is resistance to change and how you deal with that. ***Yeah and what do you think resistance is about, (laughing)*** *... it depends what you are trying to change, a lot of it is well this is the way I have done it coz it has always been this way, whereas if you've got a very strong evidence based thing like you are saying we are going to change this coz we have the evidence to support it and it works, it is much easier you know?". Emma, R., S.M., CHP 1.*

6.5.2 Exhibiting strong professional nursing identity

The majority of CNMMs related change management role enactment to their nursing identity. CNMM notions of belonging were expressed first and foremost as being embedded in the attributes and associated qualities and identity of the nursing profession. These included perceptions of altruism, care, compassion and being trustworthy:

"…. *I like to see myself as a specific nurse discipline lead ... I think management is important ...* ***Yeah?*** *There is a bit of me that likes being a manager because I can*

steer things the way I think they should be, you know don't get me wrong it's been, it's done me good this role as well, but I am still a nurse." Emma, R., S.M., CHP 1.

Another CNMM showed passion and pride in her nursing roots with a commitment to quality care:

"… I very much see myself as being a nurse at the end of the day, whatever else, I'm definitely still a nurse. Er, if somebody asks what my job is I never say, "A manager." I probably would say a nurse and then what do you do then? And then I would probably say, I manage nurses. Because ... it's hard to get out of your system". Marie, R., R.W.

When the intensity of this participant's feelings was reflected back, affiliation to the nursing origin of the role was further emphasised:

"... if somebody said to me, "Right, you've two choices, you lose your nursing registration state or get a better job", I'd keep my registration. I would keep my registration. I'd rather forego the job". Marie, R., R.W.

6.5.3 Acting as service user advocates

Furthermore an advocate approach to leading and managing change seemed part of the nursing philosophy. Firstly CNMMs perceived that they respected and included colleagues in change to build trust. They felt that understanding the links between caring for staff and optimising patient care were important:

"... as I say the patients are really your bread and butter. I don't think you can forget, if you forget that, why are you in the job? ... you shouldn't be in the job". Marie, R., R.W.

"It's why we're all here. It doesn't matter who you are, we're all in the job because we've got a patient. And although we might not touch them and deal with them in the same way as the clinical teams, that's why we're here, and I think that is my entire

one hundred per cent focus in any job that I've done is we're all here because somebody needs you and I think it's to support the development of my teams which again is about people so that they can deliver the optimum care to that person as a patient". Joyce, R., S.M., CHP 2.

The notion was expressed that nurses needed to be managed by nurses to understand the nuances of the profession and support operational teams through change:

"... I think to be in this type of job if you weren't a nurse you wouldn't be able to empathise with what people need, staff, for, and why they need them. And they aren't just here leading them and really I think it would be very ... a really bad move to have somebody in this job that wasn't a nurse, actually". Marie, R., R.W.

"I often go to meetings and I never hear a client or a patient mentioned at a meeting. And that bothers me. And I say that openly um, that you know, where are the patients in this? At the end of the day we are here for them um, that's what we're paid for, whatever level or whatever we're doing, whether you're working in the office here um, in a clerical position, I remind the office staff, every day that we're here for the patients." Marie, R., R.W.

6.6 Contingent conditions and tensions

In describing their role, many CNMMs referred to contingent conditions and tensions. This theme was found to be common in both phases.

6.6.1 Politicisation of the NHS

Politicisation of the NHS was seen to have added complexity to the role and had created some cynicism:

"... I don't want to speak politically, but it depends who's in power and the NHS is at the mercy of politics, and I think that's where it all comes down to. NHS is never stable; it depends who's in power at the time, and the same is happening in England. To me it's GP fund-holding by a different name, and that was unsuccessful in Scotland but they're rolling it out to the whole of England at the minute and I just see disaster ahead, because people are ill-advised and ill-informed. ***And do you think then, from what you're saying that politicians listen?*** *No. They don't. They don't listen; they hear but they don't listen." Isla, R., L.N., CHP 3.*

"I used to be very interested in the policies that drove and the politics that drove health. Now it's almost just about keeping your head above water. Em, mmm, you know it's very difficult because sometimes you do wonder if one department in the government are talking to another, because you get different or conflicting instructions if you like. Em, and then if you, you know, you'll know that there'll be short timescales to give them information, and then some of the stuff that comes back you think "what planet are you on?" You know "do you actually know about patient care or is it just talk?" You know, so, em I'm not sure if we're able to influence. I used to believe that we could but I'm not so sure anymore. No." Mary, R., S.M., CHP 1.

Adding to the aforementioned tensions the CHP was viewed in a variety of ways by CNMMs, as a government engineered entity that was difficult to define, as an

organisation that was confusing and complex, and for some it was not seen as an organisation at all.

6.6.2 CHP identity and partnership working

The CHP was viewed as an employing authority:

"Community partnership, I mean within the area it is our local partnership, I mean it's who we work for basically, ***is that it, you are saying it is something that you work for but do you feel*** *... I am part of that ...* ***do you feel an affinity or*** *... some of it yeah, I think some of it some of the work they do is really good I don't agree with everything, you know a lot of it is because it is government policy, I feel part of that local group if you like, I mean we work for the NHS but I work for the CHP." Emma, R., S.M., CHP 1.*

The CHP was not seen as an organisation by this CNMM:

"Well it's eh, it's not an organisation, but I mean I think partnership is a good word for it, a good description of it because it is about people working together to ensure that we're delivering the right services for the population, but we need that information to enable us to do that, and we need people whose jobs it is to find us that information to be able to keep us in the loop, you know?" Rosie, R., S.M., CHP 1.

These CNMMs had a different perception of the CHP:

"... it is definitely an organisation, but I think it is more about individuals than an organisation. I think it should be more about individuals than an organisation, I think if you start thinking of it as ... um ... an inanimate object, you will get nowhere. I think it is a group of people working, trying to work together, to improve health outcome and give good health service within the area they are working in." Mary, R., S.M., CHP 1.

"... the CHP is the hub of where everything's decided, planned, and put out from, but the CHP links into the Health Board as well. And there are other CHPs in the Region but I think they're all doing their own thing; I think they all do things differently." Isla, R., L.N., CHP 3.

Another CNMM felt that the CHP environment was muddled:

"Well the CHP I think ... it has been a confusing organisation for many, it's been a fairly flat structure, a messy structure, a structure that's been replicated several times over locally which they are addressing by going into single system, recognition of that but to work in it ... you've kind of ... almost detached yourself from it, and you just do what you've to do at this level. I think its function and its direction were not clear, as a result it confused people." Liz, R., S.M., CHP 2.

The following CNMMs outlined what they saw as challenges of the CHP partnership model, citing what they perceived as obstacles to role enactment such as differing policies and codes of practice across agencies:

"... partnership has its roller coaster, its ups and downs and health profiling could be hugely interesting to one particular person in partnership but isn't the thing that the next person wants. It's finding the balance and you feel as if you're lost in a harsh wave sometimes you know but hopefully we'll get there with it but I think we're going to be increasingly reliant on partnership working to survive". Iona, R., S.M., CHP 2.

"... it is a very long term objective to get different organisations working together. Um it is about learning to respect each other's roles and often that, instead of people openly trying to respect each other's roles and hear them, there is almost like a competition, and that breaks things down." Marie, R., R.W.

6.6.3 Middle position and semi-autonomous role

All CNMMs saw themselves as operating within the middle space of the CHP. However they felt that this space could be an exposed and vulnerable place during change:

“I don’t know if it’s me that’s going to be an area manager, if it is I don’t know what area I am going to be working in so that’s a bit unsettling.” Anne, R., S.M., CHP 2.

“... I don’t know what the future holds for me at the minute, you know. I don’t know if in the great scheme of things, when things are redesigned, if somebody else will be taking over. I really don’t know what their plans are for the future. And I think part of the problem is they don’t know either, whoever they are. ***And how does that feel for you then?*** *I’m quite demoralised at times”. Isla, R., L.N., CHP 3.*

“... when you hear about all these cuts in the press and the media it’s always that we have to get rid of these middle managers”. Iona, R., S.M., CHP 1.

These CNMMs explained further by outlining what they saw as the unpopularity of the middle manager role:

“GPs don’t like managers ***(laughter)****, because they don’t see our worth, and if there’s problems staff will always go looking to GPs for their support and it is like, when I go to the practice in a uniform they say oh you are working today? And I will say oh as opposed to sitting in my office with my feet up drinking coffee yeah? ... you know that is not aimed at me that is aimed at the manager.” Emma, R., S.M., CHP 1.*

“... well we get bad press. Middle managers, you know because you literally can hire and fire isn’t it? It’s just the perception of it, but the health service gets particularly bad press around it all”. Rosie, R., S.M., CHP 1.

CNMMs generally expressed that they experienced very limited control, feeling that hierarchical systems were driven and limited by government directives, initiatives and policies:

“... it’s concentrated at the top of the structure but also within its policies. ***From the government?*** *... Yes ... and our own policies. If you think of protecting staff you know and you’re hiring and firing and all that side of things and you’ve got an HR team, your support teams and there’s very few people that actually have that full*

power. You're accountable, again, accountability and power are different things." Liz, R., S.M., CHP 2.

"I think until you reach a very high level people all have very limited power." Joyce, R., S.M., CHP 2.

Adding to this notion of CNMM semi-autonomy, and arguably exacerbating their position, was the perception of additional limitations having been placed on CHPs by successive governments. In other words many CNMMs experienced the double whammy of exclusion and control mechanisms which were interpreted as limiting CNMM role enactment in managing change to provide quality community services. Some CNMMs expressed scepticism in terms of inclusion within political directives and felt that they had little control over the formation of SG policy and strategy with little influence in developing centrally driven targets. Furthermore target driven services were referred to as being tick box exercises that were engineered to realise political rhetoric without adequate consideration of consequences:

"Yeah well ... yeah, hence my statement, my flippant statement ... butt out and let us get on with our job ... you know targets and you know waiting list initiatives, you know, it's vote catching a lot of it ". Rosie, R., S.M., CHP 1.

"... the NHS is politically motivated. Depending what party is ruling the Scottish Government, each have got their own agenda how they see things that they want to go; for example the government that we've got at the minute vowed that there would be no prescription charges. But I don't think they thought that one out; that's a great vote earner but the revenue that they're missing from that which could be ploughed into other, you know". Isla, R., L.N., CHP 3.

"... you are not really included in the planning you know, there will be people included in the planning with the government, but you often think are they the right people?" Marie, R., R.W.

6.6.4 Financial constraints and cutbacks

Increasing financial constraints were seen by the majority of CNMMs in the recursive phase to further add to their semi-autonomous position in decision making:

"… before I wouldn't have had to escalate that risk; I'd have dealt with it because I had the resources there to deal with it and the means of doing it, but now I've got to jump through hoops to do that, so the risk is left there longer. Or it gets to a higher point because I can't action it quick enough because of all the restrictions that have been put in place." Rosie, R., S.M., CHP 1.

"Towards the end of my working time I was finding it more and more difficult to help the teams out in a difficult situation because of the financial constraints, we were more restricted. Staffing was more restricted, so you were more restricted as to who you could move and yes, that I feel very strongly, we could do a lot more, we could give a much higher service across the piece." Mary, R., S.M., CHP 1.

Another CNMM expressed concerns around implications for provision of quality care:

"… I hear the politicians saying you know that you've got to maintain or improve quality with less and less resource and you know we are getting more and more sick patients discharged from hospital, really very sick patients, transferring the care and there is no funding that's following that for us to put in the care that these people need and I do, have huge worries about that." Mary, R., S.M., CHP 1.

6.6.5 Role dissonance

Many CNMMs distanced themselves from perceived political motivations, the ethics of market philosophies and those attributable to management. There was a feeling of lack of congruence between participant values and beliefs, organisational values and decisions which had led to ethical conflict:

"I think there is a tension. Um, I do think you're asked to do things that may go a wee bit against your nursing values. I suppose it is, it's the management stuff, you know, when looking at finance, again where we're looking at finances and we're looking at it, yes, but we're trying to think ... but we're looking at finances, we're looking at high level stuff and yeah, you can read all about that and then sometimes it's difficult for people to equate that back to the patients. Patients are almost the commodity and I don't want that ... do you know what I mean? It's almost like it's financially driven ... it's all become financially driven where instead it used to be patient driven. Um, and that's essentially hard." Marie, R., R.W.

The collective contingent conditions and tensions were perceived to have professional and personal consequences for some CNMMs but also included concerns regarding the potential for adverse effects on patient care:

"I just feel that patient care is going to suffer and I don't want to be around when that happens, if these cuts ... and I absolutely understand why we have to save money and agree that we probably can ... but I think it's affecting the front line too much". Mary, R., S.M., CHP 1.

Despite these feelings, there was evidence of some CNMMs going above and beyond the call of duty:

I um, do take stuff home with me. I do ... I do not have a bleep but I do have a mobile phone that's attached to work. I do come in. I've been called out several times. Again I'm not paid for that but I do it because I want to help. I want to be a good manager. I want to be seen as being helpful, want to make sure patients are being cared for um, be ... good will as well. I think there's a lot of goodwill." Marie, R., R.W.

6.7 Professional and personal consequences

Many CNMMs cited difficulties in managing numerous conflicting priorities perceived to have been caused by competing SG and partner agency agendas along with contradictory SG policies and targets and was a strong theme.

6.7.1 Managing conflicting priorities

This CNMM used metaphor in recounting feelings of being engulfed by the number of SG imposed initiatives and priorities that had been created:

"... you've got so much on your plate that you actually try and prioritise but then something else comes in and you've got to reprioritise. So I continually … my lists change you know from day to day, I'll say do this, do that and then oh no, that goes above that. Um, so I think everybody in any role at the moment is managing conflicting priorities". Marie, R., R.W.

CNMMs recognised that whilst no single change event was unbearable, the sum of the change events they experienced was challenging:

"I re-prioritise nearly every hour in the day. ***So what does that mean for you then if you're re-prioritising every...?*** *Hard work* ***(laughter)****. It means ... What does it mean? I mean I know the priority, because you've got your CHP priorities, but as an operational manager I have my staff priorities or responsibilities to staff, so a 'phone call could just mean that I have to, that 'phone call, the outcome of that 'phone call is my priority, so I just have to take that decision." Liz, R., S.M., CHP 2.*

"I think that was really difficult to manage, conflicting priorities because on the one hand there were some non negotiables from my Manager and higher, like implementing agenda for change". Iona, R., S.M., CHP 2.

6.7.2 Reactive management

Many CNMMs in the recursive phase implied that a consequence of conflicting priorities led to reactive as opposed to proactive management:

"... you feel as if you're fire-fighting – that's the problem isn't it? And I think when you're fire-fighting it's quite difficult to think your job is developing. I'm sure it has been; I suppose my knowledge will have changed in the last year, or you know, around certain things, again how I've dealt with things might be differently, but it's hard to see." Emma, R., S.M., CHP 1.

6.7.3 Eroding support mechanisms

The implementation of market philosophies, strengthened government influence and the demand for efficiency savings was seen as having resulted in the downsizing of the Scottish NHS. Subsequently, many CNMMs indicated that that there had been a reduction in the number of nursing management positions, both at the strategic and middle levels of CHPs. This was felt to have eroded support mechanisms at all levels of the CHP structure:

"I don't think us managers are well supported. You know, we're not ... we're not. You know, there are all these policies in place and I spend a lot of time supporting my staff, making sure they're well supported, and to be honest ... eh ... no". Rosie, R., S.M., CHP 1.

"the biggest change for me has been losing my line manager which has been I suppose a bit difficult given that there has been so much different things going on within my role, so I suppose for me I now have a more senior manager, em in the chain, em, who cannot, actually give me the same support and supervision." Marie, R., R.W.

"Well it's difficult now, because there isn't anyone, you know the person, in my area, that would have supported me operationally my line manager has retired and they

*haven't filled the post em … so I am covering that post 2 days a week … so I am supporting me in that post… (**laughing)** ". Joyce, R., S.M., CHP 2.*

6.7.4 Lack of review and evaluation of CNMM role

Accompanying this position was many CNMMs perception that there was a lack of review and evaluation of the role and its boundaries. Others had received regular appraisals essential in motivating and valuing staff while others had not:

"... I think perhaps the thing that's missing is evaluating. And I think if you've got change, you can't just dump it and run. You've got to see it through and you've got to tweak it and you've got to be prepared to be wrong and look at a different approach I think. Evaluation and resetting objectives is hugely important." Liz, R., S.M., CHP 2.

"I don't think it's ever really been evaluated. Another person and I were the two first CNMMs in the area and I've not been aware that our roles have ever been evaluated." Anne, R., S.M., CHP 2.

The aforementioned issues were felt to contribute to the confusion that surrounded the role which may be a basis for misunderstanding not only for CNMMs themselves but others who are trying to grasp what the role entails. The conglomeration of these related factors ultimately led to work/life imbalance and role fatigue as experienced by the majority of the return CNMM population.

6.7.5 Role and change fatigue

"Um, sometimes you can get a bit of role fatigue because you think ... because you're constantly getting battered with different things it can be quite difficult sometimes, and say actually it's made me ... it's actually ... the thing that I stand for that's not personally me. So I suppose yeah, in some way there is a bit of role fatigue. But I can't be fighting it again, back to fight in your corner to show that you're

credible. So you're continually trying to promote um, so I suppose you can get tired. You can get very tired with that". Marie, R., R.W.

"I suppose we're a little bit battle weary because a lot of time has been spent by numerous people em, communicating what the agreed changes are, and that's through consultation". Emma, R., S.M., CHP 1.

In addition the pressure of the role for many CNMMs at work was felt to impact negatively on their lives outwith work with a prominent theme of work/life imbalance:

"I just felt that it was nothing but work, work, work, and even when I wasn't at work I was thinking in my head about some problem and how to solve it" Mary, R., S.M., CHP 1.

"... because I work hard I do think it has an impact on my family. I mean um, I do work long hours. I um, do take stuff home with me." Marie, R., R.W.

This CNMM identified the pressure perceived to be created by line management who communicated outwith contractual working hours. This had adversely influenced the attitude and behaviour of the CNMM from her experience at work. It was felt that this had had the potential to affect job performance, health and in turn the overall performance of the organisation:

"I suppose it's around, your role model and you know, if you get an email from your line manager over the weekend, it's like, am I supposed to be responding to an email being sent at the weekend or am I expected to be in at half past seven in the morning sending emails. I don't think that's actually... Because ... I'm just saying ... because then it raises people's expectations; if I'm doing it so should you be doing it" Rosie, R., S.M.,CHP 1.

6.7.6 Reduced job satisfaction

These CNMMs reflected on the effects outlined by a majority of the population who experienced an increasingly imbalanced workload and demands perceived as having

reduced the time and opportunity to fully carry out their role as they would wish. Job satisfaction was also considered to have been reduced:

"I know what the strategy is, but I like to understand it better, you know, I've always been one, which is why I came into the job, was to understand the key policy documents and be very au fait with them, but I'm probably now scanning and running, whereas before I've had a better understanding of where they've come from. Being part of the consultation even, I had – and it is our job to em ***(laughter)*** *analyse them and you know, see how it goes into operational, but I feel that's one of the things that I don't have the time to do enough of, and that's not very satisfactory job-wise for me." Emma, R., S.M., CHP 1.*

This had led to two CNMMs from within the study population having resigned between the foundational and recursive phases with an additional recursive phase interviewee expressing her intention to do the same. It is notable that this was within one specific CHP in one region of Scotland:

"... I put an awful lot of pressure on myself to try and keep the pot boiling, keep all of these balls juggling and felt that I wasn't managing it. So I felt I wasn't doing the job very well and I really didn't like that and sit easy with it. So that was one major reason for my taking the decision that I did" Mary, R., S.M., CHP 1.

*"... I knew I did not have the capacity to do the job as well as I would have liked, and therefore was not getting the same feeling of um enjoyment**,** I do not know how to put it, um job satisfaction out of it by that time, and felt it was time to step back" Mary, R., S.M., CHP 1.*

"I've made the decision in two years' time, I'm going, and I'm not going to renew my registration, I'm going to look for something completely different and I think . ***Why is that?*** *Because I'm very disillusioned with the politics and the, you know I think there's far too many people forget there is a patient ... and that saddens me,* ***mmhh*** *... actually saddens me." Rosie, R., S.M., CHP 1.*

6.7.7 Loneliness of the CNMM role

These CNMMs reflected the feelings of many with regard to feelings of inhabiting a secluded and lonely position. Some inferred that they did not feel part of the CHP community either socially, psychologically or geographically:

"…there is a sense of isolation and especially where we're based, we're isolated in our base ... we're not at a hospital setting or in a community setting, you know, we're in the centre of town um, and I do think maybe some people see that as a bit as an ivory tower type situation but we're here and they don't understand, and going back to what I said earlier, which is far from the truth. Um, we don't have to be in a place to understand it, understand it with it being physically there. So I would say yeah, there is a sense of isolation sometimes." Marie, R., R.W.

*"I was carted out to an outlying office so **(laughter)**, yes I do think that has got to do with em CHP staff not knowing who we are, or not knowing what we do because they don't see the business of you, they don't see the interactions you have all the time. And plus the fact that has probably, not being based with any of your colleagues is very difficult, your support, so, yes. But the other side of it is, which has probably given me the confidence to make the decisions I make, you know. But sometimes it's nice to have somebody there just to talk it over."*
Emma, R., S.M., CHP 1.

*"I haven't got a PA, there's nobody else working on this floor with me at all so some days you become very good at speaking to yourself because there's no one else to speak to **(laughter)**. You've got your teams but they're busy and you can't go down for a chat so it's very different from having a support team round you so I'm hoping that will change, it needs to change because if the role is going to continue as it is and get busier, it can't be done without that". Anne, R., S.M., CHP 2.*

6.8 Positive adjustment strategies

In order to cope with these substantial challenges several CNMMs felt that they used various positive adjustment strategies from exercise, delegation, saying no, managing their own and other's morale, deciding when it was time to leave the profession, and picking up their pay at the end of the month.

6.8.1 Managing work/life balance

"... to deal with that might have been to offload some of that work onto other people like the Team Leaders. Which I did to some extent but you feel that you can only do that so much because you're aware that they're very busy people too". Emma, R., S.M., CHP 1.

"I was taking things home with me and worrying about them and thinking about them and I didn't have a good healthy work, home balance ***uhuh*** *and I thought "That's got to stop"* ***That is really quite intuitive and reflective,*** *yeah, I also had family saying to me this is ridiculous the hours you are working and you've got to stop." Mary, R., S.M., CHP 1.*

6.8.2 Mobilising asset building

"... Before I went on holiday a couple of weeks ago I said, "Why am I doing this job?" And it was simply because there had been a lot of the negative bits coming and very little of the positive. And then you'll occasionally get something really positive in your email box ... you think well that's why I'm here." Marie, R., R.W.

"You think that you're badly off until you start speaking to other folk, then you see that everybody's feeling the same – it's not just you. So if everybody's feeling like that it's not quite so depressing then." Isla, R., L.N., CHP 3.

6.9 Reflection and projections

The interviews with CNMM participants was felt to give them an opportunity to be listened to and heard, facilitating them to reflect on the questions posed helping them to examine their individual past and present CNMM experiences.

6.9.1 Learning from the past

"As I've progressed in the career, in the post, I just think well I've done the best and OK somebody just has to be told I will do it but I won't do it tomorrow, I'll do it next week and they have to accept that and it's again respecting what's going on in your working life as well. But it is a constant one but I've learned to live with it. You have to." Joyce, R., S.M., CHP 2.

"I would say that each discipline needs their own manager. I was a Health Visitor and could easily manage Health Visitors, and that would've enabled me to manage School Nurses in theory, but if you're not a School Nurse and know about School Nursing, if you're not sitting knowing the policies and all that sort of thing, you can't manage it properly ". Isla, R., L.N., CHP 3.

The investigation was seen as providing an opportunity for CNMMs to voice their future predictions for the community nursing profession with narratives providing a glimpse of the wisdom that they feel have gained from past experiences, what they perceived the future to hold and their final thoughts as the interviews were concluded.

Many CNMMs felt that it would be useful for the post holder to be trained to at least ordinary degree if not Master's degree level and identified a need for various components within the training to support and strengthen the CNMM role:

"I mean I would imagine that I'd hope that most middle managers would be at least degree, um, you know degree level educated. And also you know you cannot really be that effective a manager if people below you are actually more highly qualified

than yourself. I know experience can count for a lot of things but I think gone are the days that experience is enough. I think you've got to be looking to be becoming more educated." Marie, R., R.W.

There was a perceived need to include leadership skills:

"I think that anyone coming into a new service manager post it would be really useful if they had a, and they have run courses on leadership and what not in the past , I think I we need to plan and make them more adjusted to what people are having to deal with today. ***In what way?*** *… Well, things like conflict management, that's a big thing I think". Mary, R., S.M., CHP 1.*

*"... I didn't have the leadership – I think I've said before – and I'm still asking for courses that would be relevant for me, but...****You know, is there anything around sort of educational attainment or anything, that you think would help?*** *Well yes, if I could go and do a degree or Masters or whatever, but I, you know, I don't have the time or the energy to do it. I don't have the time during the day to do it, you know, eh we give our, em, staff half a day's study or whatever; I would never get that opportunity. So yes, I mean, it would need to be in my own time". Emma, R., S.M., CHP 1.*

"I suppose being able to write papers and things, I mean I certainly feel that I, since I did my degree that I know how to ... basic things like referencing stuff. I mean I have had papers from some managers actually that were very poorly written, they're very experienced managers and they're good at managing people. But actually you've got to be now more than that, you've got to be able to write a strategic paper." Marie, R., R.W.

"What kind of, sort of support then would you give to a new person in post to learn that? *I think they would be mentored by somebody who is a bit more experienced, somebody who's been around for a while, that knows the way that staff think and work." Isla, R., L.N., CHP 3.*

"I mean I think yeah, coaching, mentoring, shadowing is all good." Marie, R., R.W.

"I think that middle managers should have some form of training so that they're up to date with what's going on. And if everybody in the CHP was coming from the same, you know, sort of background, the same level of training, I think things would be easier. ***And what would you include in that then?*** *HR is a big thing." Isla, R., L.N., CHP 3.*

6.9.2 What the future holds for CNMMs

Uncertainty was a significant feature in CNMM predictions of the future:

"Well at the moment I don't even know if that post would be replaced, cos every post is getting scrutinised in detail and I don't know if they would replace like with like ... and that is sadly a sad fact." Rosie, R., S.M., CHP 1.

Despite uncertainty this CNMM felt that there is a need for CNMMs:

"So, mmm, it's difficult to know. It's difficult to know where we'll be in one or two years' time because of the changes that we're making, or that's happening, or being imposed or whatever, so, yes. But there'll always be a need for managers some way or the other, unless of course the GPs decide to employ all the nurses". Emma, R., S.M., CHP 1.

Perceived uncertainty, constant pruning of CNMM posts and the accompanying increase in workload had contributed to this CNMMs decision to leave the NHS:

"I know even since I left that management has been reduced again. I find that extremely worrying, considering that I decided to stop, and I am actually a very positive energetic person, I decided to stop because I just felt it was getting too much, I really have concerns from the fact that it has been further reduced um because I think we can only have a poor service through it." Mary, R., S.M., CHP 1.

These CNMMs expressed lack of control regarding their roles. Many felt that it will be constantly changing and growing to meet the need of the CHP, its structure and financial cutbacks:

“Mmm ... it’s difficult to know isn’t it, in a year, two years’ time. It depends on the CHP structure to be honest, you know; do we have three CHPs or do we have one CHP? Em ... it will change because we’ve refused our community nursing structure so em, that will change” Iona, R., S.M., CHP 2.

“I think how big is job going to be and I think there’ll be a large amount of business management in it, I think there will be a large amount of general management in it as well as some operational.” Liz, R., S.M., CHP 2.

This participant echoes several others in her prediction of community nursing redesign with the introduction of skill mix, managing bigger teams and the changing role of management at mid-level:

“They may become manager of a whole team; District Nursing, Health Visiting, School Nursing, and not have the background to sustain them in that. And they are a manager as in that’s a management role, but they’ll have no real insight or understanding as to what each area of practice is doing”. Isla, R., L.N., CHP 3.

Some CNMMs foresaw the future as holding less choice and less opportunity for promotion due to the effects of the economic climate with a lack of career structure:

“I know if I chose to stay working where I am that there is no likelihood of a promoted post because of the finances and because of the redesign to expand my knowledge further.” Emma, R., S.M., CHP 1.

“... to me there’s no career structure for me, there’s nowhere for me to go.”
Marie, R., R.W.

Many CNMMs predicted unification of roles, departments, CHPs, and partner agencies with more joint working; they felt that there would be increased partnership working through joining up of services and agencies:

"I think there may come a time that then we'll all be one CHP for the whole of the region, I can see that happening." Marie, R., R.W.

"... it'll be working jointly with the local authority, you know, whether it's joint posts or whether we're managing. So things are going to change, whether it's joint budgets or its aligned budgets. Em ... yes, em, will there be, I don't know." Rosie, R., S.M., CHP 1.

Final thoughts were varied and gave the participants the opportunity to reflect on their CNMM practice and learning during their time in the role:

"... at the end of day we're here for a patient. I've said throughout but I do think we're here for patients and for clients and um, never forget that." Isla, R., L.N., CHP 3.

"... tolerance, I don't have any regrets about doing the role. I don't, I had no miserable, totally miserable moments like that. Communication and how important it is in the fast moving environment we are in and that's something that has not been good from above". Liz, R., S.M., CHP 2.

"As long as the NHS is politically motivated, there are going to be problems". Isla, R., L.N., CHP 3.

Finally this CNMM related a distinctive message:

"On issues, you know releasing time to care, stuff like that, I mean you can access these documents you know where it is coming from, some of it its good and some ... like any government, but the problem is ... the government should butt out and let us get on with our job! ***(laughter)****" Emma, R., S.M., CHP 1.*

6.10 Recursive phase: synthesis of findings with initial reference to literature

As already mentioned, foundational phase findings resonated with the CNMM participants holding meaning for CNMMs in the recursive phase (see Appendix 16 for an example of analysing a recursive interview).

The recursive phase provided a more in depth understanding of how CNMMs experienced their role resulting in further distilling and definition of sub themes (see Table 22).

Table 22: Recursive themes

Superordinate themes	**Theme clusters**
Changing context and consequences	Role complexity, Role fluidity, Widening span of control
Role enactment strategies for managing change	Enacting engaging leadership, Exhibiting strong professional identity, Acting as service user advocates
Contingent conditions and tensions	Politicisation of the NHS, CHP identity and partnership working, Middle position and semi-autonomous role, Financial constraints & cutbacks, Role dissonance
Professional and personal consequences	Managing conflicting priorities, Reactive management, Eroding support mechanisms, Lack of review and evaluation of the CNMM role, Role & change fatigue, Reduced job satisfaction, Loneliness of the CNMM role
Positive adjustment strategies	Managing work/life balance, Mobilising asset building
Reflections and projections	Learning from the past, What the future holds

Continued, increasing and accelerating change contexts and consequences was the most noticeable feature of CNMM work as described by recursive phase interviewees. Similar to the foundational phase, and in order to carry out change, this cohort also espoused enacting engaging leadership. Alimo-Metcalfe et al (2007) and Bradley & Alimo-Metcalfe (2008) indicate that this type of approach can have a positive effect on wellbeing and morale. Schmidt's (2004) research concurs with this approach within the context of organisational health and wellbeing. Exhibiting strong professional nursing identity was perceived as shaping their CNMM leadership style. CNMMs were distinguishing themselves as patient and team advocates in leading change (Goodrick and Reay 2010). Upenieks (2000) found nurses to accept change more readily when they had trust in the leader and when the aim of change was to improve care as opposed to being financially or politically driven. Accordingly there were several conditions and tensions described, such as the growing challenge of financial constraint and cutbacks. This was seen to have contributed to the adoption of a reactive management style by many CNMMs as a way of managing change due to continually reprioritising workload whilst carrying on with "the daily business". This concurs with Currie (1999) and Ainsworth et al (2009).

In addition meeting financial targets was reported to have resulted in CHP delayering with a reduction in CNMM numbers and felt to have created subsequent expansion and increased fluidity of the role and remit. This increasing span of control has been described as causing the ripple effect of lack of mentoring, increasing stress and decreasing job satisfaction (Shirey 2009) with the potential to overload managers beyond their individual capacity resulting in a detrimental effect to the CNMM, team and work environment and potentially patient care. Consequently CNMM accounts illustrated the difficulty of describing their function in its entirety, and a poor understanding of the role by teams and others. Despite remit change, individual titles or role descriptors of the return cohort remained largely unaltered.

Moreover the evolution of increasingly target driven CHPs seemed to have resulted in CNMMs perceiving the NHS as being continually politically controlled and driven. Research suggests that although targets have led to positive change, they have disadvantaged quality, performance improvement and led to short termism (Scott et al 2003). Furthermore CNMMs illustrated the challenge of grappling with conflicting

government priorities. As in the foundational phase, most recursive phase participants felt they inhabited a middle semi-autonomous position, experiencing little control or influence over change or priorities, which is contrary to Currie and Proctor (2005) and Carney (2004) who found that flat organisational structures facilitated middle managers involvement in organisational strategy development. Moreover the CHP as an entity was still viewed as a somewhat confusing and unwieldy organisation in its aim to increasingly encompass partnership working. Partnership working was also perceived to continue to be challenging. Despite interdependency between agencies being government led, organisational barriers remained such as differing values, aims, priorities and funding (Mann et al 2004). Collectively, the aforementioned factors were attributed to role and change fatigue reducing job satisfaction in many cases, with many referring to the loneliness of the position. Role dissonance was again described and implication of emotional disassociation with the management and economic function of their role, termed “role distance” (Bolton 2003) who suggests that it is a particular feature of professionals managing peers in middle management roles.

The previously perceived lack of managerial support and lack of review of the manageability of the expanding CNMM role was more pronounced for recursive phase participants as further delayering had resulted in additional loss of senior supportive roles for CNMMs in this particular region. CNMMs felt that in order to cope with this they used various positive adjustment strategies from exercise, delegation, learning to say no, managing their own and other’s morale or deciding to leave the profession. Two accounts confirmed that the reasons that they had resigned was a collection of the aforementioned issues and not having felt listened to by their supervisors which they felt had contributed to burnout, concurring with Laschinger’s (2006) findings.

6.11 Recursive phase findings – conclusion

The recursive phase interviews indicated that change had continued and increased. The majority of CNMMs perceived they were operating within a climate of increasingly challenging financial pressures. This had resulted in the delayering of CNMM management support. A regional executive nurse post and a Professional Nurse Lead post in one CHP had been lost, significantly reducing leadership and support within that structure. In addition, continually expanding roles were reported as still not having been reviewed which had made change management more challenging due to the increased amount of work. There seemed to be the feeling that CNMMs in one specific CHP were over controlled and undervalued.

CNMMs felt that they had learnt from the past and that there was a need for CNMM training that should include leadership, mentoring and shadowing as the role would continue to change and expand due to continued reduction of CNMM numbers. They felt that the future held uncertainty due to continued delayering that would lead to poorer service provision. There was suggestion that CNMM teams would be continually redesigned, with reduced community nursing structures predicted which would lead to a lack of opportunities and career progression for the population. There was a feeling that ultimately CHPs may merge and health and local authority services would also merge.

A stark message was that if the NHS continues to be politically target driven then the challenges for CNMMs in managing change and delivering quality services would continue.

CHAPTER 7: EXPANSIVE PHASE FINDINGS

7.1 Overview of chapter

Chapter Seven presents the expansive phase which included three additional Scottish regions thus broadening the study geographically. The expansive phase findings commence with graphically represented themes which are colour coded to aid overview of superordinate and TC findings. A more detailed account of findings from interviews is then presented structured around the themes that emerged, using expansive participant narrative extracts. It concludes with synthesis of the findings informed by initial reference to the literature.

7.2 Expansive phase: Superordinate Themes and Theme Clusters

The objectives of the expansive phase were the same as those for the recursive phase.

As already mentioned, the foundational phase STs and TCs were reported to resonate with participants in the recursive phases. The inclusion of the expansive phase provided the opportunity to widen the study to further elaborate and gain distinct understanding of how other CNMMs experienced their role which resulted in further iterative refinement of sub themes **(Figure 11).** The expansive phase comprised eight interviews.

Colour code descriptors of identified Superordinate and TCs from the expansive phase are outlined below

Figure 10: Colour code descriptors – expansive phase:

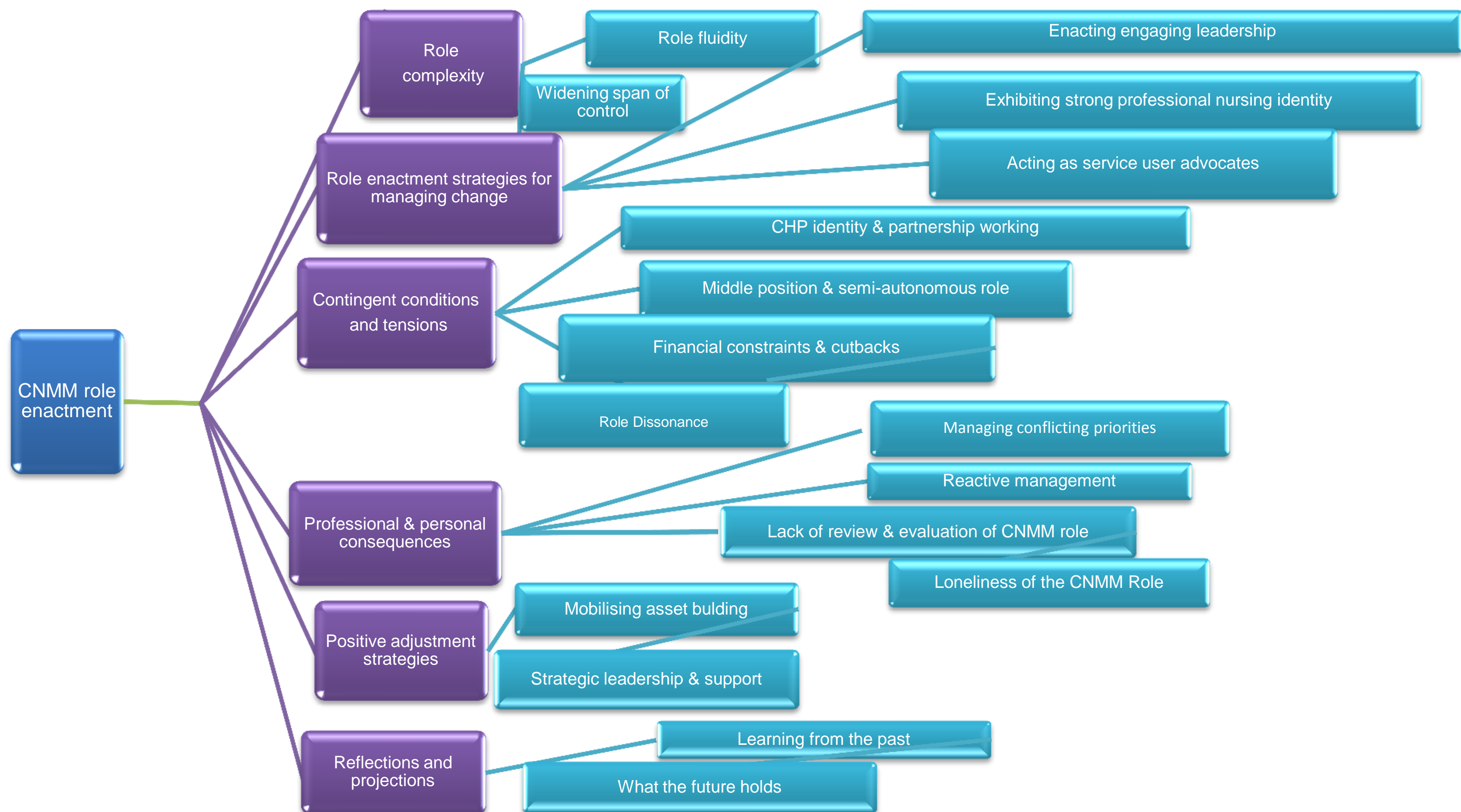


Figure 11: Graphic representation of expansive phase findings

7.3 The CNMM role within the CHP setting in the expansive phase

There was some differentiation in CNMM role types within the expansive phase. Three new descriptors of Generic Manager, Wide Generic Manager and Nurse Consultant were identified. The first two roles in particular showed that these CNMMs were managing some multi-professional and multi-agency personnel in addition to nursing teams. This included the daily management of some allied health professionals and city council healthcare worker staff with profession specific leads being maintained. This arrangement was in place to support clinical governance and advice on practice issues and may indicate progress in advancing CNMM role management within a CHP interagency team.

Again the expansive phase CNMMs indicated a perceived lack of delineation between management and leadership in enacting the role. Many CNMMs felt that they enacted both and suggested that leadership was a component of the management role. Some had defined leadership roles with minimal management while other roles were perceived as managing with a leadership component. The subsequent narrative accounts present an illustration of expansive phase CNMM role types.

Wide generic manager

This CNMM descriptor type encompassed a broader role and remit in terms of management and leadership. This included planning, as well as managing budgets and teams with responsibility that spanned across NHS CHP nursing, Allied Health Professionals (AHPs) and some local council employees. This CNMM acted as lead professional for community nursing. Council employees and AHPs were supported by a profession specific leads for professional issues.

"I manage Community Nursing and wards that was in addition to my role when we were newly the CHP. So I've got school nursing, district nursing, health visiting, and I manage integrated response team which is a multi-disciplinary team. There's social work, rehab care assistants it's a joint team there's social work involved and health. There's physio, OT, and there's twelve rehab care assistants in the team, and their

purpose is to support early discharge, or prevent admission. I also manage a community rehab which is a health team that's physio OT district nurse and level 3 carer. She's employed by the council she works with the District Nurse ... the OTs and Physios go to their professional head for professional issues but I manage the budget for the team and manage their team." Laura, E., W.G.M., CHP 5.

It was notable that this particular CNMM perceived that she had had some autonomy and control in the development of her role. (This is outlined in Chapter Eight to capture the particular.)

<u>Generic manager</u>

The generic manager type descriptor role was not as wide as the former. This CNMM had professional lead and management responsibilities for all community nursing disciplines across the CHP including the community hospital. Management of public health co-ordinators across the CHP was also a component of the remit. This model has the potential for improved integration and cohesion of the public health function within the CHP along with increased opportunity to influence partner agencies:

"... school nursing health visiting and then the other for community nursing, um district nursing and treatment room." Jill, E., G.M., CHP 6.

"I also line manage the Public Health Practitioner and there's elements of that post that has got a degree of joined-upness, if that's the right word, it's not to do with the funding of it but it's to do with national project work that's sits across the local authority and the CHP as well." Fiona, E., G.M., CHP 7.

<u>Consultant/Professional Lead</u>

This role was more of a professional, advisory, and consultative nursing specific role and encompassed involvement with practice and conduct issues with elements of education and specific service redesign with minimal line management responsibilities and was not a role identified in either phases one or two:

"... professional lead for nursing but we are not the managerial lead. My dual role is I'm senior nurse advisor, I'm also interested in and specialise in professional development so that's any kind of training, any kind of new clinical skills brought on etcetera". Joy, E., C.L., CHP 4.

"... strategic nursing input and advice and that can range from anything from complaints from family, friends, relatives and HR conduct things in relation to nurses that you take up and reply to or work with HR. Depending on how you work with the manager in that locality, you may well get some line management, more managerial issues that they don't pick up which are more nursing and that works differently across the three CHP ... the three localities" Kate, E., C.L., CHP 8.

7.4 Role complexity

This was again found to be a strong theme during the exploration.

Role complexity in the context of change was again cited and echoed by this CNMM. There was further indication of the challenges of the role with pressure to contribute to cutting costs while at the same time improving quality and facilitating staff wellbeing:

"... there is a focus on how we do things more efficiently and we reduce waste and we improve safety compared to also looking at all the other things around care and involvement, staff involvement and staff wellbeing. All of these things that we need to do and how you manage all of that has probably added a greater complexity to the role". Diane, E., C.L., CHP 5.

7.4.1 Role fluidity

New and changing roles and remits to meet the needs of the CHP organisation were seen as problematic for some CNMMs, their managers and teams with the role felt to lack clarity for others:

"I think for a lot of people they don't really understand what I do and they'll go 'what does she, where, what, what does she?" Grace, E., G.M., CHP 4.

These CNMMs also experienced complexity in enacting roles to meet flexible and changing job descriptions:

"….they probably wouldn't be able to quote my job description but then I can't do that and again this is one of the flaws in our role." Angela, E., G.M., CHP 6.

“I don’t know in all honesty if I have ever reached the role being whatever the brief it was. I still see where I want it to be and I’m striving towards being that” Diane, E., C.L., CHP 5.

7.4.2 Widening span of control

The thread of doing more with fewer resources continued throughout the study and was perceived in the expansive phase to increase workloads and responsibilities. In common with previous findings management numbers were seen to be decreasing along with the erosion of supportive structures:

“I have to say over the past six months I have noticed that colleagues and myself, our workload has catapulted, exponentially, I was going to use that word but I don’t know if that’s the right word ... because other people’s roles when they leave and retire aren’t getting filled so then the roles get divvied up so people are getting teams to manage the previous that would have been development opportunities for six months within the team, do you know what I mean, that sort of thing? So there’s that kind of internal of people with a workload they just can’t manage, and therefore everything starts to become a priority because it’s last minute.” Kate, E., C.L., CHP 8.

7.5 Role enactment strategies for managing change

7.5.1 Enacting engaging leadership

Like CNMMs in both the foundational and recursive phases CNMMs from the expansive phase referred to utilising a relationship-based democratic style leadership to gain shared vision in enacting the role through change, as the following excerpts indicate:

"I think in relation to managing change, I guess, I didn't think I used to be, I mean there's the whole transformational side, there's looking at leadership and I relate to that. But within that ... there's all the dimensions around power, around brokering, around mentorship. There's so many complexities I think there's all that." Diane, E., C.L., CHP 5.

This CNMM identified resistance as part of the change process and accommodated it in a positive way:

"... my experience is that when you force change on people it doesn't stick, they'll do it for a wee while but it's not the status quo, they need to evolve into it and go on the journey and go through the change curve however you say it, they need to resist it, think it's a good idea, take it forward." Fiona, E., G.M., CHP 7.

7.5.2 Exhibiting strong professional nursing identity

This was one of the strongest themes across all stages of the investigation and evidenced in a high percentage of CHPs across all three regions and phases. Like previous CNMMs perceived notions of belonging were primarily vested in the nurse identity and associated values of the nursing profession in the expansive phase:

"... my morals and underlying principles are that you are caring and compassionate, you are trustworthy, you know" Angela, G.M., CHP 6.

"We've done a lot of work over the last couple of years around what are our values and what is it we would be aiming to do." Kate, E., C.L., CHP 8.

Participants expressed ideals that supported a moral framework including passion and pride in being nurses with a commitment to quality care, suggestive of engaging leadership traits:

"One of my main aims is that people don't see me too far removed from being a nurse and, as I say, when I go and speak to people I still think I'm nursing, by the long stretch of the arm, I'm influencing you who influences how that patient is cared for, so I think I'm a nurse, and when we go through a change, whatever that is, I want to keep nurse my title. It is my identity. It's completely who I am. I've always wanted to be a nurse and I love nursing". Diane, E., C.L., CHP 5.

"I think I am a nurse to the core and I think I would be very proud to be that. I think that in my previous role, in my long term positions I learned probably quite early on in my career that delivering direct patient care I can improve the care of the person in front of me by taking on roles that influence the data you're still delivering nursing care. You're just doing it in a different way on a bigger context." Angela, E., G.M., CHP 6.

However another CNMM felt her identity lay within a different discipline:

"I would describe myself as a nurse manager, I do not first and foremost think of myself as nurse, but that is because, uhm, I have got a health visiting background". Jill, E., G.M., CHP 6.

7.5.3 Acting as service user advocates

All CNMMs implied that they led and managed change by incorporating nursing philosophy, respecting and including colleagues, building trust and keeping patient care at the core of how they enacted their role:

"... if you actually put your feet in the patients or the clients shoes and walk a mile in them I suppose what you perceive is other people's moral compass, probably your own, and other's moral compass and it helps you to manage and work with that person." Joy, E., C.L., CHP 4.

The link between quality of patient care and professional development were seen as important by this CNMM:

"I think the point of my job is to provide the highest ... it is the nurse bit ... is to provide the highest level of patient care that we can. I think the point of my job as well though, is to develop the workforce. And that is sometimes about us being creative about putting new mechanisms in place, about not just, think about money, there's other ways that we can be creative. I think it's about empowering people, about developing people and I think it's really about the profession of nursing."
Diane, E., C.L., CHP 5.

7.6 Contingent conditions and tensions

In describing the role, the majority of CNMMs in both the foundational and recursive phases referred to contingent conditions and tensions as a common theme which was also perceived by CNMMs in the expansive phase. Various causes were cited, as shown below.

7.6.1 CHP identity and partnership working

Throughout the investigation the CHP was viewed as a government engineered entity that was difficult to define, confusing and complex. However one CNMM from the expansive phase cohort experienced feelings of belonging to and being a part of the CHP:

"Well I think I am the CHP. Yes, I'm part of it definitely." Angela, E., G.M., CHP 6.

Another CNMM identified the CHP in geographic terms and felt that the concept had not evolved much wider than health:

"... I visualise it as a geographic bounded area, so it is the geography of it, you know, it is the sort of demography of it and then within health it is the structure uhm and the people within it that work in it, work within it ... I suppose I still see the CHP as health." Fiona, E., G.M. CHP 7.

The financial climate was believed by several CNMMs to have created barriers to genuine partnership working and was perceived as being a work in progress within a hostile and threatening environment, an image invoked by this quote:

"I think there are absolute tensions in partnership working and I would absolutely agree with that particularly when you're looking at other agencies. And I think that is probably heightened with regard to the financial climate and all the pressures and, dog eat dog ... and look after yourself ." Kate, E., C.L., CHP 8.

7.6.2 Middle position and semi-autonomous role

The majority of CNMMs saw themselves as operating within the middle space of the CHP which was viewed as being difficult and vulnerable:

"I think being in a management role is a very vulnerable role. People can say whatever and do whatever really they would choose to do and they do say they're upset and not feel 100% and that's fine. As a manager you have to be so crystal clear in relation to what you say to anybody about anything in order to be in line with HR policy or that would come back at you." Diane, E., C.L., CHP 5.

This CNMM felt that being in the middle of the organisation was difficult when different levels of the hierarchy are at different stages of progress:

"I sometimes think that the middle is a difficult place to be because, above is decreeing what should be happening and expect you to make it happen and the other bit is getting an understood and acceptable message across by being supportive and that's a challenge ... and we are in the middle with the pace of change and different people are in different time zones on both sides ... so ... between a rock and a hard place!" Jill, E., G.M., CHP 6.

Several CNMMs indicated that they cushioned challenging demands to make change less threatening and acceptable for teams by endeavouring to translate rhetoric into action:

"you are kind of that person in the middle, the sponge, the buffer, conduit, whatever it's called, from above, above being senior nursing or senior management within the NHS organisation and the government to your workforce or those on the ground." Diane, E., C.L., CHP 5.

"I think I try and be a bit of a buffer to that and try to facilitate a process ... what's going on ... and look at how you make some of that palatable in relation to how you

support things to move forward. So it's kind of tricky sometimes." Joy E., C.L., CHP 4.

The majority of CNMMs perceived that they enacted difficult roles through leadership, making sense of the change that needed to happen, and then linking the strategic and operational chain together. They did this through communication and selling the message to foster team engagement working towards the ultimate goal of action:

"For middle managers, leadership is very wide and you can look at leadership from a deficit base or a strength base, you need to be able to pull ... pull all of the pieces together ... in the middle, I think the work of the government is very much done in isolation and policies are not always formed together with other departments, and we have to try to get them to fit in so that it is manageable or at least make some kind of sense of it, and I often think, how do I support service delivery? ... which is a challenge and up against that there is the financial climate ... it is not easy."
Fiona, E., G.M., CHP 7.

Comment was made that being in the middle signified an important function in being able to make a difference. There was the view that the CNMM contribution to the change processes was crucial:

"I was on a leadership course a couple of years ago and they kept going on about how important the middle was, that it needs to be recognised as being the kind of conduit to making change happen, because the middle is the place that's in contact with the above, strategic bit, and, and… the other operational bit and has to get the two to connect together for action to happen." Angela, E., G.M., CHP 6.

"And I do believe that I can make a difference to them and patients that they care for and it's high enough but low enough, do you know what I mean?" Diane, E., C.L., CHP 5.

However this CNMMs use of metaphor and language gave a graphic account of the experience of control and containment within the CHP hierarchical structure demonstrating the limits sometimes placed on middle actors charged to take change forward. This account suggested that freedom to act, think, and innovate to enact change can be stifled and was felt to have created CNMM frustration:

"How does power affect you from above? If it affects you at all? *Well, you get boxed, car-parked, shelved.* ***They're all terms for what? Say what you think.*** *To put you back in your box. They're all terms for don't be thinking of punching above your weight or your pay rate." Kate, E., C.L., CHP 8.*

Adding to this notion of CNMM semi-autonomy and arguably exacerbating their position was the perception of additional limitations placed on CHPs by successive governments. Their perception was one of having had little influence in developing centrally driven targets. Furthermore target driven services were inferred to as being tick box exercises that were engineered to realise political rhetoric without adequate consideration of consequences:

"Well the government are ... are producing targets all the time and you have got your HEAT target and you've got your local delivery plans that it filters down and then you've got promises that are made to the public and to patients on what they should expect and expectation and reality often are quite far apart". Jill, E., G.M., CHP 6.

"... very much in my view, driven from, you know, a strategic Scottish Government prospective because um, well clearly there was a lot of um, resistance to that and frankly, scepticism ... and difficulty in trying to translate that". Kate, E., C.L., CHP 8.

7.6.3 Financial constraints and cutbacks

This led to CNMMs distancing themselves from the motivations attributable to management and the ethics of market philosophies that had been introduced to the public sector by various governments. There was a lack of congruence between

participant values and beliefs, organisational values and decisions which led to ethical tensions:

“We've got a bit of tension happening just now that’s to do because of efficiency savings that we are having to make”. Fiona, E., G.M., CHP 7.

7.6.4 Role dissonance

“I think some of the tensions with the role ... there’s definitely got to be the budgetary element ... and the “must dos”. The list of things that must be done compared to the list of things that are probably in the best interests of your population and your group. So I think there’s the financial climate we’re in and what the organisation’s corporate objectives are, compared to what people are currently out there doing and having done for twenty years.” Diane E., C.L., CHP 5.

7.7 Professional and personal consequences

Mirroring the foundational and recursive phases, the expansive phase interviewees cited contingent conditions and tensions which were perceived to lead to professional and personal consequences for most CNMMs including the negative aspects for management in general:

*"... management, it still is, my perception is that it is still a little bit of a dirty word **Why is that then? Why is it dirty?** I think because managers previously have done such a bad job. I think they've really cocked it up. They don't have leadership style. I think they've either been transactional and therefore do as I say, do as I, you know, do as I say, not as I do or they've been transformational, too transformational and they've been wishy-washy and they've been flapping about in the wind, you can't get a decision" Angela, E., G.M., CHP 6.*

7.7.1 Managing conflicting priorities

Expansive phase participants indicated the difficulties of managing numerous conflicting priorities caused by competing SG and partner agency agendas along with contradictory SG policies and targets:

"I think the national drives are becoming, or feel to me at the moment, overwhelming and it's the mere, the mere vastness of trying to catch all that and communicate down, to have at the moment ... it's a bit overwhelming not just for me but the whole team and erm ... I just feel ... 'woah come on we're going through hard times'. Everything is great ideas and all the initiatives of the ideas but there's just too much at one go." Joy, E., C.L., CHP 4

This CNMM recounted feelings of being engulfed by the number of SG imposed initiatives and priorities:

“(I) ... juggle a million balls in the air you know, balance you know too much work within a short period of time, trying to isolate the things that are priorities and uhm you know deliver on that within the working week”. Laura, E., W.G.M., CHP 5.

Whilst the experience of managing priorities was seen as something positive and perceived in an exciting light by another CNMM:

“The managing conflicting priorities, I kind of thrive on that one and I don’t know whether it’s a tension. I think it adds a variety”. Angela, G.M., CHP 6.

7.7.2 Reactive management

CNMMs across the CHPs in the expansive phase implied that a consequence of conflicting priorities was reactive as opposed to proactive management role enactment:

“We’re expected to deliver on what somebody is saying from the government so I mean it is coming from the government”. Kate, E., C.L., CHP 8.

7.7.3 Lack of review and evaluation of CNMM role

Lack of review of the span and scope of the role was raised by several CNMMs which was a general finding across all phases of the exploration. This CNMM provided a crucial observation, as clear agreed guidelines and supervision are important to support the type of CNMM role enactment expected to deliver NHS change and achieve targets:

“I would say my job has been changed and my job description has been changed. But that’s not in the context of it being reviewed as in, you know, within the framework of meeting my objectives, obviously the annual appraisal comes into play, but that’s not that direct connection between my job as opposed to my performance

within it, and whether or not that's what, you know is needed for the service" Laura, E., W.G.M., CHP 5.

7.7.4 Loneliness of the CNMM role

This CNMM represented the feeling expressed by some others, of seclusion and loneliness and not feeling part of the CHP community, either socially, psychologically or geographically:

"It is quite an isolated role, again maybe personally less for me than it felt like it used to be, uhm but certainly when I first came into a nurse management role it was very very isolated, but uhm I suppose the scope of it is really huge as well." Jill, E., G.M., CHP 6.

However another CNMMs experience was indicative of a more supportive environment which was perceived to reduce the impact of stress:

"Maybe because I've been working at this level for a wee while now I'm not so frightened to phone people up and say 'I know you want the comments on this paper and the deadline was yesterday but you'll notice I haven't put in any, it's going to be another week' now if you make that phone call it makes all the difference, if you don't and you're conscientious it nags you and you're sitting at ten o'clock at night trying to do it, and you write a load of garble at ten o'clock at night, so I think personal practice and confidence, and knowing that you're getting that one-to-one support from your own line manager to improve ... that helps." Laura, E., W.G.M., CHP 5.

7.8 Positive adjustment strategies

In order to cope with these challenges many CNMMs used various positive adjustment strategies from exercise, networking, and managing their own and other's morale, which contributed to building resilience.

7.8.1 Mobilising asset building

"Knowing that I've got colleagues that would support me if there was any issues or things like that, there is support there, so it keeps you going. My colleague has got a really witty sense of humour and she's quite funny at times, even when things are really bad for her or I, she's quite cheery and comes up with things that keeps you going, get a laugh." Laura, E., W.G.M., CHP 5.

"Sometimes you know when you have done something good, don't you? And it feels, or you've had an interaction with a family, or you phoned them because you've heard ... thanks ever so much for phoning, for taking the time. Or you speak to staff or something like that or you get your warm fuzzies back, Warm fuzzies. So you need a warm fuzzy ... I do." Joy, E., C.L., CHP 4.

7.8.2 Strategic leadership and support

In addition the following support mechanisms and values were perceived by these CNMM as assets to further support the CNMM role, their health and wellbeing, in particular having direct links with an Associate Nurse Director, a role not mentioned previously:

"I had my PDP so I meet relatively regularly with the Associate Nurse Director and with my manager and we set professional objectives with the Associate Nurse Director and I do my care assessment GP with her as manager". Angela, E., G.M., CHP 6.

“Erm we also have, it’s a nurse who is Head of Services and Associate Director of Nursing so within her role she is a nurse so even if I’m not consulted at this level she is managing those line managers that’s making these decisions, so we’ve a safety net if, I call it a safety net, but we’ve got someone there too that’s assessing the professional side of things as well, which I think you have to.” Grace, E., G.M., CHP 4.

These accounts gave the impression by many CNMMs from the expansive phase cohort that they felt adequately supported to maintain a balance that enabled and strengthened them to enact their role through change, in particular again through a connection to the Associate Nurse Director:

“I am operationally managed by the local clinical services manager and I am professionally bi-countable to the associate nurse director. ***Yeah, okay, and is that a group structure, do you find that you’re supported? Do you feel supported?*** *Yes, I think of always nursing we’re together, that would be really good but my local clinical services manager is grand.” Kate, E., C.L., CHP 8.*

Another CNMM provided an insightful account comparing the support she had experienced as the CHP had evolved:

“**What kind of support do you get in your role?** *Ahem,* ***(laughing).*** **Be honest...**
I get my support from my line manager, i.e. the chief nurse, and I get, I would say significant support from my team managers who are in place because they’re the ... you know the direct interface with the clinicians actually. Um, and well obviously, you know I personally engage in things like, actual learning and clinical supervision. So kind of depending on the, I suppose external pressure at the time I’ll maybe step up the frequency of that, enough to just help support myself or sustain myself through it at particular periods of time.” Angela, E., G.M., CHP 6.

An additional support utilised by a CNMM included self-directed reflection, and opportunities for learning and development which contributed to feelings of being engaged:

"I don't feel disengaged and alienated. But I have felt all the top three there and it's not nice and did I go to anybody, my line manager and say 'Do you know what?' No, I didn't. Could I have done? Yes I think she would have been receptive. I think she would have done everything, but that's my own internal control freak mechanism, I need to do this for myself. I'll get some books and I'll read them and feel very fancy and highlight them and think Oh yes, I'm learning and whatever and felt better about myself and that was good." Kate, E., C.L., CHP 8.

7.9 Reflection and projections

7.9.1 Learning from the past

The interviews with these participants gave them an opportunity to be listened to and heard, facilitating them to reflect on the questions posed and helping them to examine their individual past and present CNMM experiences:

"As I'm deeper into the role the more and more I listen. ***Why?*** *Because … I think the nurses that I'm working with now know that if they can put across their argument if you like and it's not, I don't mean argument, argument. But you know, to that particular theory or idea I have, if it's strong enough that will change things I'll go 'you know you're right, right I'll go back and tell them we can't, we can't do that because of that' and now that they see that I'll follow it through and feed back to them they're more willing to open up". Diane, E., C.L., CHP 5.*

"I've been crafting my management style. I was a little bit of a bumblebee in a jar when I started. Because I was kind of running around, doing everything I've learnt that I don't need to do that and I know how to get my point across, I know how to influence. I know how to, my network of where I go and get advice, to do what I need to do". Angela, E., G.M., CHP 6.

The majority of CNMMs identified a need for training and support at the mid organisational level to support and strengthen enactment of the role:

"You need to have a buddy or you need to have guidance when you come into post. That's probably not a correct terminology, a buddy, a mentor, whatever you want to call it. You need to have, when you come into post you need to have a structured orientation. And I mean structured, I don't mean, have we shown you where the fire exit is?" Grace, E., G.M., CHP 4.

"It can be any sort of support that fits your needs; it can be as little or as much, depending on whatever it is. I think you just need a tool kit, don't you? Fiona E., G.M., CHP 7.

7.9.2 What the future holds for CNMMs

This CNMM captured the feelings of the majority that continued change would be a feature of the NHS and CHPs in particular referring to the report carried out by the Audit Commission:

"… given when ... the audit that was done, I think there could be changes afoot depending on the government isn't it, but be interesting to see ... the NHS never stays same for very long so I would imagine there'd be change soon." Laura, E., W.G.M., CHP 5.

Many felt that the CNMM role was an important role particularly with the shift of care from the acute to the community sector:

"I think the future of nursing is going to be the community. I think the future of nursing management, lead nursing, all of that is in the community, is going to become more and more vital." Angela, E., G.M., CHP 6.

This CNMM ended on a positive note:

"I enjoy my job. I like my job and I like to be able to think that we can provide a service that's required for our population. The job is so variable, I enjoy the variation and the challenge it brings, I'm never bored, there's lots to do, it's different." Laura, E., W.G.M., CHP 5.

The following transcript excerpt is offered as an indication of the value these CNMMs attributed to participating in the investigation and voiced their interest in the outcome and their appreciation of being heard.

"I found this really interesting, I was really interested in what your you know, the work that you are undertaking here, and I would be fascinated to see, you know, your end result in terms of whether there is any commonalities of experience, uhm, because structures are all obviously different across Scotland but fundamentally even though

the structures are different, people must be undertaking broadly the same you know have broadly the same issues and responsibilities and things within that, so I would be fascinated to ... I have found it really good to have the conversation with you and to participate in it. " Joy, E., C.L., CHP 4.

7.10 Expansive phase: synthesis of findings with initial reference to literature

As already mentioned, foundational and recursive phase themes were reported to resonate with participants. They also held meaning for CNMMs in the expansive phase. The inclusion of this phase provided further elaborated distinct understanding of how CNMMs experience their role resulting in further definition of sub themes **(Table 23).**

Table 23: Expansive phase themes

Superordinate Themes	**Theme Clusters**
Role complexity	Role fluidity, Widening span of control
Role enactment strategies for managing change	Enacting engaging leadership, Exhibiting strong professional identity, Acting as service user advocates
Contingent conditions and tensions	CHP identity and partnership working, Middle position and semi-autonomous role, Financial constraints & cutbacks, Role dissonance
Professional and personal consequences	Managing conflicting priorities, Reactive management, Lack of review and evaluation of the CNMM role, Loneliness of the CNMM role
Positive adjustment strategies	Mobilising asset building, Strategic leadership & support
Reflections and projections	Learning from the past, What the future holds

CNMMs from the expansive cohort experienced constant and increasing change within the NHS. This was described as the main workplace context in which those interviewed functioned. Their existence in the middle was perceived to signify the CNMM function. This cohort felt that they made a difference, with their contribution to change processes seen as crucial. However, inhabiting the middle space within the

CHP was viewed as being difficult and vulnerable especially when different levels of the hierarchy were at different stages of the change process. They expressed feelings of seclusion and loneliness and in some instances not feeling part of the CHP community, either socially, psychologically or geographically. However they felt supported due to robust Community Nursing structures and leadership, reported to have become embedded since the formation of CHPs which wasn't evident from the preceding phases.

CNMMs described wrestling with the global consequences of the financial crisis (Doetter and Götze 2012) expressing concerns around perceived adverse effects on service delivery (Bamford & Daniel 2005) from cost cutting exercises. In addition structural delayering was seen to contribute to the widening span of CNMM control and the expectation for increasing role fluidity contributing to role complexity. Lack of review of the span and scope of the role was raised by several CNMMs which was a general finding across all phases of the exploration.

However, in contrast to the findings of the foundational and recursive phases, many CNMMs from the expansive phase perceived that they had strong leadership with a more supportive nursing structure. This environment was felt to support role enactment and was perceived to reduce the impact of stress.

This situation was seen to help balance the difficulties of managing the challenges of reactive management, numerous conflicting priorities, competing SG policies and targets and partner agency agendas. Again this inclusion ameliorated high level change. Several CNMMs expressed scepticism concerning political directives perceiving that they had little control over the formation of SG policy, strategy or cost containment. In other words many CNMMs experienced the double whammy of exclusion and control mechanisms such as being "regulated through state hierarchy" (Doetter and Götze 2012), interpreted as limiting CNMM role enactment. However there was a perception that roles were supported due to the aforementioned leadership which appeared to encourage empowerment.

Like previous participants and in order to take change forward these CNMMs suggested that they attempted to cushion teams from the challenging demands of change by translating government rhetoric into less threatening and acceptable messages for teams. They espoused that they involved teams as members in the change system by defining the change problem, and mutually collaborating (Konrad 2006). This type of approach could be described as "engaging leadership":

"Engaging leadership is essentially open-ended in nature, enabling organisations not only to cope with change, but also to be proactive in shaping their future. At all times engaging leadership behaviour is guided by ethical principles and the desire to co-create and co-own ways of working with others towards a shared vision" (Alimo-Metcalfe et al 2008 p.16).

Interestingly, this notion was accompanied by illustrations of how CNMMs drew on their nurse identity with one case in particular referring to role modelling to guide management style. Exhibiting a strong professional nursing identity was one of the strongest STs across all stages of the investigation and evidenced in all CHPs across all three regions. This appeared important as opposing philosophies sometimes resulted in moral confusion that led to role dissonance which required on-going identity work to keep rooted in nursing thinking by linking actions to patient care.

CNMMs in this cohort expressed use of various positive adjustment strategies including seeking senior and peer support, keeping a sense of humour, exercise, networking, and managing their own and other's morale, which was felt to contribute to asset building. Additional support utilised included self-directed reflection, and learning and development which contributed to feelings of being engaged. Collectively these factors were seen to contribute to the comprehensibility, manageability, and meaningfulness of the role. CNMMs felt that collectively these factors supported and strengthened them to take change forward.

In predicting the future from reflecting on the past these CNMMs observed that the main challenge of the role in the future would continue to be change. Many felt that a

structured training programme should be an essential requirement for CNMMs to prepare them to carry out their varied role. Many felt that they had crafted their skills over the course of their careers. Several perceived that being a CNMM was a worthwhile, enjoyable and varied role, and one that would be of increasing importance in times to come.

7.11 Conclusion of expansive phase findings

Interview findings from the expansive phase indicated that change had continued and increased at a pace. The majority reported the challenges of increasing financial pressures accompanied by delayering. In common with other CNMMs they experienced continually expanding roles as some CNMM posts went unfilled to meet financial savings and were not reviewed in terms of manageability. This was seen to have led to reactive management styles which were not a preferred choice.

There was indication that CN Senior Management and Executive Nurse structural levels in these three CHPs remained largely unchanged. The maintenance of these posts was perceived as valuing community nursing and was felt to contribute to supporting the role of CNMMs and community nursing in general. Moreover CNMMs felt that sustaining a specific identifiable professional advisory Lead Nurse post and a separate Senior Community Nurse Management post verified the need for the expertise required to support all community nursing levels within the structure including CNMMs. In addition this support was viewed as accessible, empowering and open and appeared to make sense in adding strength for CNMMs in managing their role.

Despite experiencing similar challenges to the other participating CNMMs, none from the expansive cohort expressed an intention to either retire early or leave the post in the near future. A summary of main commonalities and differences between findings in all phases follows.

7.12 Summary of commonalities and variances found between all phases of the investigation

Overall the experience of role enactment through change for CNMMs related to associated influences on CNMM role and remit. Most participants attested to utilising a project approach in enacting their role through change (Bate et al 2004). Combined with increasing change the CNMM role was frequently defined as large, continually expanding and fluid with a complex variety of functions. Increased SG initiatives and perceived overload was viewed by CNMMs to have created accompanying risks such as working additional unpaid hours, feelings of being overloaded and not coping for some. This was felt to create the potential for unplanned and unintentional oversights with the potential to contribute to errors, stress and in a few cases burnout.

7.12.1 Commonalities

In every phase of the investigation CNMM roles were experienced as being complex fluid and diverse. Roles were difficult to define and ill understood by teams and by some CNMMs. Due to change, redesign and restructuring in particular, the CNMM role was described as having been "cobbled" together to meet the needs of the CHP organisation and financial containment which was felt to lack review and evaluation.

In enacting their role through change CNMMs espoused using democratic engagement change strategies with the teams they managed. They identified and drew on their underpinning professional (nurse) identity to lead change and act as service user advocates through the process.

All participants experienced tensions relating to their middle position in enacting their role. This included politicisation of the CHP and cost containment, which was felt to result in a lack of power and semi-autonomy. Many perceived that their lateral and vertical position relating to CHP structure and partnership working with external NHS agencies also created strain. In addition they wrestled with what they perceived as

the opposing philosophies of nursing and business values, with political and organisational imperatives causing role dissonance.

These tensions resulted in professional and personal consequences with some common TCs across all phases of the investigation, such as managing increasing and competing priorities and felt to lead to CNMMs adopting a reactive management style and a feeling of loneliness in the middle. Many CNMMs in all phases identified a need for support and education to enable them to carry out the role. However this may not necessarily be enough in themselves. SG strategy is lacking in this particular area despite the drive to modernise nursing in the community.

7.12.2 Differences in patterns

Recursive phase interviews showed variances, with some CNMMs in this cohort having experienced an erosion of the CHP community nursing structure due to the loss of Senior/Executive Professional Lead community nursing roles within the CHP structure to meet cost cutting exercises. This was viewed to result in a lack of expertise, leadership, and support for CNMMs and devaluing of community nursing in general. This loss was felt to exacerbate the lack of review and evaluation of the CNMM role which contributed to role and change fatigue and reduced job satisfaction. Two CNMM participants from this cohort experienced burnout and had resigned from their posts as a consequence with another expressing an intention to retire early.

Expansive phase findings were found to be more positive with the retention of specified and separate clearly identifiable roles of Senior/Executive Professional Lead Nurse and CNMM Manager within the CHP structure. This had resulted in the perception that community nursing was valued, supported and listened to with strong clinical governance and advocacy for community nursing and CNMMs. None of this cohort expressed feeling of burnout with none considering leaving the role despite facing similar challenges and tensions. Further interpretation of the data indicated that the majority of this CNMM cohort felt listened to, valued and encouraged to become empowered which was felt to support CNMMs in coping with and managing

the complexities of the role. These job-related factors predict engagement as outlined by Saks (2006). It is also important to note that CNMMs in the expansive phase had a different education profile from the other phase participants.

As already discussed this study explored the work experiences of CNMMs in enacting their role through change processes. Their perceptions of the organisational context in which they operated included various stressors from the challenges they faced on a daily basis. According to Burns (1990) any form of change creates stress in individuals which they interpret in order to identify if they have the resources to cope (Anisman & Merali 1999, Jordan 2002).

Further examination of the collective findings from all phases identified two particular examples of CNMM role enactment through change which outlined the impact that differing workplace environments had on individuals in different regions and CHPs.

As already outlined in Chapter Four, IPA involves being concerned with a dynamic relationship between the part and the whole and "acquaintance with particulars" (Smith et al 2009 p.31). Exemplars are now outlined to acquaint the reader with particulars in more depth than the aggregated themes have permitted so far.

CHAPTER 8: ACQUAINTANCE WITH PARTICULARS: TWO CONTRASTNG EXPERIENCES

8.1 Overview of chapter

Chapter Eight outlines acquaintance with particulars via two contrasting CNMM experiences. Smith et al (2009 p.31), advocate that “acquaintance with particulars is the beginning of all knowledge – scientific or otherwise”. Two CNMM exemplars are selected from different CHPs and across different phases. Exemplar one is from the foundational and recursive interviews and has a longitudinal aspect. This is followed by Exemplar two’s life world experience from within a different CHP and region of Scotland in the expansive phase. Extensive narrative extracts from interviews detail these CNMMs experiences. Following discussion of each individual exemplar the chapter concludes with integrative analysis.

8.2 Overview of exemplars

Both individuals had spent the majority of their working life within the NHS and had been in the CNMM role for at least 10 years. The exemplars were chosen because of distinct variance between the two and the consequent learning potential they afford. Exemplar one (Mary) highlights the experience of eventual burn out, which resulted in resignation from the NHS. Exemplar two (Laura) highlights how this CNMM remained in post due to perceived support which contributed in helping to deal with the complexities of the role and appeared to have avoided burnout.

8.3 Exemplar one – Mary

The following account is from a participant who was interviewed across the foundational and recursive phases helping to build a picture across a span of time. It chronicles the effects of the pressures this CNMM had experienced over a period of two years commencing with an account of taking up post at the inception of what was then a new role and how it felt being a CNMM in the early years.

8.3.1 Foundational interview

At the point of taking up post, this CNMM experienced feelings of being engaged with and passionate about the role. There was transcript evidence of professional enthusiasm, innovation, and energy that helped connect the CNMM to the CHP organisation, to nursing, CHP partner teams and ultimately service users:

"I don't know if I consciously thought of myself as that in that respect of ... as a leader but, the trailblazer aspect, I suppose, I didn't even consciously think of myself in that role at the time. I just knew that there were a few of us who were on a specific committee and we were all really committed to that specific role and loved it." Mary, F., S.M., CHP 1.

She reflected on how the role had changed over time inferring that change was a constant feature of the CHP. This was viewed as challenging resulting in the need to maintain personal equilibrium:

"When I first came into this post ... it was a different post then ... into management ... a change was a piece of work that you took on board and implemented. It's almost becoming now, and ... ah ... it's not something unusual that you set time aside to do, you almost now have to incorporate it into your day to day ... how do I buffer myself? It's hard, I think, you have to think ... is this a change that I must do, in which case you have to get on and do it as best you can". Mary, F., S.M., CHP 1.

The inescapability of change within the NHS was acknowledged and the need for it to be approached in a balanced, realistic and pragmatic way outlined. Using metaphor provided a way for this CNMM to make sense of her individual experience of change and its consequences:

"Change is inevitable, it's an ongoing process, you have to change or you're left behind but you have to change for the correct reasons and you have to be changing to try and improve services ... I would hope that, you do come full circle but you need to be leaving behind bits and keeping the better bits, so that maybe you're still moving full circle, but you're moving along the track in different circles. ***That's a very good visual analogy.*** *Yeah! You've got a railway track and the wheels are moving along not just going round in a ... say like a Catherine wheel." Mary, F., S.M., CHP 1.*

The speed of change was perceived as beginning to intensify for this CNMM:

"I think the pace of change is accelerating, I don't know that it could accelerate much more actually, because when you look at all the work that's going on, it's very very hard to pin point an area that's not going through some sort of change, so I don't know that the pace of change could speed up much further ... I think workload would become unmanageable and I, feel that almost already, that is the case really." Mary, F., S.M., CHP 1.

Personal management of change, engagement with colleagues and CNMM line management was seen as an essential component of managing the change process:

"… one of the ways in which you cope with having to deal with a number of changes at once, is through discussion, sharing out who is going to become involved in what and take that particular thing forward and through discussion, with your line manager and through looking at the objectives for the CHP or for the NHS, be agreeing which of these changes you really have to do sooner rather than later." Mary, F., S.M., CHP 1.

She drew on a proposed change for community nursing current at that time, namely VAIC, which she felt was difficult to comprehend expressing that the amount of work required for such a major change was not recognised at government and strategic level:

"*I've never ... I've never been convinced, that this concept of the overarching nurse with all her many hats is an achievable one. I can't reconcile in my head how they could become one." Mary, F., S.M., CHP 1.*

Again use of metaphor to make sense of her world was used. CNMM role enactment through change was seen to be becoming more superficial and less thorough:

"I'm very much a person who is into detail, you asked about my style and I'm very much a completer finisher and very much into detail, and that could be a plus but I'm also aware that it can be a minus as well, coz what I'm feeling is that, within the NHS, I don't have time to plan and execute things in as detailed a way as I would like and land up really, you don't, this, what I've described, almost becomes aspirational and what you land up doing is skimming the surface ***mmhh*** *and doing just enough to get you by and move on to the next phase". Mary, F., S.M., CHP 1.*

Feelings of tension between the philosophies of the NHS business ethos and traditional professional values were being experienced:

"You're driven by wanting to do a good job for the patients and for the people who are looking after the patients, but finance has a huge part to play, obviously, if you don't have financial resource sufficiently, around that, one of the ways around that, is giving less of something ... ***mmhh*** *... stopping doing something ...* ***mmhh*** *... or diluting your resource in some way by doing things with less staff and those are all really hard painful decisions to make". Mary, F., S.M., CHP 1.*

Perceived outcomes of this experience were related to standards of care:

Because you might, in fact you do, want to deliver a gold standard service but you are forced to recognise that at times you can only deliver bronze. Well it is hard and it's going to become even harder, I'm sure of that in the coming years". Mary, F., S.M., CHP 1.

In addition this CNMM felt that her experience in relation to ethical issues and concerns around risk were not being acknowledged by her manager and politicians:

"I'd just like to compare the amount of change and work it creates is not always appreciated or accounted for. Senior managers and politicians have to remember that if you put too much food on a plate or too many books on a bookshelf, things are bound to fall off, it's the risk that that creates". Mary, F., S.M., CHP 1.

Nursing values were described as underpinning role enactment through change for this CNMM. Maintaining the caring aspect of nursing and translating accompanying values into a supportive management style was felt to facilitate nurse teams to provide quality care to service users:

"Emmm ... I suppose as a manager I still think of myself as someone who is helping patients which is what nursing is all about and I do that or how I explain it to myself is that I do that via helping the nurses who are at the front line to deliver that care to the best of their ability." Mary, F., S.M., CHP 1.

8.3.2 Recursive interview

By the time of the recursive interviews this participant had left the profession, but she felt it important for her story to be heard. She perceived that in the time between the foundational and recursive phases that her role had become too pressurised. This was explained as being due to complex and growing demands which had contributed to her resignation:

"Well, I have left the role ... there was a lot of pressure in the job which conflicted with my other life, and I just felt that I couldn't do the job to my level of satisfaction and still have time to have a life outwith work as well. " Mary, R., S.M., CHP 1.

Since the foundational phase interview this CNMMs account of the CHP was one of a "curates egg" as is illuminated below:

"... do I think they're better or less good? ... I suppose the answer to that would be some things are better, a lot of things are not better in my opinion." Mary, R., S.M., CHP 1.

This CNMMs experience was of an expanding CHP and a diminishing community nursing management team, perceived as resulting in complex and increasing workloads and a reduction in support. This situation had been discussed between her peers and their line manager. There was a feeling that the line manager gave no real support, solutions or effective leadership to genuinely support the CNMM team. In other words lip service was paid:

"... the CHP was becoming ever bigger and more complex and the management structure within the CHP wasn't growing because of financial constraints. So that resulted in managers and nursing staff, and very possibly wider staff too, although I can't speak for them, but with regard to nurses and managers yes it did result in far more work coming all of our way. And it didn't seem to me like we, as managers, had found a very good way of coping with that. **"** *Mary, R., S.M., CHP 1.*

Here, the CNMM reflected on how the CHP had evolved over a time continuum, from its inception as an LHCC, comparing time past and present. There was inference that organisational growth had resulted in lack of connectedness for this individual:

"I think the CHP has become so big as to be almost unmanageable now. ***Hmm, hmm*** *... I think that when it was a smaller organisation, you knew all the rest of the team and had a much closer working relationship. Whereas now, the team is massive and we work closely with all groups of people that there's no way that we*

can know about what happens in other parts of the CHP. Though, I feel a lot more like a cog in a huge wheel there, whereas I felt like an integral part of the team in LHCC days." Mary, R., S.M., CHP 1.

In addition this CNMM perceived that there was a lack of actively supportive line management which was seen to be underpinned by a command and control ethos without shared priorities, and had led to feelings of disempowerment, and lack of trust:

"I was aware that at a General Manager and board level there was power ... ***Why do you think it works in the way it does?*** *... I suppose again to some extent, it has to come down to personalities and the priorities of those personnel and because they're in a ... feeling a place of seniority ... they can say ... well this is what you further down in the organisation have to do, and I didn't always agree with it but I suppose there are times when you just have to do it. If you yourself are not at that level to say, no I'm not." Mary, R., S.M., CHP 1.*

She went on to outline how she felt that she wasn't heard:

"... I'm thinking now of my immediate line manager, I suppose I might have felt disempowered because perhaps I might have felt that sometimes she didn't listen enough to my point and how I was trying to see things". Mary, R., S.M., CHP 1.

This senior managerial approach was discussed with CNMM colleagues who felt that there needed to be recognition at higher level of perceived lack of senior managerial support, to little avail:

"... we CNMMs had discussions ourselves and said ... well, you know something needs to be done at a higher level. But it didn't happen very effectively." Mary, R., S.M., CHP 1.

There seemed a profound need for this CNMM to get this point across:

"I think it's, I think it's important for people to realise that that's how certain managers feel and I know that I'm not alone in feeling that way because I know that other people that I have spoken to feel the same way." Mary, R., S.M., CHP 1.

The situation had resulted in this CNMM feeling that the particular role she had enacted was not valued:

"... I hope and believe that most people felt the value of my roles but, you know, you would sometimes pick up that people didn't appreciate what you did. What part you had played. The importance of you ... you sometimes felt that there were those that might have thought, well does that role really need to exist?" Mary, R., S.M., CHP 1.

Despite these challenges this CNMM faced there was indication of continued motivation as is evidenced in her attempt to deliver complex services. There was suggestion of integrity being applied to a situation which did not feel right and contributed to the decision to resign:

"I put an awful lot of pressure on myself to try and keep the pot boiling, keep all of these balls juggling and felt that I wasn't managing it. So felt I wasn't doing the job very well and I really didn't like that and sit easy with it. So that was one major reason for my taking the decision that I did." Mary, R., S.M., CHP 1.

The workplace environment with competing priorities and the constant complexity of role enactment through change adversely impacted on this CNMMs health and wellbeing resulting in burnout which was aptly expressed:

"I know that with pressure some people thrive on having a lot to do and a lot of competing priorities etc but I became very worn out by it and I can certainly empathise with role fatigue. It got to the point where I felt that all my cylinders containing motivation and whatever else you need to do the job – you know, I was really feeling that I was running on empty. All these little cylinders were empty by the time I left. " Mary, R., S.M., CHP 1.

The solution for this CNMM was through identifying an exit strategy in order to survive:

"I suppose coming onto the positive adjustment strategies, my strategy was to have an exit plan and in my last year I suppose I was working towards that exit plan and felt I could cope with whatever was thrown at me because I knew it wasn't going to be there for much longer". Mary, R., S.M., CHP 1.

8.4 Exemplar two – Laura expansive interview

Exemplar two reflects on the CNMM role as one that is challenging. However this account illustrated how various support mechanisms including senior management support contributed to retention and coping strategies.

Initially this CNMM found difficulty in becoming role proficient. However she felt supported by a manager who acted as a role model:

"To begin with it was challenging" Laura, E., W.G.M., CHP 5.

There was a feeling that a great deal of learning and mastering of various skills had been necessary within a short space of time but this was viewed as a positive learning experience:

"I suppose it was a steep learning curve in the beginning but when we came on board, we had a very good manager at the time and she was very good so you followed her, how she managed up to a point. ***A role model?*** *... Yes she was and we learned a lot from her." Laura, E., W.G.M., CHP 5.*

This participant used the investigative interview to reflect on the knowledge gained over time to craft the role and make it manageable. This learning experience was felt to have supported the development of confidence building skills. There was support to develop her strengths and hone change management approaches. This contributed to self-assurance in challenging demanding colleagues, and negotiating in an assertive, diplomatic, positive and non-threatening style:

"There's different cultures within nursing that people are very different, I've learned how to manage people better like a clinical director who is a really strong, forceful character but when you get to know him, and he is fighting or he respects how you manage, how you do things now and you learn how to negotiate and how to get where you want to go without stamping on toes and things". Laura, E., W.G.M., CHP 5.

In addition there were two crucial distinct posts supporting this CNMM within the community nursing structure. A professional advisory Lead Nurse post and a line manager provided support and expertise on different role aspects, which may also have added to strengthen the manageability of the role:

"… we do have a head of nursing within the CHP who has a nursing background but she's not a manager, she's just for professional leadership". Laura, E., W.G.M., CHP 5.

Furthermore, this participant perceived that having a clear supportive nursing structure within the CHP was positive in terms of having an identifiable and visible professional nurse leadership. This leadership was seen to concentrate on providing guidance for professional issues and investment in the development of the nursing workforce as opposed to a management role and appeared to be an important distinction. In addition this CNMMs experience was that her line manager was easily accessible being supported by regular individual meetings that facilitated understanding. These two roles were seen to clarify the expectations of the CNMM role which collectively provided connectedness:

"I would have six weekly meetings with my manager and she would be saying what she's expecting me to do or ***So it's clear?*** *Yeah ... there's clear guidelines, but if something comes into the CHP it might come in to the general manager and she might bypass a locality manager and come straight to me, it depends what it is." Laura, E., W.G.M., CHP 5.*

Moreover there was inference of cohesiveness supported by a trusting atmosphere within teams both within the NHS and across agencies:

"... we all work quite closely together, we've got good links. When they're introducing new projects, like, your senior managers will pull on whoever has got the most experience, like, just now there are looking at hospital homecare, setting that up, so they've asked me to be involved in that and when its venturing into child health it

would be my colleague that would be involved rather than me. We work quite well together". Laura, E., W.G.M., CHP 5.

She felt listened to and respected which encouraged engagement with the role:

"... I think we are quite well respected within the CHP and if we've got an issue or whatever because we are, for example, because of efficiency savings now, we've got to ask a general manager for any post that we want to fill or advertise and as long as you justify why you're wanting it, I've never been refused, I put an email off and it comes back "that's fine" so I feel that they respect what we are doing". Laura, E., W.G.M., CHP 5.

This had resulted in a feeling of connectedness to and with the CHP community along with the perception that nursing and the CNMM role was a vital one and viewed as valuable by teams and others:

"I'm part of it, the CHP, it isn't where I'm employed, the CHP needs to deliver a service which is much wider than just this but I feel that I'm doing my bit by delivering a service for the nursing and the other community teams. ***Does that mean you feel like a component of the CHP?*** *Yeah I feel part of the CHP, we consulted them on the management team, so we sit at meetings every month". Laura, E., W.G.M., CHP 5.*

This CNMM perceived that she was respected and empathised with community nursing staff at the coal face and saw that the role was necessary to support teams. She felt responsible to employ a duty of care towards them:

*"I think it's a vital role to support the ground staff because they're dealing with the public and they've got a difficult role as it is so they do need support, when things go wrong or they (**teams**) need to know there've somebody they can call on ... it gives them some sort of security". Laura, E., W.G.M., CHP 5.*

This CNMMs approach was felt to create respect and understanding of the complexity and challenge of the CNMM role with colleagues resulting in what appears to be co-operative relationships within teams. This was seen to sustain and reinforce a supportive ethos that ran through the CHP structure and culture:

"... when the team leaders first came in a few of them have said "I didn't understand how you manage all this and that" but because you're used to doing it you just get on and do it. You can have really busy spells where you're working late and things but then it evens out, you get a quieter time. You are never twiddling your thumbs". Laura, E., W.G.M., CHP 5.

This may have been due to feeling in control because of a perceived degree of power as outlined below that led to feeling empowered trusted and valued:

"... I feel I'm given autonomy to do my job and left to do it. I feel they value what I do and they trust I get on and do it so I don't feel undervalued in any way". Laura, E., W.G.M., CHP 5.

In turn power was seen to be shared with teams which this CNMM believes shows respect towards and valued teams. It was felt that this had contributed to positive working relationships. Aspects of engaging leadership were evidenced here such as building trust between leaders and followers:

"I try and empower my team leaders to do their job, I try and let them have scope but I feel they respect because they always come back asking "is it okay to do" and I say 'aye it's fine' but it's a two way thing. I respect them and they respect me". Laura, E., W.G.M., CHP 5.

When role fatigue was discussed via the use of the graphic representation of phase one themes, this CNMM felt that being engaged contributed to a sense of coherence and wellbeing in the workplace:

"... role fatigue, sometimes when things ... when there's a lot going on we can maybe feel a bit exasperated, would you say ... but, I never wake up and think oh no... I have to go to work, so ***(small laugh)*** *I'm quite happy to go into my work. Sometimes a disengagement I feel, sometimes things are discussed higher up ... and they do involve me in it if it's relevant." Laura, E., W.G.M., CHP 5.*

In order to sustain a positive balance this CNMM identified asset based coping strategies to further build resilience such as exercise, identifying support networks, and the benefits of humour:

"I do make sure that I take time to do something for myself like I go swimming in the morning before I go into work or something like that so I've got time to myself and it helps you unwind, or if you've had a bad day I would go and do it at the end of the day or something. Knowing that I've got colleagues that would support me if there was any issues ... or things like that, there is support there, so it keeps you going. My colleague has got a really witty sense of humour and she's quite funny at times, even when things are really bad for her or I ... she's quite cheery and comes up with things that keep you going, get a laugh". Laura, E., W.G.M., CHP 5.

Collectively, these support mechanisms appeared to maintain this CNMMs engagement with the CHP resulting in satisfaction with, and enjoyment of, the job:

"I enjoy my job. I like my job and I like to be able to think that we can provide a service that's required for our population. The job is so variable, I enjoy the variation and the challenge it brings, I'm never bored, there's lots to do ... it's different". Laura, E., W.G.M., CHP 5.

The overall impression given by the CNMM of the character of this particular CHP and structure was one of an inclusive organisation that enabled and empowered nurses at all levels. The account suggested that there was a comprehensible cultural continuum of support through separate line management and lead professional nurse roles and professional development through role modelling within community nursing. This appeared to be an enabling factor in giving the participant confidence

to challenge colleagues at high level with inference that arguments put forward were listened to, understood, considered and acted on and may be a protective factor in maintaining engagement.

The following illustration indicates how the CNMM role was enacted in terms of perceived tensions and conflicts at all levels including senior executives through managing change:

“How you manage tensions and conflict is important, you have to listen to people and find out what it is that’s bothering them and why they don’t want to go forward and then put your case forward to them.” Laura, E., W.G.M., CHP 5.

Relationships that provided opportunities to discuss change to gain consensus to move it forward was seen as important along with being listened to. In addition being trusted to implement change consistent with individual management style appeared to be important to role enactment and indicated a culture of high performing teams:

“... at the time one of the clinical directors felt that I was doing it too slowly and I had to say, if he wanted it done like tomorrow, I had to say to him “look the manager, he needs to back off or I'm not doing it” because it would just be a different approach, a different style and it doesn’t work, it's not my nature”. Laura, E., W.G.M., CHP 5.

“I thought what about us doing it, spoke to my colleague and she was for it as well so we tried it and saw how well it worked and then when we rolled it out”. Laura, E., W.G.M., CHP 5.

“I got to do it as I did ... I was able to put my case across and they listened to me so it was fine”. Laura, E., W.G.M., CHP 5.

“So we asked who was interested and then did it that way, we felt that was the best way to do it ... we did it that way and it worked”. Laura, E., W.G.M., CHP 5.

Change was seen as an opportunity to overcome challenge as opposed to a threat. By not being prescriptive about the way this CNMM managed change and maintaining openness, the CHP executive management could be seen as being receptive to reviewing change processes when the CNMM identified that it was not appearing to work well. This ultimately resulted in two way communication, trust and the success of new initiatives:

"I always look for a solution, I try not to say "we can't do something" I try and look beyond that and try and find a solution so we can assist somebody or what we can do and I get frustrated that people who just say "no" without thinking, when I know they could do something, they could balance something and manage it, do it, but I usually get round it by saying "we'll file it" or whatever and we'll review it and if it's not working we will go back to whatever". Laura, E., W.G.M., CHP 5.

This chapter highlights two particularly polarised exemplars in terms of their experience of workplace stressors. The particulars of these exemplars are important in terms of the different outcomes for each CNMM in terms of employee engagement.

8.5 Discussion exemplar one – Mary

In the foundational phase this CNMM portrayed the use of engaging leadership with teams by highlighting the need for communication along with team leadership skills and working with multi-agencies termed “boundary spanning” (Floyd and Woolridge 1994, 1997 and 2000) which contributes to effective strategic change. During that time a strong link of engagement with the patient along with informal networks appeared to contribute to the meaningfulness and manageability of the role, however a sense of overload was creeping in. Mary valued the ability to deliver high standards of care for service users and was frustrated by the negative impact strict financial control was having. Incongruent with her values, SG set targets had also been felt to interfere with the autonomy and freedom of the role to make professional decisions to facilitate the delivery of “gold standard” services. Reconciling these conflicts had proven difficult and there was indication that CHP CNMM line management was unsupportive. Despite attempts to engage with senior management regarding the issues outlined above, this CNMM felt that her voice had gone unheard. A culture of structural empowerment (Kanter 1983) was not evident, i.e. having access to information, support from organisational leadership, adequate resources to do the work, opportunities for personal and professional development and empowerment to contribute to achieving organisational goals (Matthews et al 2006, Ming 2008).

By the recursive phase engagement with the service user continued to be maintained. However consistent and prolonged pressure to achieve targets had caused this CNMM to become worn out and “jaded” (Levi et al, 2004). There was evidence of reduced job satisfaction and increased job tension as the fiscal squeeze tightened. Lack of job control and the extent to which the participant felt unable to complete assigned workload appeared to compromise engagement with the CHP. This resonates with the report of Topakas et al who found that the levels of change in NHS employee engagement in England between 2009 and 2010 had fallen and correlates with a study of 1,919 Finnish dentists (Hakanen et al 2005). The relationship between this individual and her experience of the work environment had created an imbalance in equilibrium (Theofilou 2012). These factors affected the

participant’s health leading to the exhaustion of coping resources perceived as burnout. The syndrome of burnout is recognised as as a growing occupational health problem (De Silva 2007), and an important occupational hazard for people-oriented professions such as healthcare. It manifests in feelings of exhaustion, lack of personal accomplishment and depersonalisation (Theofilou 2012).

In this exemplar there appeared to be a deficit in the professional nursing structure and nursing professional leadership at higher level. This was perceived as having negatively impacted on support for the middle layer creating stress. Healthcare is recognised as a stressful occupation, and work-related stress is a major obstacle to staff engagement (King’s Fund 2012).

As Buggins (2013 p.21) notes: “Healthcare organisations are often not very supportive places to work.” She argues that providing staff with “psychological safety” is key.

In this case leaving her job was felt to be the only alternative for Mary to survive the demands and complexity of the role in an unaccommodating atmosphere. Disengaged staff are four times more likely to leave an organisation and it can cost up to 150 per cent of the departing employees salary to replace them (Corporate Leadership Council 2004). This is significant at a time when costs are a huge consideration for the NHS.

8.6 Discussion exemplar two – Laura

Exemplar two portrayed the use of engaging leadership and highlighted the benefits of communication with CHP teams and working with multi-agencies in enacting the role. Exemplar two had a different experience with several factors for effective strategic change based on Floyd and Woolridge (1994, 1997 and 2000). For example this CNMM perceived that there was a supportive community nursing structure, with strong leadership with good communication. Team leadership was valued throughout the CHP structure and with partner agencies which stimulated the formation of networks and networking. There was a strong link of engagement with the patient, the CHP and colleagues across networks. Delivering excellence in care services during strict financial control and government set targets had been felt to have had less impact. Laura appeared to be supported in terms of the allocation of adequate resource via negotiation. In addition it was implied that this CNMM had a good relationship with top managers who were seen to value and respect the CNMM role. Moreover there was clarity of expectations. This CNMM was listened to and involved in strategic thinking and planning with devolved authority and freedom to act in introducing change according to her style. There was an engagement style culture throughout the CHP workplace which was perceived by this CNMM to underpin how business was carried out. Laura felt empowered, able to challenge and be trusted to make decisions and carry them forward. This resulted in her feeling actively supported to develop her strengths and believe that people were willing to listen to her ideas. She felt involved in developing and determining CHP vision, with easy access to executive management (Alimo-Metcalfe et al 2007) and the Associate Director of Nursing.

This suggests that supported, empowered and valued CNMMs can remain engaged with their role and the CHP. They can adopt positive workplace approaches in the enactment of their role through change. Furthermore this supportive culture appeared to support role meaningfulness and manageability, acting as a buffer to the challenges of the CNMM role. West and Dawson (2010), report that individuals are much less likely to leave the service when they work in effective and supportive teams.

8.7 Cross-exemplar analysis

Vanwynsberghe & Khan (2008) emphasise that people learn meaningfully by developing cross-connections between related concepts. Therefore cross-exemplar analysis was used to harness further insight. Exemplar knowledge was accrued, by comparing and contrasting the particular between the two exemplars to produce new knowledge. These differences are now considered.

There appeared to be specific differences between the two exemplar CNMMs in relation to their experiences of senior management in terms of connectedness and empowerment (or lack of) and the link to employee engagement with the organisation. Lindstrom and Eriksson (2010) outline the importance of individual empowerment to gain control of life.

This is particularly relevant to the overall study with the two exemplars emphasising noteworthy variances. Both reflected on the CNMM role from commencement of the post and the inception of CHPs which emerged from LHCCs. Mary did not experience a culture of senior line management support and resources that could have strengthened the manageability of the role. This particular CNMMs personality style did not appear to have been valued or considered, resulting in the negative experience of burn out. There was suggestion that this CNMM did not feel listened to, trusted to make decisions, or supported to develop her strengths. This is the opposite of what would be expected in a culture of high performing teams (Alimo-Metcalfe et al 2007).

On the other hand Laura appeared to be flourishing despite the challenges of the role complexities and work environment. There was evidence of respect, empowerment through active support, being listened to and involved in decision making. This CNMM was supported to achieve vision through development of her strengths. There was a perception of strong senior nursing leadership, evidencing a culture of a high performing team. This can be linked to comprehensibility, meaningfulness and manageability of the role. In addition feeling valued may have

supported engagement with the organisation and the retention of this participant (Scott et al 2003).

Previously occupational stress and burnout literature pointed to the personal characteristics of the individual in contributing towards negative health (Medland et al, 2004). Conversely current and expanding research identifies environment and organisational structure as the primary contributors to stress and burnout (Shirey 2009). Consequently, "employee perceptions of their own wellbeing are heavily influenced by the culture in which they work" (Mowbray 2011 p.16). This issue is therefore one that NHS CHPs should take heed of. Many organisations have reported improvements in productivity, retention of staff and a reduction in sickness absence after tackling work-related stress. I argue that we need to take a more proactive approach in the prevention of stress in the CNMM population by taking action to reduce the potential for stress.

Freed & Dawson (2006) use metaphor to describe the role middle managers have in general, suggesting that they are the company's engine, as they set the pace for executing the strategic plan and focus on the organisation's priorities. The use of this mechanical metaphor reflects the Tayloristic style of management and systems structure that have been historically applied to the NHS (Freed & Dawson 2006) in an attempt to create efficiency. Mintzberg (1989) argues that concentrating on efficiency allows measureable cost saving benefits to overshadow less quantifiable social benefits completely, and social values get left behind. This may be dehumanising as human beings are complex, therefore CNMMs will face major challenges for the foreseeable future.

As mediators, CNMMs may find it difficult to negotiate a successful route between competing challenges, role conflict and ambiguity, and remaining engaged with the organisation. As has been shown by the exemplars strong leadership and support was perceived as a protective factor.

These aspects will be further considered and developed in the more wide-ranging discussion in the next chapter.

CHAPTER 9: DISCUSSION

9.1 Overview of chapter

The purpose of the discussion chapter is to cohesively pull together the strands of the empirical findings and make sense of them through in-depth interpretation, analysis, and synthesis. It starts with reflection on the study's aims, research questions and parameters. It then summarises relevant literature that has emerged during the course of the investigation in order to consider the meaning of the findings in contemporary context. This involves consideration of both the outer and inner macro contexts within which CNMMs were operating at the time of the investigation.

There then follows consideration of role content, form and set in order to bridge between the general understandings from healthcare literature, and empirical evidence from the thesis about the life world of CNMMs. This life world highlights the crucial role of CNMMs professional identity, in particular their perceived nursing values, which appear to help them to interpret and enact the leadership and management aspects of their role through change. Reflection on divergent experiences of CNMMs follows leading to consideration of the conditions within which the CNMM role can be best supported and empowered. In particular, the application of a salutogenic perspective emerges as important. The chapter finishes by highlighting a very recent study of middle managers in Scotland's social services which has much resonance with this study's findings.

9.2 Reflection on the purpose and nature of the study

The aim of the investigation was to understand the lived experience of CNMMs working in evolving CHPs in Scotland, as they enacted their roles within the context of processes of change and to explore related implications. The literature on this subject was found to be deficient and therefore the study sought to answer the following questions:

1. What are CNMMs perceptions of their role within CHPs?
2. What are CNMMs experiences and views of how they negotiate and manage change within CHPs?
3. How do CNMMs understand the impact on themselves and others?
4. What sense do CNMMs make of this?
5. What does this mean in the context of wider understandings from the literature in Scotland and the UK?
6. What are the implications for practice, policy, education and research?

Chapters Five to Eight presented syntheses of the findings in relation to questions one to four. These chapters forefront the words of the CNMMs themselves following the Interpretative Phenomenological Analysis (IPA) approach. As outlined in Chapter Three, the method applied is phenomenological, hermeneutic and idiographic. CNMMs used their own words to offer an understanding of their thoughts, commitments and feelings (Reid et al 2005). However, IPA study involves the researcher's own interpretation of what emerges by engaging in the double hermeneutic. In other words "trying to make sense of the participant trying to make sense of their experience" (Smith 2009 p.53). Chapter Nine now attempts this in order to address questions five and six. My primary interpretation is evident in the analyses and synthesis presented in Chapters Five to Eight and a key part of this was the use of the foundational phase theme maps with those interviewed in the recursive and expansive phases (answering questions one to four). In the present chapter there is a conscious "stepping back" to use literature to achieve a secondary level of interpretation, addressing questions five and six.

It is firstly important to consider the parameters of the study beginning with what is covered. The study has focused on in-depth perceptions of CNMMs. They all had middle management experience having been recruited to their posts from within the NHS. The participants mainly comprised of women in their middle years with long backgrounds and current foregrounds in community nursing in the NHS. They had inhabited nursing for a long time, and had personally invested in it. Many had limited leadership/management training, having learned their craft mostly "on the job". Therefore the study has focused on the life world as related by a particular group. The findings have been presented to mainly portray CNMMs perceptions and experiences of role enactment through change in their own words. Interviews took place over a period of time and geographical span involving a sustained dynamic process of IPA. This provided the opportunity to capture interests and values throughout the investigation and to interpret data continuously (Colebatch 2006, Fischer 2007). Ongoing analysis and interpretation elicited key themes. In this regard the findings showed substantial areas of convergence, with some distinct areas where experiences differed.

Having considered what the investigation has examined and how it has been carried out it is important to clarify what the scope of the investigation has not included. Due to the study design, influenced by time and financial constraints, it does not explore similar in-depth perspectives from other key actors within their work contexts, for example views on CNMM role enactment through change from the perspectives of other senior and junior managers and teams.

9.3 Contemporary context as a lens

Given this limitation it is therefore useful at this point first to step back from the findings and view them within the wider frame that has emerged during the course of this study, provided by relevant contemporary literature. Therefore the next sub sections review and use this literature to explain concurrent outer and inner contexts relevant to understanding the experiences of contemporary CNMMs. The main literature sources are presented in terms of subject and chronology in Table 24.

Table 24: Health policy and research literature relevant to understanding contemporary Community Nursing Middle Manager contexts

Subject/ Date	Author	Title
Community Health Partnerships		
2007	**Scottish Government (2007)**	Better Health, Better Care: An Action Plan. Scottish Government, Edinburgh.
2010	**Watt et al (2010)**	Study of Community Health Partnerships. Health and Community Care. Scottish Government Social Research. Queen's Printers of Scotland. Edinburgh.
2011	**Audit Scotland (2011)** **Robson (2011)**	Review of Community Health Partnerships. Prepared for the Auditor general of Scotland and the Accounts Commission. The national Service in Scotland: Subject Profile. SPICe Briefing. The Scottish Parliament .
Community Nursing		
2006	**Scottish Executive Health Department 2006a)**	Visible, accessible and integrated care report of the review of nursing in the community in Scotland. Executive, Edinburgh.

	Scottish Executive (2006b)	Modernising Nursing Careers: Setting the Direction. Scottish Executive, Edinburgh.
2007	**Scottish Government (2007)**	Better Health, Better Care: An Action Plan. Scottish Government, Edinburgh.
	Pollock (2007)	Responses to VAIC. The Practitioners Voice. A report commissioned by QNIS of the views of practice nurses concerning the introduction of the new Community Health Nurse role. Briefing Paper No 5.QNIS, Edinburgh. http://www.qnis.org.uk.
	Quickfall & Pollock (2007)	Community nursing: redesign in Scotland. British Journal of Community Nursing 13, 373-377.
2008	**Scottish Government (2008a)**	Overview of Evidence Relating to Shifting the Balance of Care: A Contribution to the Evidence Base. Scottish Government, Edinburgh.
	Kennedy et al (2008)	Establishing the contribution of nursing in the community to the health of the people of Scotland: integrative literature review. Journal of Advanced Nursing 64,416-439.
2009	**Kennedy et al (2009a)**	Scottish Government Social Research. Review of Nursing in the Community: Baseline Study. Scottish Government, Edinburgh. http://www.scotland.gov.uk/Resource/Doc/266873/0079883.pdf
	Royal College of Nursing (2009)	A Sustainable Future: voices on a Vision. RCN, London.

2010	**Royal College of Nursing (2010)**	Pillars of the community: the RCN UKs position on the development of the registered nursing workforce in the community. RCN, London.
2011	**Gray et al (2011)**	Professional boundary work in the face of change to generalist working in community nursing in Scotland. Journal of Advanced Nursing 67,1695-1704.
2012	**Haycock-Stuart (2012)**	Modernising community nursing in Scotland Community Practitioner. Volume 85, Number 3, March 2012, pp. 13-13(1).
	Machin et al (2011)	Maintaining equilibrium in professional role identity: a grounded theory study of health visitors' perceptions of their changing professional practice context. Journal of Advanced Nursing, 68 (7). pp. 1526-1537. ISSN 0309-2402.
	Elliott et al (2012)	Study of the implementation of the new community health nurse role in Scotland – Research Findings Scottish Government Social Research Edinburgh Report: http://www.scotland.gov.uk/Publications/2012/03/1388/0
	Mackenzie-Baker (2012)	Research Findings: http://www.scotland.gov.uk/Publications/2012/03/3600/0
2013	**Dickson et al (2013)**	Time for a change in community nursing? A critique of the implementation of the review of nursing in the community across NHS Scotland. Journal of nursing management. 2013,21,339-350.
	Machin & Pearson (2013)	Health visitors' interprofessional working experiences: implications for their collaborative public health role. Journal of Health Visiting, 1 (1). pp. 31-38. ISSN 2050-8719.

	Elliott et al (2013)	Professional role identity in shaping community nurses' reactions to nursing policy. Journal of Nursing Management DOI: 10:1111/jcnm.12153.
Community Nursing Leadership		
2010	**Haycock-Stuart et al (2010)** **Haycock Stuart et al (2010)**	Understanding leadership in community nursing in Scotland. Community Practitioner, 2010 Jul; 83 (7): 24-8. (journal article-research, tables/charts) ISSN: 1462-2815 PMID: 20701188 Volume 83, Number 7, July 2010, pp. 24-28(5). Emotional labour within community nursing leadership. Community Practitioner, 2010 Sep; 83 (9): 24-7. (26 ref).
2011	**Cameron et al (2012)**	Exploring leadership in community nursing teams. Journal of Advanced Nursing 68(7), 1469-1481. doi: 10.1111/j.1365-2648.2011.05869.x.

9.3.1 Outer context: primary care in the UK

Drawing on Sines (2009), the key issues involved for primary care within the UK are outlined providing an outer context relevant to Scottish community nursing **(Table 25).**

Table 25: Key issues affecting primary care

Key issues affecting primary care
■ Demographic changes including an ageing population, with the associated health needs and the impact on the working population.
■ Increased longer-term disorders and complex conditions.
■ Evolving patient/user expectations, partnerships and empowerment for users; users as co-producers of care.
■ Reorientation of health and social care with the rapid shift towards community care.
■ Evolving staff skill mix, for example, assistant practitioners.
■ Emphasis on the evidence/research-base.
■ Interprofessional and interagency working.
■ Emphasis on governance, accountability, standards.
■ Ethical issues relating to healthcare advances, scientific and technological developments.
■ A focus on health promotion, public health and tackling inequalities, staying healthy, prevention of ill health and self-management.

Alongside these key issues and perhaps in an attempt to manage the inherent challenges associated with them, Hunter (2005) observes that the NHS has been in a state of permanent revolution having gone through at least five major structural reorganisations with numerous policy initiatives. This plethora of change over the years has included the application of market philosophies to the NHS, the shift of acute to primary care in the community, competing priorities from imposed government driven targets, and an expectation that these changes are attainable through partnership working. As Shortell (2004) indicates in this context, healthcare delivery is as much a managerial as it is a clinical challenge.

9.3.2 Outer context: primary care in Scotland

The early evolution of CHPs in Scotland was explored in Chapter Two. As already mentioned, the "Better Health Better Care" (Scottish Government 2007) action plan put CHPs at the heart of the agenda for shifting the balance of care from the acute to the community setting. As such these organisations were designed to facilitate greater integration between the NHS and local authorities. Therefore evaluating CHPs is important, but in 2008 Freeman & Moore considered them too new for their effectiveness to be measured. During 2010, Watt et al examined CHP progress in effecting partnership working through the lens of those at high strategic level. The population interviewed included general managers who perceived that, despite some challenges, the CHP in their area was working well and would continue to build on progress.

However, the findings of Watt et al were in complete contrast to those of Audit Scotland the following year (2011) which highlighted that CHPs were not functioning as well as had been suggested. This audit highlighted several flaws which included CHPs not having the necessary authority or influence over resources to implement the changes required to meet the responsibilities invested in them. Furthermore CHPs were found to be set up in addition to existing partnership arrangements (e.g. Community Planning Partners) which had led to duplication and a lack of clarity about their role. In addition cultural and operational differences between NHS Boards and councils had acted as a barrier to partnership working between health and social care. Limited progress had been made in shifting the balance of care across the health and social care system at a national level and was highlighted in a SPICe briefing by Robson 2011 (p.13). Furthermore some national health trends were found to be worsening. For example, more elderly people and those with long-term health problems were being admitted to hospital as emergencies. While there was an initial drop in the number of patients being delayed from leaving hospital, this was now rising.

It is important to note that these two highly contrasting reports are the only substantive evaluative evidence of the organisational context within which the CNMM population had been working during the time of my study. The investigation carried out by Watt et al (2010) was limited. It notably captured a participant sample consisting of those who operated at high strategic level, and whom, it could be argued, had a vested interest in a positive outcome from the study. This could be considered a weakness. Whereas more credence could be given to the findings of Audit Scotland which was set up as a statutory body in April 2000, under the Public Finance and Accountability (Scotland) Act (Scottish Government 2000). In addition the Auditor General is independent and is not subject to the control of the SE or the Scottish Parliament. Indeed, following the audit, the Cabinet Secretary for Health and Wellbeing was reported in the press as saying CHPs "have to change" (BBC News 2011) indicating how seriously the findings were being taken by the Scottish Government. Crucially, CNMMs (along with others) are totally invisible in both studies, highlighting their relative unimportance on the wider CHP stage, despite the importance attached to the integral role of community nursing in the delivery of government policy at the time.

9.3.3 Outer context: policy influencing community nursing in Scotland

Delivering for Health outlined the strategies to take forward Building a Health Service Fit for the Future (Scottish Executive 2005b). It presented the plan for the NHS in Scotland over the following 20 years. The underpinning principle was for care provision to be delivered in the community, putting community nursing at the heart of the Scottish Government's vision for high quality healthcare (Scottish Government 2012). An action point from Delivering for Health (Scottish Executive 2005a) was the review of nursing in the community, VAIC (Scottish Executive 2006a). Crucial to VAIC was the proposed creation of the generic CHN, replacing the specialist roles of health visiting, school, family and district nursing. This new role, along with a related educational programme, was piloted in four Scottish Health Boards over two years moving to the implementation phase in April 2008 (Unison 2009).

In 2007, the Queens Nursing Institute Scotland carried out a series of community nurse focus groups across Scotland (Quickfall & Pollock 2007) and found that participants were not convinced of the new role.

Evaluating the impact community nursing actions had made, by use of an integrative literature review, Kennedy et al (2008) found there to be little empirical evidence, concluding that resourced research was needed to quantify their work. In 2009 the SG commissioned Kennedy et al (2009a) to provide quantitative and qualitative evidence via a baseline study using mixed methods. These consisted of questionnaires and focus groups in the four NHS development sites identified as part of the Review of Nursing in the Community in Scotland during 2008. Views and satisfaction of CHNs with their current role, their views on the proposed model, views of their clients and their experiences of receiving care and support from nurses in the community were collected. The results showed that many participants perceived that community nursing work was invisible with community nursing roles poorly understood. They concluded that there was little empirical evidence to support a generic community nurse role. Only one-third of community nurses were supportive of the model (32%). Conversely over half (67%) expressed little or no support (Scottish Government 2009a). In April of the same year the Royal College of Nursing published an alternative vision for community nursing, “A Sustainable Future: voices on a Vision; A companion to the RCN Vision for Community Nursing in Scotland” (2009). By May 2009, unions were lobbying the new Scottish Health Minister. These collective actions resulted in VAIC being suspended across Scotland. A more inclusive approach was then adopted and a National Modernising Community Nursing Board established in 2009. Over the course of the next two years a vision for community nursing in Scotland was developed involving NHS Board Nurse Directors and their staff to guide the programme. The culmination of this work was The Modernising Nursing in the Community interactive website which was introduced in 2012.

These contextual influences were significant for the CNMM population during the span of my investigation. More generally, uncertainty and flux about the future of community nursing was a feature of the period of exploration. Two of the CHPs in my

sample had participated in the VAIC pilot but ultimately neither of their parent Health Boards had supported implementation of the proposed VAIC model. Indeed, VAIC can be seen as almost entirely an intra-nursing initiative, driven by the SG Chief Nursing Officer at that time. Notably, Dickson and Coulter-Smith (2012) criticised the SGs detached style of leadership

Furthermore there had been very little pressure from other professions or CHP impetus to make this proposal happen (Macduff 2007). Therefore it could be contended to be a strangely dislocated initiative from the perspective of the employing organisations. The inner context is now considered in relation to relevant literature that emerged during my study.

9.3.4 Inner context: recent empirical research relating to Community Nursing and CNMM role enactment

From the perspective provided by this brief overview of relevant contemporary literature it can be seen that there is external evidence that, during my study, CNMMs were in general highly likely to be enacting their role within a context of much change and uncertainty. Moreover this literature raises questions about community nursing leadership in terms of quality and support.

Haycock-Stuart et al (2010) found limited evidence concerning leadership in community nursing in Scotland. Adopting a qualitative, interpretive method including semi-structured interviews and three focus groups which comprised of 31 participants, they studied nurses in leadership roles at a more operational level than my own study and community nurses in three Health Boards in Scotland. The participants included eight district nurses, twelve community staff nurses, three health visitors, two nursery nurses, two healthcare assistants, five team leaders, three lead nurses, one acute manager from the community sector, one assistant director of nursing and two directors of nursing. It is unclear exactly how many in the sample were CNMMs as defined in my own study, but the above would suggest that no more than five would be CNMMs in these terms.

Whilst my study explored the perceptions and experiences CNMMs at strategic level, Haycock-Stuart et al (2010) concentrated on investigating leadership at operational level. They specifically examined the interaction between policy and leadership development in community nursing**.** The research concluded that government policy was considered to have failed. Later that year, Haycock-Stuart et al (2010) studied community nurse team leaders and community nurses in Scotland who perform their role at operational level. The study provided some insight into the emotions involved in enacting their role. Twelve qualitative interviews were undertaken with 14 District/ Community Nurses, 12 Community Staff Nurses and 5 Health Visitors. Interestingly, their results correlated with some of the findings of this study, namely the challenges and tensions of performing a leadership role in community nursing and feelings of being unsupported.

Contrastingly in a further study carried out in Scotland, Cameron et al (2012) discovered supportive practices towards teams associated with transformational leadership. Their study applied an exploratory descriptive design, utilising individual semi-structured interviews and focus groups in four case-studies, with a total of 54 participants. Two case-studies focused on district nursing teams and two involved public health nursing teams, located in two geographical areas. The participants were found to utilise a model with significant emphasis on the importance of personal relationships and support. Their findings portrayed that operational leadership perceptions and practices differed from the acute sector, highlighting a more "quasi-family" model. This was felt to be due to the home setting context in which community nurses carry out their work, in relative isolation and low visibility. In contrast to nurses working in the acute sector it was found that community nurses related to each other at a distance because of the nature of their work, often working alone in stressful situations. It was suggested that this requires very strong emotional and psychological support from colleagues. An alternative explanation offered was that it may be "because community nurses are primed to think in terms of family health they may therefore be predisposed to think of the team in this way" (Cameron et al 2012 p.12). Some of these findings also correlate with my study in terms of

CNMMs attesting to enacting an engaging leadership style, with some comparing teams to families in their narratives.

Between 2002 and 2008 a group of seventeen UK health visitors in community healthcare were studied by Machin et al (2013) using a different methodology from this study. Grounded theory and constant comparative analysis via direct observations and individual interviews was the method applied. Akin to the findings of my study they found health visitor roles, like CNMM roles, were perceived to be unclear leading to role identity fragmentation and conflict. They concluded that re-establishing equilibrium and consistency in health visiting identity was a priority. In addition professional role identity was investigated by Elliott et al in 2013 concentrating on the effects it has in shaping community nurses' reactions to nursing policy. These two publications have significance in their correlation with CNMMs experiences of working in complex systems, being affected by role change and challenges to role identity. Their nurse identity was valued by CNMMs and shaped how they reacted to taking forward SG nursing policy. Certainly identity emerged as a significant aspect in my study which will later be discussed. This more general literature provides a useful counterpoint to the very specific in depth perspectives gained from the particular CNMMs in my empirical study. In order to build further understanding, and to bridge between these perspectives and analysis, I now draw on seminal work from Merton on role sociology as an interpretive lens.

9.4 How CNMMs experienced their role

In 1957, Robert K Merton postulated that:

“Contemporary sociological theorists are largely at one in adopting the premise that social statuses and social roles comprise major building blocks of social structure. This has been the case, since the influential writings of Ralph Linton on the subject, a generation ago. By status ... Linton meant a position in a social system involving designated rights and obligations; by role, the behaviour oriented to these patterned expectations of others” (Merton 1957 p.110).

However Merton differed from Linton in as much as he identified that individuals in society “do not have one single associated role but an array of roles” (Merton 1957 p.110). In 1893 Emile Durkheim a French sociologist published his doctoral dissertation “The Division of Labour in Society” (“De la division du travail social” – later translated in 1964). He looked at the advent of professionalism relating to the division of labour of modern industrialised society and postulated that sudden change causes a state of anomie due to normlessness. The concept of anomie is broad, but is regarded as a state where norms (expectations on behaviours) are confused, unclear or not present. Changing conditions as well as the associated adjustment of life leads to dissatisfaction, alienation & conflict. He observed that social periods of disruption brought about greater anomie.

The application of these theories are important in terms of the ongoing analysis and interpretation of how the workplace was experienced by CNMMs in enacting their role through the disruption perceived to be created by the change going on at that time.

Useful definitions of aspects of role are provided by Macduff (2007) as follows:

- **Role content** – activities undertaken
- **Role set** – nature and scope of relations with colleagues, those managed and managing and associate expectations in terms of function status and power

- **Role form** – professional domain(s) identity and associated cultural meanings
- **Role development –** expansion or extension of content, form, and/or set as gauged by normative or ipsative criteria.

These are now applied to provide structure to the discussion that follows.

9.4.1 Role content: shifting ground

The majority of CNMMs perceived the role as ambiguous, adjustable, fluid and shifting to accommodate changes, correlating with O'Gorman's (2005) study of middle managers in general. This was evident from the variety of CNMM titles that differed between CHP organisations, CHPs in the same region and across the three regions studied. A considerable complication for many CNMMs was felt to be the character of the middle management role which was not clear cut, connected to job titles or to job descriptions (Checkland et al 2011).

Without having the detailed examination provided by this study, CNMM role enactment may otherwise appear to be perceived as straightforwardly set within a fixed context. However the CNMM accounts provided in this thesis offer an important insight via individual and collective experiences of unpredictable role adaptation. This was associated with change both political and financial which influenced job descriptions, organisational structures and hierarchies, strategic and operational government, regional and local policies. CNMMs felt that they facilitated teams to change and to implement change directives. In order to increase efficiency and maintain quality service delivery CNMMs were expected to satisfy the "change driven" expectations of strategists. Indeed Hunter (2005) alludes to NHS managers having become addicted to change, in terms of their political masters and mistresses expecting them to respond to and deliver whatever is decreed.

Nonetheless, over the course of the study the pace of change to accommodate efficiency gains endured, leaving CNMMs "change dazed" (Shirey 2009 p.3), compounding the challenge of CNMM role enactment. CNMMs acknowledged that

change is a steady state and has to be lived with. Feildberg (2007) in Lishman (2007) uses Hughes and Pengelly's 1997 notion of this state as one of dynamic stability – the reality in an ever changing world. Change was in the air that middle managers breathed (Amado & Ambrose 2001) and appeared to be a turbulent process, especially within the CHP organisational climate. However most management theorists have not provided advice on how to lead and manage organisational change (Abrahamson 2004) thus making change processes for CNMMs more challenging.

As key players in instigating change through centrally directed targets CNMMs alluded to ''change fatigue''. Role and change fatigue were perceived to be a consequence of the span and quantity of work assigned to CNMMs, the complexities of the nature of their work, and the expectation for new working patterns, roles, skills and behaviours required to be adopted by them. An English study by Stevens (2004) suggests that reforms are placing greater emphasis on shifting professional boundaries and engendering flexibility describing this as 'constructive discomfort'. Consequently CNMMs experienced role fatigue due to demands made on them to implement government driven initiatives and meet targets with shrinking resources. It is likely that the pace of change will continue and accelerate for the foreseeable future as organisations continue to be reinvented via political and technological developments.

The complexity of the CNMM role was aligned to the functioning of the CHP organisation predicated on partnership working. Partnership working further complicated the CNMM role as it functioned within acute and primary healthcare, and multiple partner agencies such as local councils, the voluntary and private sectors and across many disciplines. In terms of role content all CNMMs perceived the role as complex with widening spans of control within the activities they undertook. Considerable management and leadership responsibilities across an array of community nursing disciplines and services were recounted. Two CNMMs in the expansive interview cohort managed a team that included a discipline other than nursing. The non-nursing members of the team were employed by the local community council supported by a profession specific lead with day to day

management by the CNMM. This may suggest that the partnership philosophy was more embedded in these CHPs having advanced partnership work by extending managerial control across partner agencies.

In general the CNMM remit included managing budgets, operational processes, HR duties, assessment of staff competency and overall responsibility for safe effective and quality service user care. As such CNMMs executed a “bundle of obligatory activity within systems of social action often with multi professionals and agencies” (Koteyko and Carter 2008 p.484). In doing so they supported SG and executive management’s strategic initiatives involving change through their teams. CNMMs suggested that in order to enact the role they performed several activities at once to support government led change. In addition they were expected to contribute to achieving targets whilst grappling with the practicalities of translating multiple and often competing priorities (such as health improvement, efficiency, access to treatment and treatment – HEAT targets), into effective action whilst maintaining the delivery of day-to-day services.

Most CNMMs cited measures such as HEAT performance indicators as a form of control of the complex partnership CHP system by the government. Politically driven targets were viewed as being there for politicians and not necessarily for the good of the NHS or the public. As Iles (2011 p.26) aptly puts it:

“Performance can then be trumpeted in the media, whether or not it accords with the wishes or experiences of people on the ground”.

Furthermore it was implied that senior managers often focused on reaching performance targets at the expense of development (Hollenbeck & McCall 1999). Targets were often viewed as tick box exercises that had been engineered to realise political rhetoric without adequate consideration by politicians of the wider effects within the CHP and multi-agency system (including the effects on staff, and patient care which was perceived as negative).

CNMMs understood the need to monitor performance and budgets and deliver economic value. However these concepts could clash with their nursing values,

particularly in terms of ensuring quality. It is notable how some CNMMs felt that there had been increasing government control in terms of targets which had also impacted on role enactment. This control, however, was seen to have been applied at both strategic and operational levels. In addition CNMMs perceived that central government control had increased despite successive governments claiming to have devolved power into the NHS (Department of Health 2000, Department of Health 2001). These changing parameters of national priorities by governments were seen by CNMMs as fluid, influenced by political rhetoric in fashion at the time (Greener & Powell 2003) and felt to have reduced CNMM autonomy.

Interestingly CNMMs often used metaphor in talking about aspects of what they did. Several CNMMs described their role as a juggling act e.g. *"juggle a million balls in the air you know?"* The use of the term juggling has connotations of maintaining many objects in continuous motion in the air and keeping an eye on all of them so that nothing drops or gets lost suggesting all objects have equal importance. In addition CNMM accounts referred to the diversity of their roles and remits as wearing *"many hats".* This alludes to the variety and number of roles and responsibilities requiring to be enacted through change, concurring with the findings of Conway and Monks (2011). With each "change of hat" the CNMM assumed a different role creating a situation that was seen to be confusing for the individual, colleagues and partner agencies with uncertainty about overall role purpose. Over the course of the investigation the majority of CNMMs echoed Savage's (1993) assertion that the NHS had experienced increasingly contentious change. Managing and implementing change was found to be an "add-on" that CNMMs were expected to fit in around the margins (SEHD 2007), whilst at the same time continuing to deliver services or "*keep the pot boiling"* as one CNMM put it. This creates a picture of concentration on ensuring that the water is at exactly the right temperature as an unwatched pot can quickly go from boiling to overflowing. In other words, paradoxically, the role involved maintaining the status quo through change.

Collectively, these demands were creating considerable strain for the majority of CNMMs. In conceptual terms, this was referred to as having *"too much on your plate at one time".* This choice of metaphor was used by several CNMMs mainly within the

foundational and recursive phase cohorts and illuminates their feelings of being overwhelmed with too much work that couldn't be completed and was in danger of being dropped. Described by one CNMM for the many, the role was captured as functioning "*between a rock and a hard place*" inferring that choices between alternative actions had to be made which created problems by not satisfying everyone in the process. Information sharing and controlling rumour was seen as a fundamental role in managing change, otherwise, as one CNMM put it "*it's the old Chinese whispers and you end up with an ant's nest of problems".* The use of these metaphors indicate perceived difficulties in the giving and receiving of communication which can be misunderstood when taken out of context or when the meaning is corrupted or distorted. This was believed to be inherent in the CNMM role component of assigning meaning to change directives.

This use of metaphor by CNMMs in my study correlates with several other empirical studies where authors found metaphors useful in examining phenomena. For example, Kuhse (1997), examined nurses' history of subservience and, argued that metaphors not only draw attention to similarities that already exist, but create similarities. Froggatt (1998) found metaphors useful in examining the emotional work of nurses working in palliative care and Wurzbach (1999) discussed moral metaphors present in nursing. More recently, Gray et al (2011) noted metaphor use by community nurses and managers in an exploration of professional boundary work through change. Via case study Goodman (2001) specifically explored the use of metaphor in nursing literature and research with practitioners and others. Priorities for, and definitions of district nursing, were examined including whether insights could be offered about the situation and experiences of nurses during a time of policy change. Findings showed that a shared group of metaphors were used to capture district nursing work by district nurses, GPs and nurse managers. Interestingly some of the metaphors used in her study were the same or very similar to those found in mine. I concur with her conclusion that an examination of metaphoric language offers an opportunity to examine what otherwise would be tacit or even misunderstood in nursing work. Indeed it also aided the IPA double hermeneutic method of making sense of CNMMs making sense of their experience.

9.4.2 Role set: the view from the middle position

Discourse outlining the complexity of the healthcare work environment was key in assisting CNMMs to articulate their understanding of the world in which they made judgments and decisions through change. The principles underpinning these changes were identified by CNMMs as cost effectiveness and a drive to shift acute services into the community. Both the CNMM role and CHP were viewed as being fluid with widening spans of control. The context of their position therefore was considered to be driven by policy and reorganisation that was viewed as political, economic, socio-cultural and geographical in terms of its influence both outwith and within the healthcare setting. These influences were felt to have impacted on the nature and complexity of the CNMM role and others' expectations. It is therefore not surprising that CNMMs felt that there were considerable contingent conditions and tensions in enacting their role through change in the perceived demanding and complex work milieu. Notably these tensions included their semi-autonomous middle position (Currie and Proctor 2005), and this is now considered in more detail.

Many CNMMs felt it crucial that as leaders they needed to have more than the semi-autonomous power that was apparent in their accounts, to empower teams and frontline staff in delivering safe quality care. This correlates with the work of Regan & Rodriguez (2011) who studied nurse empowerment from a middle management perspective in the acute setting. Regan & Rodriguez (2011) draw on Kanter (1993), and Greco et al (2006) who define empowerment as the ability to get things done by having the capacity and authority to mobilise resources, provide support, opportunity and information. Yet in considering their overall remit for the delivery of safe quality care, CNMMs perceived that they had a vast amount of responsibility but felt that they had limited control (Regan & Rodriguez 2011) or power over the movement of resource to increase efficiency due to financial constraint. An additional consequence of financial constraints and organisational cutbacks was restructuring and delayering (Litter et al 2003).

CNMMs perceived that this had resulted in reduced senior nurse management posts. Vacated senior nurse posts disappeared or were left unfilled due to financial

constraints. As a consequence CNMMs experienced their roles as having become broader in scope and more pressurised similar to the findings of Thomas and Dunkerley (1999), who specifically explored middle managers experiences in downsized organisations. This is a general trend of European middle management (Vouzas et al 1997). CNMMs experienced their roles as having become broader in scope and more pressurised with fewer having greater responsibility for wider duties due to restructuring (Dopson and Stewart 1990).

Mitchell (2011) refers to research carried out by Alison Petch, Director of the Institute of Research and Innovation in Social Services (IRISS) which showed that restructuring services does not necessarily lead to improvements. This notion is also supported by Duffield et al (2007) who found little evidence of improved efficiency or outcomes from restructure in the hospital setting. Worryingly, the detrimental effects of organisational change were found by Harenstam et al (2004) to be greater in the public sector due to the increase in the differentiation of working conditions. Supported by empirical evidence, Abrahamson (2004) cautions that gurus have been over prescribing highly destabilising change management processes for several decades especially when related to cost efficiency. Moreover he highlights that initial cost savings associated with cost cutting exercises disappear within one and a half to two years.

These influences were felt to have contributed to the increasing amount of alteration CNMMs were expected to manage. There was expectation from the SG, Health Boards and accountants to introduce and maintain skill mix and apply imposed delays in recruitment to cut costs. This resulted in redesign of community nursing teams. Sometimes redesign was challenged by GPs whose expectations of CNMMs were seen as unrealistic given that CNMMs were required to follow the drivers set by the SG. At the same time HR and team colleagues expected CNMMs to adhere to NHS HR policies designed to maintain a healthy and fair workplace.

Contrary to Currie & Proctor (2005) and Carney (2004) who found that flat organisational structures facilitated middle managers involvement in organisational strategy development, the majority of CNMMs in the foundation and recursive

phases of the investigation expressed scepticism regarding genuine opportunities to do so. Most CNMMs in these cohorts perceived that they were becoming disempowered with little influence, with some experiencing a lack of organisational support. Interestingly a recent working paper Wulf (2012) presents evidence to support the notion of disempowerment. She asserts that flattening structures leads to the opposite of what it promises to do by pushing decisions up the hierarchy rather than facilitating autonomy. In addition some CNMMs referred to their own management being absent in terms of support. Again this was most evident within one CHP, but was also reported as occurring in others. This is of concern as literature indicates that negative perceptions of middle manager nurses adversely effects staff development and patient safety (Regan & Rodriguez 2011).

As noted already, the semi-autonomous role, imposed and shifting targets, the continued expectation to provide universal and equitable services in the eye of a stark economic downturn, and the uncertainties and instability that change creates, had resulted in a form of anomie (Saunders et al 2005) for some CNMMs. Another contributing factor leading to anomie was “goal ambiguity” as outlined by Baggot (1997). Goal posts were seen to be altered by the government. There was evidence of some CNMM disengagement from the politically controlled NHS (but not from service users), with a small but significant number of the CNMM population having left or planning to leave due to disillusionment and perceived overload. Again this was specific to one CHP.

Notably however the additional phase CNMM cohort had a different experience. Many felt that they were respected, empowered, listened to and included in strategic decision making by senior nurse and executive management. This is of note as a study by McDonald et al (2010) suggests that nurses demonstrate greater commitment to the organisation and improved job satisfaction when involved in power sharing activities and this may have positively influenced health and wellbeing and resilience within that specific CNMM group. In all phases however there was a feeling of having inadequate influence over the formation of policy and strategy at government level along with a perception that they had negligible authority in developing centrally driven targets. They alluded to the complexity of the role whilst

at the same time having to contend with the perceived speed of change, the “tricky” position they inhabited between strategic intent and operational service delivery, whilst at the same time dealing with different people at different stages in the change timeline. Hewison (2002) carried out a study of middle managers in the NHS and found from the limited amount of work that has been conducted in this area that, environmental, professional and personal tensions and paradoxes existed similar to the perceptions of CNMMs in this study. In their investigation of middle management in the Netherlands, Sweden, and the UK in public and private sector organisations, Holden and Roberts (2004) indicate that middle managers are facing increasing pressures by being asked to do more with less. They conclude that this will cause increased stresses and strains on those performing the pivotal middle management role. Again this resonates with the population in my exploration.

The CNMM experience for all participants was strongly associated with inhabiting the middle position. Paradoxically, although CNMMs could be seen as being surrounded by colleagues in the course of their work, the majority of participants referred to feelings of isolation. CNMMs were wedged between differing interests of partner agencies (Thomas & Linstead 2002). Sims (2003) noted that the middle management role is characterised by being peculiarly lonely, precarious and vulnerable, which corresponds with my findings. Many CNMMs referred to the reduction of middle management numbers by delayering to contain costs, thus diminishing their opportunities for support and networking. Indeed the zeal to contain costs had also led to the reduction of supportive administrative staff, an issue identified by one CNMM as exacerbating feelings of loneliness. This participant experienced having absolutely no administrative support due to cutbacks, outlining the situation as one of solitary working being based on an empty floor in an outlying building, not seeing anyone from one day to the next unless there was a concerted effort made to do so. Others also described being based in buildings that did not offer opportunities to be close to peers on a daily basis and the support that affords. McConville and Holden’s (1999) study of middle managers found them to be isolated from others in the management hierarchy and experienced ‘role dissonance’ because of the contradictory position they occupied in the organisation, situated between executive management and the work teams. Many CNMMs alluded to

receiving assignments without adequate resources, manpower or material to execute them, creating further feelings of alienation.

Fears of job loss in the current financial downturn was seen as further impacting on feelings of isolation as CNMMs were aware of the vulnerability of inhabiting the middle layer, which was perceived as often the first to be cut in times of financial constraint. Moreover several felt the role was perceived as unpopular by the public in general, and highlighted negative perceptions they had experienced from members of the team and GPs in particular. Preston & Loan-Clarke (2000) reported similar findings from a case study of an NHS Community Trust based on 39 interviews with middle managers. Indeed The King's Fund report on leadership and management in the NHS began by observing that, “whenever politicians talk about management it is almost invariably a pejorative term and often equated sneeringly, with bureaucracy” (The King's Fund 2011 p.1).

Yet, ironically CNMMs saw themselves as being the very group who delivered unpopular messages in palatable form, to stimulate government driven change. This criticism of middle management function obscures important strategic and co-ordinating work. Moreover middle management seems an identity that nobody wants, with Hyde et al (2011) suggesting that middle managers have become the lost tribe of health service. A recent study by Parris et al (2006) studying middle managers from across Australia's private sector found that increasing workplace demands also affects a middle manager's personal life. An article in The University of Western Sydney News archives highlighted her study stating that:
“being in the middle can mean dealing with an increasing workload from senior management, as well as being delegated more responsibility for human resource issues. Role ambiguity and role conflict in having to pursue opposing goals may also lead to feelings of separateness. However, the particular demands of the middle management role are rarely talked about" (2006 Ref: Vla556)

The article concluded that organisations need to listen to the distinct voices of middle managers. These conditions were felt to create uncertainty, adversely impacting on service users, staff and CNMMs who were expected to enact new and old tasks

simultaneously. This correlates with Bennet & Durkin (2000) who found this to be the case for middle managers in general. However, organisational boundaries, distinct tasks, authorities and roles were felt to have become blurred creating a kind of recursive relationship between individuals, structure and agency resulting in stress (Borehinger 1999). This was viewed as a challenge to all community nurses, but CNMMs felt they were particularly tested being the group tasked to manage change through social interaction with professionals and stakeholders at many levels within multi sectors. However many CNMMs noted that senior managers were also under government control through policies to collectively meet measurable targets, especially those predicated on partnership working.

A further challenge in role enactment for many CNMMs was partnership working with agencies other than the NHS. There was a perception that partnership agencies had complicated structures, diverse governance arrangements and organisational differences, mirroring Audit Scotland's (2011) findings. Partnership thinking was viewed by the Secretary of State for Health in Scotland as a method for providing the main force (Greener & Powell 2003) for change in aiming to create a primary care driven health service. Primary care and CHPs are "primarily the operational delivery arm of primary health services at local level" (Watt et al 2010 p.15). The goal was for partnerships to deliver services in response to local need by multi-agencies working together. CNMMs experienced this environment to be constantly restructuring and delayering to cut costs. At the same time CHP organisations were observed as continually expanding and developing with wider, more complex and sometimes confusing expectations. Collectively, over the three regions examined, the views of the CNMMs resonated with the "cluttered landscape" of CHPs described in Audit Scotland (2011).

Furthermore differing CHP structures and governance arrangements were identified, with organisational variations between the NHS and local authorities. Some (mainly in one CHP) but not all CNMMs reported a lack of co-ordination. All identified capacity and financial resources as the main challenges in enacting their role through change. Some felt that this built barriers to partnership working (this was

most evident in a specific CHP). Consequently, these collective factors were seen to complicate role enactment.

Audit Scotland (2011) suggests that CHPs have led to duplication of effort with poor collaboration between agencies. In addition the audit found a poor track record on shared resources, objectives and priorities with the added value aim of partnerships over the past decade unclear despite CHPs controlling significant budgets. Understandably Audit Scotland (2011) recommended a review of partnership arrangements. As already discussed, the organisational identity of the CHP with its key role in acting as an adaptor and link between the various agencies (Audit Scotland 2011) to collectively meet government set health improvement targets added to the complexity of CNMM role enactment. CNMMs found collaboration was required across interagency boundaries with marked differences in organisational cultures, attendant norms and patterns of work. This was challenging and many CNMMs indicated that strong professional leadership was required.

However leadership can not necessarily overcome the detrimental effects of wide spans of control, even under the most positive of conditions (Shirey 2009). Employees become victims of job overload when they are given extensive portfolios (Channuwong & Kantatian 2012). Reflecting on their position many CNMMs acknowledged the ripple effect that their role expansion had for teams and allied health professionals whom they believed had a similar experience. This showed insight into the difficulty for all parties concerned in reconciling a number of different interests (Iles 2011) and the challenges brought about by the imposed change seemed to influence the way CNMMs enacted the role in managing teams and resources. Like other middle manager colleagues, CNMMs were found to concurrently be both purveyors and recipients of change (Currie 1999), and the foci and agent of change (Holden & Roberts 2004). They were both managers and managed, seeing themselves as functioning in the middle of the organisation both laterally and vertically, within health and across partner agencies.

This state of affairs was seen to have diminished CNMM authority to plan, control and specify staffing levels in order to deliver services and prevent teams becoming

overloaded and stressed. Navigating the background and change landscape in which CNMMs were functioning was perceived by most as demanding and confusing. However, there was CNMM intention to maintain and improve quality for service users.

9.4.3 Role form: how CNMMs navigated change through professional identity

Despite these factors the vast majority of participants espoused commitment to the caring aspect of the NHS basing their management philosophy primarily on their nursing value base. Several organisation studies consider the public health sector as highly institutionalised with defined professional identities that have developed through time. Workplace identity appeared to give CNMMs a sense of meaning and purpose (Walsh and Gordon 2008) centering on what it meant to them to be a nurse (Avis 2005, Bessant 2004, Weiss & Welbourne 2008). This helped make their identity and culture definable and recognizable, (Bloor & Dawson 1994, Morgan & Ogbonna 2008).

As evidenced in the narratives, CNMMs appeared to activate a positive link between their concept of self (nurse) within the context of group membership (in this case the nursing profession) to act as a buffer through change (see Schmader et al 2008) for themselves, for teams and ultimately service users. In this way CNMM identity was seen to be embedded in, and guided by the associated ethical principles of the nursing profession. Notions of belonging were strongly entrenched in the nurse tribe (Kirpal 2004). CNMMs showed insight into their feelings, and deeply held values, reflecting on the meanings they derived from the caring aspects of their work identity (Iles 2011). The awareness of having an identity is, according to Erikson (1973) in Kirpal (2004 p.18), tied to the “perception of one’s own sameness and continuity in time and the related perception that others also recognise this sameness and continuity”. This was the strongest theme across all phases of the investigation.

CNMM professional identity and beliefs seemed to be core to their leadership style in enacting their role through change. According to Giddens (1991) in the post-

traditional order, self-identity is reflexive. It is not a quality of a moment, but an account of a person's life. The predominance of this characteristic is noteworthy as it indicates that the participants held fast to demarcations based on their established nursing vocational traditions throughout their careers. This quality may have contributed positively to a sense of belonging, continuity and stability for themselves, and for teams to relate to in the shifting and demanding work context (Kirpal 2004). In other words CNMMs reported exhibiting strong professional identity in enacting the role. Research indicates that both work identities, work and employee engagement as outlined in Appendix 11, improve organisational outcomes, by increasing employee motivation (May et al 2004), yet their connection is too little discussed in research (Popova-Nowak 2010). This is not quality or cost effective in the long run if the aforementioned nursing values become lost to the NHS.

As already outlined CNMM professional role identity was predominately aligned with the values, beliefs and norms of the nursing profession rather than managerial ideology. Uncomfortable in putting the ethos of business culture before patient care (Learmonth 1997), the associated ethics and values of managerial ideology were seldom condoned by CNMMs. In addition it was felt that the managerial role held negative ethical connotations for the public, politicians and some colleagues. This was seen to be due to the opposing ideologies associated with managerialism and NHS caring principles. This concurs with Kelly (2013) who found that public service occupations such as nurses, fire fighters, those in the army, and teachers were judged to be inherently more ethical than others.

Most CNMMs implied some emotional disassociation with the management and economic function of their role, termed “role distance”. Bolton (2003) suggests that it is a particular feature of professionals managing peers in middle management roles. That is not to say that CNMMs did not enact that role component but there was recognisable tension between the opposing philosophies of private sector values and caring. In many ways the narratives concurred with Clarke & Newman’s (1997) description of “hybrid” management (Hewison 2002). The manager identity was perceived as negative or ‘anti-identity’ or a ‘not-me position’ (Sveningsson and Alvesson 2003, Sveningsson and Larsson 2006). A small minority had no issue with

managing per se. However, the participants were not only trying to work with the two sets of values leading to clashes between service and corporate concerns but also with their professional and personal values, caught in what Stanley (2006) terms an "ethos gap" which may have contributed to role dissonance.

CNMMs reconciled the management component of the CNMM role by aligning it with altruism and caring. "Every social group invariably couples its scale of desired ends with moral or institutional regulation of permissible and required procedures for attaining these ends." (Merton 1938).

Merali (2003) asserts that Tayloristic approaches towards the management of healthcare professionals do not lend themselves to the unique context of the NHS and I would argue nurse identity and the essence of caring. A further complicating factor is Mowbray's (2010) suggestion that middle managers within the NHS have to contend with two particular features arguing that there are two health organisations running alongside each other concurrently, the "background" and "foreground". The "background" organisation is huge and bureaucratic ensuring the "foreground" organisation works effectively. The "foreground" organisation is described as being chaotic in nature because professionals need to be able to respond to the individual needs of service users and every single change in the planning of and delivery of care. "The people in the middle are the middle managers, who must respond effectively to both the constraints placed by the background organisation and to the professionals in the foreground" (Mowbray 2010 p.15). CNMMs implied that they grappled with these tensions in order to enact their role through change.

In an attempt to balance opposing philosophies and financial constraints they maintained a strong nursing identity to support quality and advocacy for the service user. This is depicted in Figure 12.

Background

Foreground

CNMM

CHP & Health Board

NHS

Government

Global influences

Continually Planning, Prioritizing and Coordinating Efficient Care

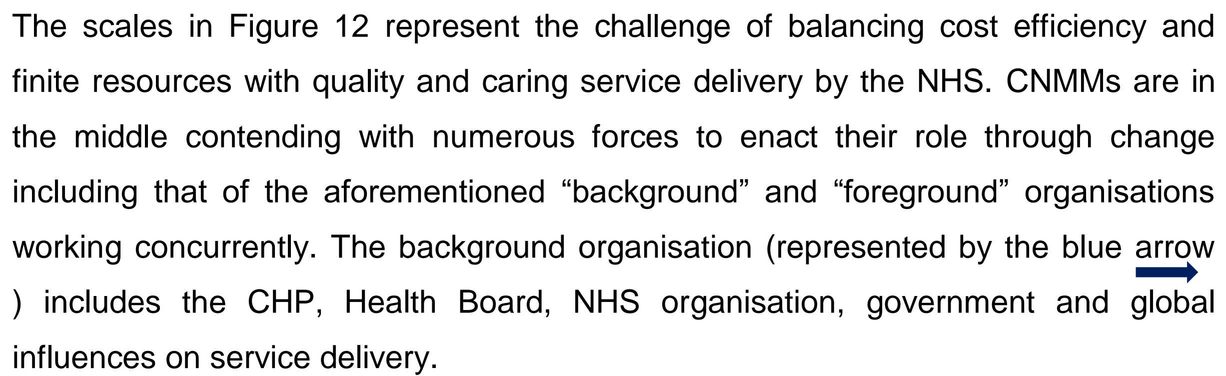
INTERDISCIPLINARY TEAM

PATIENT & FAMILY

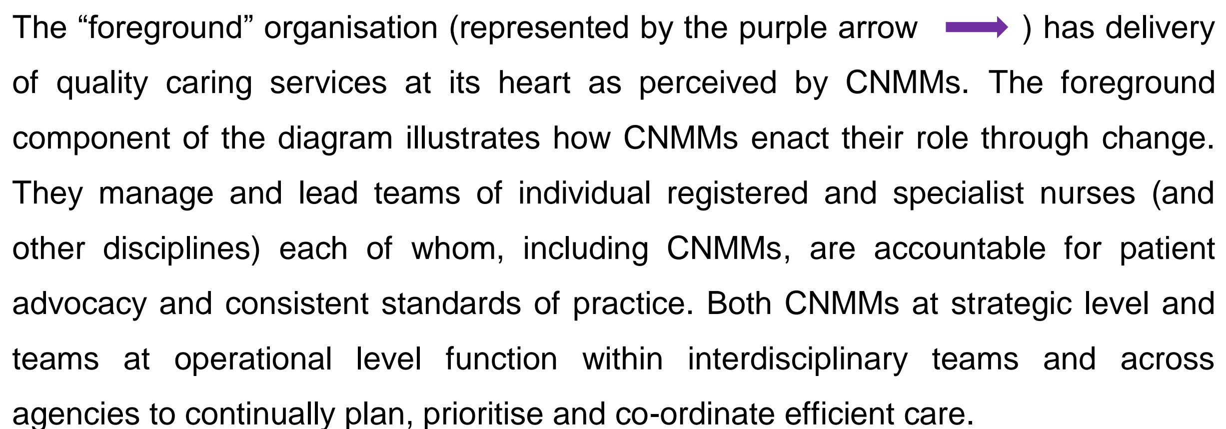
REGISTERED NURSE

Accountable for Patient Advocacy and Consistent Standards of Practice

Figure 12: Balancing the "force fields" influencing CNMM role enactment through change



The scales in Figure 12 represent the challenge of balancing cost efficiency and finite resources with quality and caring service delivery by the NHS. CNMMs are in the middle contending with numerous forces to enact their role through change including that of the aforementioned "background" and "foreground" organisations working concurrently. The background organisation (represented by the blue arrow) includes the CHP, Health Board, NHS organisation, government and global influences on service delivery.



The "foreground" organisation (represented by the purple arrow) has delivery of quality caring services at its heart as perceived by CNMMs. The foreground component of the diagram illustrates how CNMMs enact their role through change. They manage and lead teams of individual registered and specialist nurses (and other disciplines) each of whom, including CNMMs, are accountable for patient advocacy and consistent standards of practice. Both CNMMs at strategic level and teams at operational level function within interdisciplinary teams and across agencies to continually plan, prioritise and co-ordinate efficient care.

These "traditional public service and professional values now exist alongside a strong business ethos, and greater transparency and accountability at all levels of the system means there is greater scrutiny on performance and outcomes" (Scottish Government 2012 p.6). Participants typically articulated that role enactment was underpinned by a clear set of nursing values. Machin et al (2011) suggest that stability (equilibrium) in professional role identity is critical in increasing the value that nurses place on their role, particularly in the face of role change. In times of uncertainty and challenge such as the economic climate throughout the study, CNMMs drew on what they valued and maintained i.e., the nursing core of the role, which guided their response to change. In this light it is important to look more closely at their discourse around their leadership and management roles.

9.5 Analysis of leadership and management

9.5.1 Enacting engaging leadership

Thus CNMMs typically portrayed themselves as adopting a leadership style congruent with the nursing profession (Sofarelli & Brown 1998, Lindholm et al 2000). They attested to creating an empowering work environment by facilitating access to information, supporting and identifying resources. They suggested that they articulated and communicated persuasively to create a meaningful vision for teams that could be understood and shared. Acting as conduits, CNMMs believed that they provided frameworks that connected teams to the organisation and the goal or mission. At the same time they felt that they listened to concerns, respected individuals and in some cases acted as mentors or coaches. In this way, CNMMs in all phases across the participating CHPs referred to utilising characteristics of a relationship-based democratic style leadership in leading change.

In terms of meta-theories of change, this suggests the use of normative – re-educative strategy. Those who apply this methodological approach to change consider intelligence as "social" rather than rational. Their aim is to identify a relationship between the values of the system (and teams) and the values of the organisational environment. It facilitates involvement of as many team members as possible and CNMMs aspired to involving as many members of teams as practicable in the change system. They attested that they defined the change problem, and mutually collaborated with teams. Collectively this approach could be described as "Engaging leadership", defined by Alimo-Metcalfe et al (2008 p.16) as:

"an approach to leadership that is essentially open-ended in nature, enabling organisations not only to cope with change, but also to be proactive in shaping their future. At all times engaging leadership behaviour is guided by ethical principles and the desire to co-create and co-own ways of working with others towards a shared vision".

CNMMs identified their role and remit as being both “people and task-oriented perceiving that successful implementation of change required clear and persuasive communication” (Huy 2001 p.76) even if they personally didn’t agree with it. Prior to embarking on change CNMMs typically felt that all those involved or at least as many as possible needed to understand it (Paton & Boddy 2007). In the first instance CNMMs actively engaged in making sense of change for themselves. They explained how they then translated their perceptions of change policy by adopting “sense-making and sense-giving” micro practices (Rouleau 2005) to sell change (Birken 2011). In addition they seemed to act as “barometers” gauging the change atmosphere by tuning into team reactions and rumours. This informed how change messages could be best translated to teams (Balogun and Johnson 2004) as clearly as possible, picking up and attempting to reduce any misunderstanding.

CNMMs indicated that they synthesised information to create knowledge through social networks (Birken 2011) with wider teams. There was a general feeling that this approach aided understanding and a shared vision of strategic plans. This was felt to facilitate buy-in at all levels (Nielson et al 2010) to achieve the vision both within the NHS and across agencies to stimulate action. Floyd and Woolridge (1997) indicate that this type of boundary spanning role is positively correlated with achieving desired organisational outcomes such as efficiency, effectiveness and financial performance. By enacting the role in this way CNMMs felt that that they interpreted and framed strategic SG objectives for front line staff (McGurk 2009) believing that enacting proactive leadership was central to the process. This deliberate application of knowledge within the context of change to positively influence teams suggests a degree of skill. This kind of expertise is also identified by commentators such as Balogun et al (2005), Rouleau (2005) and Hoon (2007) in their studies of middle managers.

Importantly many CNMMs believed that they consciously maintained a relationship with the service user through teams. One CNMM memorably summarised her role as *“nursing by the long stretch of the arm”* indicating an attachment to nursing and patient care despite being chronologically and considerably geographically removed.

CNMMs recognised the multiple demands that organisational decision-makers have to make. Nevertheless they believed that in acting as advocates they led and sustained change by campaigning for the necessary nursing resources to ensure quality patient care and prevent staff burnout. Negarandeh et al (2006) found that supports from head nurses were seen by Japanese nurses to promote advocacy.

CNMMs felt that behaviours such as understanding hierarchical structures and promoting collaboration provided a link between caring for staff and ensuring optimum care for service users. CNMM accounts implied that as a population they intuitively understood the value of applying their professional and personal ethics to their management style. Moreover, it could have contributed to promoting a "stress prevention" culture within teams to positively influence health and wellbeing. However in a phenomenological study Hellwig, Yam, and DiGiulio (2003) found that lack of time and doing more with fewer resources act as the main barriers to advocacy. This is important as many CNMMs experienced reduced ability to support individuals and teams as they have would have wished. It also affected the nature and scope of relations with colleagues, those managed and managing, and the associated expectations of function, status and power, i.e. role set. Describing their working atmosphere the majority of CNMMs inferred that they functioned in a setting that was increasingly reactive, making planning problematic.

9.5.2 Reactive management

Despite the positive leadership enactment strategies reported, many CNMMs described the role as "*fire-fighting*" and that they *"trouble-shoot daily operational issues",* thus reducing CNMMs ability to be proactive. This reactive as opposed to proactive management orientation was recounted by CNMMs as the dominant characteristic in managing change due to continual reprioritisation of workload and still carrying on with the daily business. This concurs with Currie (1999) and Ainsworth et al's (2009) studies of middle managers, as highlighting one of several tensions CNMMs had to contend with in managing change. Political aspirational rhetoric in the form of achieving SG driven targets was perceived as an added

burden observed as creating negative effects on the CNMM population and teams. This was also found in Mathena's (2002) examination of leadership in nursing. Most CNMMs accounts of their middle locus, associated proliferation of work assignments, and additional roles and remits were felt to have resulted in reduced capacity for them to offer direct management or leadership support to teams. This was much less in the expansive phase. A practical implication identified by CNMMs was the reduction of time to plan, which was seen to negatively impact on their ability to identify and prevent any problems early. Some CNMMs remarked that they were unable to develop, read, digest and reflect, to make sense of current strategies and policies or devote the amount of time they would wish to proactively inform, support and manage teams through change.

Planning ahead for short or long-term changes in the workplace was seen as an essential primary feature to manage in a proactive style. CNMMs asserted that proactive management techniques require adequate time. They are characterised by thinking ahead, anticipating and planning for change or crisis that contributes to employee empowerment. Managers who focus on proactive leadership behaviour are more successful in completing projects on time, on budget and to the specified standard as well as achieving the strategic purpose of the project (Barber & Warn 2005).

9.5.3 Taking stock

The realities of the work world for CNMMs created perceived tensions which were recounted as having professional and personal consequences for them as individuals and as a group. Work intensification linked to managing competing priorities appeared to create a further tension for CNMMs in maintaining their "balancing act". They felt that the amount of change initiatives introduced by the government had contributed to a perceived overload of work. Only one participant reported that they thrived on this type of challenge. CNMMs indicated that they were expected to take on additional roles, be skilled jugglers in supervising more people, exhibit leadership and strategic management skills, manage budgets and be IT

literate whilst ensuring the quality of care and clinical competence across the continuum of care. Hellinghausen (1998) describes a Wall Street Journal illustration which provides representation in cartoon form of a nursing middle manager with six arms juggling pens, paper, and telephones and states “add a couple more arms grasping syringes and financial charts and you’ve got the picture of today’s nurse manager”. In addition it was highlighted that increasing spans of control at all management levels caused by downsizing, restructuring, and delayering had spawned a knock-on effect of lost posts at all hierarchical levels leading to role alteration for CNMMs (and others). In 2005 the SE recognised that:

“Leaders with managerial positions are encouraged to emerge through clinical routes, for example, and often have to ‘pick up’ leadership development, managerial knowledge and skills on a do-it-yourself basis” (SE 2005 p.11).

This resonates strongly with the experiences of CNMMs. Moreover the National Leadership Council’s Framework points out that improving delivery of services for patients, service users, and carers requires consistency (NHS Leadership Academy 2011). Their Leadership Framework (2011) diagram is very useful for summarising the CNMM position (see Figure 13).

Figure 13: Leadership framework diagram

Leadership Framework (National Leadership Council 2011)

As can be seen, seven domains make up The Leadership Framework. The two left and right outer domains, creating the vision and delivering the strategy, focus more on the role and contribution of individual leaders especially those at strategic level. However CNMM participants felt that they had little control in creating the vision and setting the direction for community nursing in CHPs. This was felt to be SG led via policy, with little genuine consultation with the CNMM profession. CNMMs felt that they didn't create but rather translated the SG vision and its related targets.

Haycock-Stuart and Kean (2013) argue that a top down approach to implementing policy for shifting the balance of care to the community setting is contrary to a grass roots organisation and service delivery. On the other hand CNMMs did perceive that they had some control in translating SG policy into action through teams. These aspects of role enactment through change corresponded with the Leadership Framework. For example they demonstrated personal and professional qualities by holding fast to their nursing roots and described how they worked in partnership with others. In addition they portrayed that they managed and led community nursing teams by acting as change agents to set the direction to deliver SG strategy. Moreover in doing this CNMMs strongly felt that they played an active role in delivery of services to users, through *"nursing by the long stretch of the arm".*

Certainly, tight government set budgetary controls were seen to have created contradictions and tensions for middle managers in general, in managing teams through change (Williams 2004). CNMMs in this study felt this stifled role enactment and training opportunities. This is a crucial point as they will continue to perform a leadership role within a climate of increasing financial constraint and cutbacks for the foreseeable future. Importantly there has been "relative neglect of middle managers and clinicians entering leadership roles in mid-career" (The King's Fund 2012 p.31) with leadership development in the NHS having "focused more on staff at the beginning of their careers or those already in senior leadership positions" (The King's Fund 2012 p.31). Indeed the Scottish Executive (2005 p.11) states "It is simply not good enough to expect experienced clinicians to be effective 'positional' leaders without providing access to comprehensive leadership development and managerial knowledge and skills development". However financial constraints on the NHS

imposed by the government along with radical changes stimulated by budgetary cuts have adversely affected CNMM numbers and training opportunities impacting on leadership skills. Being several levels below top-level administrators on organisational charts, middle management positions are often the first to be eliminated when organisations downsize or restructure. However for change to be taken forward, enough CNMMs with the right management and leadership skills will be vital for the NHS and crucial for CNMMs.

Although strengthening leadership and team work is seen as part of the SG modernisation vision (the SG website: www.scotland.gov.uk 2012), it is notable that community nurse management is completely absent. Given that demands will be placed on managers as leaders of change in modernising community nursing, this is of concern. Especially given that a health informatics review identified:

"a general shortage of the skills required to plan and implement change programmes in all their stages, from effective integrated planning, through technical deployment, business change and on to benefits realisation. This shortage, of appropriately experienced change managers, is present in both the NHS and the independent sector" (Department of Health 2008 p.19.)

Therefore having a well-educated NHS CNMM workforce will contribute to retaining engaged (Appendix 17) experienced staff thus saving valuable resources to manage change and more vitally maintain quality in patient care.

9.6 Learning from diversity: how can the CNMM role best thrive?

Narratives indicated that CNMMs experienced significant workplace adversity like middle managers in general (Jackson et al 2006). Most CNMMs cited similar work world challenges such as increasing spans of control, larger portfolios, fluid job descriptions, and perpetual change. In addition difficulties associated with role amendment was evidenced by CNMM descriptions of financial constraints which had led to flattening of structures. Some CNMMs, particularly in the foundation and recursive phases, and one CHP in particular, reported concerns regarding the negative effects that the current political austerity policy was creating. They felt the constant paring of CNMM posts within CHPs was undermining the CHP community nursing infrastructure (Kelly 2013 p.52).

The knock on effect for CNMMs was disappearing support mechanisms, perceived to have left the CNMM population and the community nursing profession as a whole in a weakened and disempowered position. There was a reported lack of evaluation and review of portfolios in terms of the overall role and its boundaries, a basic task essential to role holders, their managers and teams in understanding priorities of the role (Fitzgerald et al 2006). CNMMs reported that job descriptions were not reviewed on a regular basis to help ensure that the core functions and priorities of the post were clear and feasible. They suggested that this had resulted in the role being misunderstood and unrealistically constructed. In addition they experienced a perceived lack of support in terms of review and supervision which concurs with Shirey's (2009) findings. CNMMs increasingly focused on achieving set targets yet felt that they had not contributed in any way to the formulation of SG directives. In turn this was felt to have contributed to the semi-autonomy of their role. In addition they had to manage competing priorities creating role fatigue. The intricate pressures of what were seen as the opposing philosophies of business and caring was felt to exacerbate this weariness (Garside 2004). Many CNMMs referred to feelings of being overwhelmed, reporting significant work life imbalance and feelings of disempowerment.

Nonetheless, CNMMs had continued to feel a sense of pride and passion in being a member of the nursing profession. This was borne out in the way participants described adhering to a particular set of personal and shared nursing values which they sustained and harnessed. I argue that this provided "continuity in the face of an ever-changing system and an "internal compass" to guide them in challenging circumstances" (Scottish Government 2012 p.9). This "internal compass" may be important for promoting positive behaviours, acting as service user advocates, and maintaining a sense of personal responsibility and values, which according to Stern (2006) are considered core to the concept of professionalism. Despite the aforementioned challenges, professionalism appeared to be evident in the CNMM population in their "implication of commitment to vocation and to public interest" (Scottish Government 2012 p.8). This was something that CNMMs had control over, kept them engaged with teams and service users, and arguably helped sustain them in their role. CNMMs acknowledged the challenges of carrying out their role and attempted to balance these by identifying coping strategies to deal with stress drawing on past experiences to strengthen personal resilience. It is fair to say that there was absence of concrete managerial support for some of the CNMM population, but common in all regions CNMMs utilised and sought a number of coping strategies indicative of resilience building.

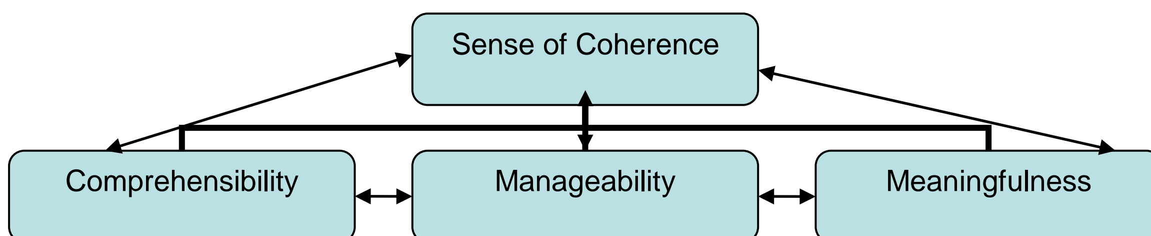
They seemed to employ an approach similar to the asset based salutogenic model of Antonovsky (1997) to manage the perceived stresses of the CNMM role. The salutogenic paradigm or model embraces a "health ease/disease continuum" with individuals falling between the two boundaries. It rejects the notion that stressors are "inherently bad" (Strumpfer 1990 p.267) and encourages exploration of why some individuals endure and others do not (Antonovsky 1997 p.37). The latter is my reasoning for including two exemplars in the thesis to identify workplace factors that were perceived by each CNMM to influence their meaning – making and salutogenic functioning. This perspective centres on the identification and use of personal resources inside a person or in the environment that maintain a healthy status. The development of the salutogenesis theory in healthcare has increased over the last two decades with the recent innovative shift from the pathogenic paradigm. The

notion of salutogenesis (Appendix 12) sits within the paradigm of positive psychology and provides a particular perspective to the way health is viewed.

The salutogenic concept is a theoretical guide for health promotion, based on three components that make up a Sense of Coherence (SOC) and is being explored for workplace health promotion. A strong SOC has been found to protect against anxiety, depression, burnout and hopelessness and is strongly and positively related to health resources such as optimism, hardiness, control, and coping (Eriksson and Lindström 2006). This "Sense of Coherence" according to Antonovsky (1993d) has three dimensions, comprehensibility, manageability, and meaningfulness (see Figure 14).

Figure 14:

Antonovsky's (1993d) "Sense of Coherence"



Interestingly all CNMMs appeared to intuitively try to identify protective factors or "assets" to counteract stress citing several of the five evidence based routes to wellbeing (Aked et al 2008) such as connecting with colleagues and friends, being active, and feeling their work to be worthwhile. Narratives outlined things such as: exercise, regularly engaging and connecting with colleagues, becoming more assertive, feeling able to say no when workloads felt unmanageable, seeking and receiving support from senior management, getting regular reviews, and identifying supportive mentors, allies and networks. This correlates with the findings of Channuwong & Kantatian (2012) who investigated stress management strategies for managers. A number of CNMMs mostly in the expansive phase indicated that what

sustained them in the role was enjoyment of the job and feeling that it had a purpose in making a difference which may positively support a SOC. However for a small but significant number of CNMMs in the foundational and recursive phases it appeared that despite their efforts their SOC could not be sustained leading to organisational disengagement and burnout. Clearly there were differing supportive factors that had influenced individual CNMMs to thrive or not. The NHS Confederation asserts that: "middle managers often have some of the most crucial but stressful jobs because they have to balance the requirements of senior managers with those of their clinical colleagues" (NHS Confederation 2007 p.30) and goes on to suggest that the NHS has tended to undervalue its middle and junior managers.

There was evidence of CNMMs not feeling valued resulting in reduced job satisfaction for some. This requires due consideration given that literature finds positive associations between job satisfaction, empowerment and managerial support (Chang et al 2009). Support mechanisms varied across regions in general and some CHPs in particular. There were particular experiential differences between the two exemplars outlined in Chapter Eight. It is useful here to outline how these differing experiences have aided understanding of how CNMMs can be supported. This was perceived as being substantially affected by the presence or absence of support for CNMMs by their supervisors. It is notable that a systematic review of research studies examining the effects of restructuring on nurses, demonstrated decreased satisfaction with their supervisor as a result of changes in the relationship and loss of trust with administration (Upenieks 2003).

CNMMs in the foundational and recursive phases and in one CHP in particular, felt a lack of focus by their manager on how they were coping during and following re-engineering. The turbulence of constant change was felt to have taken precedence over concerns about individual CNMM stress. For Mary in particular, those in supervisory roles were perceived to manage more than lead, with a control and command style, resulting in disengagement which was evident in other CNMMs within this CHP. The very large spans of control linked to restructuring were viewed in this particular instance to have negatively impacted on communication, links and collaboration between differing nursing levels, professions and groups in the

workplace (Hertting et al 2004). A significant number of CNMMs in this CHP felt that this was associated with adverse effects on their health, mental wellbeing, safety (Kalimo et al 2003, Vahtera et al 2004) and patient care with some becoming disengaged to a degree and disconnecting with the CHP, but not the philosophy of caring within the NHS, nor with service users.

A CIPD (2012) study states that employee engagement is composed of being positive in the performance of work, contributing intellectually and experiencing positive emotions and meaningful connections with others. This is crucial as the effects of restructuring in this specific CHP was seen to have had a negative effect on CNMMs working conditions health and wellbeing (Laschinger et al 2006) due to a lack of the said meaningful connections. This situation was perceived as contributing to increased stress levels, decreased job satisfaction (Shirey 2009) and negatively affecting CNMM health, leading to role overload and fatigue. Role overload and role conflict are significant predictors of job-related burnout especially for those working in human services that are bureaucratic such as the NHS (Smith 2010) and both were evidenced, including “burn out”. It is therefore important that SG leaders, the NHS and supervisors of CNMMs along with HR better understand the causes and symptoms of change fatigue and how they can contribute to minimising the impact on this population. Once recognised it can be dealt with and prevented by positive action as described by the expansive cohort and Laura’s experience.

The expansive phase cohort’s different experience may have cushioned some of the tensions outlined above. These CNMMs gave the impression of strong senior nurse leadership and management within their CHPs with many reporting that they felt listened to and that there was clarity of expectations i.e. comprehensibility. CNMMs felt they were involved in strategic planning and that they had devolved authority with freedom to act. This suggests that supported empowered and valued community nursing middle managers remain engaged with their role and the CHP. There was an engagement style culture most notably within the expansive region executive CHP structure which these CNMMs perceived underpinned the workplace. A particular outcome of engagement is the intent for employees to remain with an organisation. No CNMMs within this cohort expressed a desire to leave, indicating that human

capital was maintained, morale was good, recruitment costs reduced, and therefore cost effective.

Given that CNMMs are challenged with grasping changes they do not plan, and negotiate the details with teams equally removed from the strategic decision-making, engaging management style may not only sustain CNMM job satisfaction and support resilience but also prevent CNMM rejection of change. Laura seemed more able to maintain SOC which seems likely to have been due to the positive perception this CNMM had of the CHP and management. In this case it was viewed as having a clear supportive nursing management structure with a separate strong professional lead. In addition this participant experienced role clarity and job satisfaction which appears to have facilitated her ability to manage job tension. These factors appeared to have facilitated comprehensibility, manageability and meaningfulness, the very components that are related to engagement and a high level of SOC. (Lindstrom and Eriksson 2010 p.34).

The varying quality of interactions experienced by CNMMs with their line managers in different regions, and one CHP in particular, was marked. This is highlighted within the two exemplars. Notably, Constable & Russell (1986) showed that high levels of support from supervisors for senior nurses such as CNMMs reduced emotional exhaustion and buffered negative effects of the job environment. Cortese et al (2010) found job satisfaction correlated with supportive management. They identified that job satisfaction is decreased by job demand whereas supportive management behaviours increased job satisfaction. In those CHPs where CNMMs perceived that they were listened to and received interpersonal support, there was a general feeling of effective collaboration suggesting an environment with a high emotional quota (Amabile & Kramer 2011).

Consequently, it would be particularly beneficial for the managers of CNMMs to provide such support, give adequate feedback about performance and review the span of the role to improve increased self-esteem (Frankel 2008). Opportunities for upward feedback increases engagement through greater participation, which, in turn, relates to greater understanding of wider organisational issues as well as personal

involvement (Robinson et al 2004). Effective senior and executive CNMM leadership also encompasses individual-level feedback, which can increase both engagement and performance (Alimo-Metcalfe & Alban-Metcalfe 2007). As change is a constant in the health service, interest in CNMM wellbeing is highly relevant since perceived reciprocation of effort is an important motivator of engagement and related behaviours. In addition work overloads and time constraints are significant contributors to work stress among nurses in the community (Channuwong & Kantanian 2012) and found to be similar for CNMMs. These factors were perceived by CNMMs to have contributed to role and change fatigue. Indeed the accounts echoed this in terms of the effects on work/life imbalance and this was found to be particularly so for those in the foundational and recursive phases. Work life balance was felt desirable to support leadership along with learning to feel comfortable with saying no when appropriate. This specific skill was felt to require development especially by the aforementioned group. There was a view across all phases that support via training would be desirable (Shirey 2009) to support resiliency for CNMMs.

Work/life imbalance correlates with increased stress and the potential for burnout (Channuwong & Kantatian 2012). Support for CNMMs was reported to be variable across the CHPs examined. Some CNMMs experienced being listened to and adequately supported, whilst others felt a lack of support with a few perceiving that they had almost no support. Yet there has been a recent shift in government policy away from a health and safety risk emphasis on managing negative stress towards one of actively promoting mental health, wellbeing and performance which has important implications for all UK employers and their employees and therefore executive and senior managers. 'Promoting mental wellbeing through productive and healthy working conditions' has been introduced by The National Institute for Clinical Excellence (NICE) (2009). In addition, the NICE guidance is also in tune with other recent initiatives such as the Boorman Report, Department of Health (2009) on NHS staff health and wellbeing, which looked at improving organisational and management behaviours in the NHS and embedding staff health and wellbeing into NHS systems and operations.

It is also therefore important that management development should be incorporated in the current Modernising Nursing in the Community toolkit along with application of the salutogenic model. A recent systematic review concluded that the salutogenic model as a health promoting resource offers the means by which individual resilience may be improved and people may be helped to feel physically and mentally healthy, with a good quality of life and sense of wellbeing (Eriksson and Lindström 2006). In addition a report by Aked et al (2008) presented to the UK Government's (2008) Foresight Project identified five actions to improve wellbeing that could be encouraged to build into individuals lives. There are commonalities in both models. I suggest that combining the two provides a consolidated and novel model to contribute to an organisational stress prevention culture that recognises quality healthcare begins with ethical people management. The collective outcomes of the combined model aim to stimulate resilience, self-esteem, cognitive capacity and emotional intelligence. All these elements have been identified by the CNMM participants as essential components of enacting the role. Moreover a combined model **(Table 26)** may also have some potential in acting as an antidote for anomie affecting current and future CNMMs and others.

Table 26: Salutogenic/foresight health promoting workplace model

Modified from Antonovsky (1997) & Aked et al (2008).

Salutogenic Model – Sense of Coherence (SOC) (Antonovsky 1997)	**Foresight project five actions –** Aked et al (2008)
Comprehensibility (life has a certain predictability and can be understood)	Connect – developing strong relationships and social networks
Manageability (resources are enough to meet personal demands)	Be active – more exercise and play improves wellbeing
Meaningfulness (life makes sense, problems are worth investing energy in) (Antonovsky 1993)	Take notice – self-awareness and the importance of developing social and emotional literacy.

	Keep learning – social interaction, self-esteem and feelings of competency
Emotional closeness, which refers to the extent to which a person has emotional bonds with others and feels part of their community.	Give – reciprocity, trust and helping others (studies show that co-operative behaviour activates the reward area of the brain)

'Engaging for Success', MacLeod and Clarke's Review of Employee Engagement for the Department of Business, Innovation and Skills (2009) looked at the evidence and business case for the link between employee engagement and performance Little support, low interest in listening or attempting to tackle workplace problems results in a lack of trust and poor relationships (Channuwong & Kantatian 2012). This notion correlates with the negative impact found in one CHP for some CNMMs health and wellbeing which eventually affected some CNMMs perceptions of performance, resulting in resignations and planned resignations. People's intention to leave is an indicator for actual leaving behaviour, denoting how employees generally feel about their work and their working environment (Shirey 2009). According to Alsoofi et al, (2000), burnout and coping strategies seem to be related significantly. The use of withdrawal or avoidance coping strategies is associated with high levels of burnout as outlined in Mary's case, while low burnout levels are associated with constructive or active (problem-focused) coping strategies (Schaufeli and Enzman 1998, Schaufeli et al 2002).

As a group therefore CNMMs need to be supported adequately by their supervisors in order to lead and manage teams through change if the NHS is to reap the benefits of Macleod and Clarke's (2009) recommendations. By applying the suggested guidelines CHPs would be in a stronger position to maintain health and wellbeing across the hierarchy and avoid staff burnout. Work life balance is not only essential for mental health and wellbeing it is ultimately cost effective for the organisation. There needs to be a SG standardised joint approach with staff at every level.

All CNMMs felt they had learnt from the past and reported how they had managed themselves and teams over time. The majority felt that in order to function adequately, timely training at an appropriate level with accompanying adequate support would be beneficial. There was a feeling that an essential requirement for the role would be having a suitable package of education. This might involve post registration higher degrees and change management and leadership theory. There was also indication that shadowing, coaching and mentoring would be beneficial along with a toolkit offering options for individual learning needs.

Looking to the future many CNMMs identified uncertainty as a main feature of the NHS along with continued change and increasingly limited resources. The majority felt that structures would continue to flatten with less middle management posts but wider roles and remits. They feared job insecurity, job losses and lack of career opportunities for themselves and future CNMMs. They predicted less opportunity for career progression, or moves within the organisation and heightened insecurity. This concurs with de Ruyter et al (2008) who argue that embedded public sector guarantees of job security and career advancement is in danger of being eroded due to demands for greater efficiency and the modernization of service provision from central government.

In addition, it was felt that these conditions would maintain the trend of lack of mentoring for themselves and their teams, leading to increasing stress and decreasing job satisfaction (Shirey 2009), throughout teams and organisations. The majority of CNMMs argued that the continuation of this kind of role complexity would have the potential to overload managers beyond their individual capacity resulting in a detrimental effect to the nurse manager, team work, environment and quality of service delivery. Paradoxically this might manifest as “presenteeism” for many CNMMs, which is linked to working excessive or unpaid hours and working when ill (Aronsson et al 2000, Simpson 2000). For change to be successful most felt that it will require continued engagement, influence and negotiation with a wide variety of professional colleagues, from those assisting in front line care (the teams CNMMs managed) to those holding the power to re-define services (CNMM management). Despite these issues participants felt that the future of healthcare will in the main be

delivered within the community setting and because of this concluded that there will always be a need for the CNMM role.

Furthermore retirement rates will increase significantly over the next ten years (Buchan 2007), in the ranks of middle management resulting in a reduced number of experienced CNMMs at a time when the role will be essential to supporting NHS change.

If the NHS as an organisation is going to survive the challenges of change, attention needs to be devoted to nursing middle management level and the culture in which they work. Crucially The NHS Confederation (2007) argues that the NHS is management lean having a low proportion of managers thus diluting their capacity to facilitate change. Moreover, Burgess and Currie (2013) dispute the current government policy of delayering and reducing middle management posts to protect frontline staff. They suggest that this practise results in loss of the added value that professional hybrids bring to the organisation, their knowledge and expertise which negatively impacts on the smooth running and safety of services. Furthermore cost savings have not been fulfilled (Currie & Procter 2005, Floyd & Wooridge 1994).

I argue that the CNMM role in driving change is not commonly recognised, consequently they have been poorly recognised and valued by governments the NHS and the public, this needs to be readdressed.

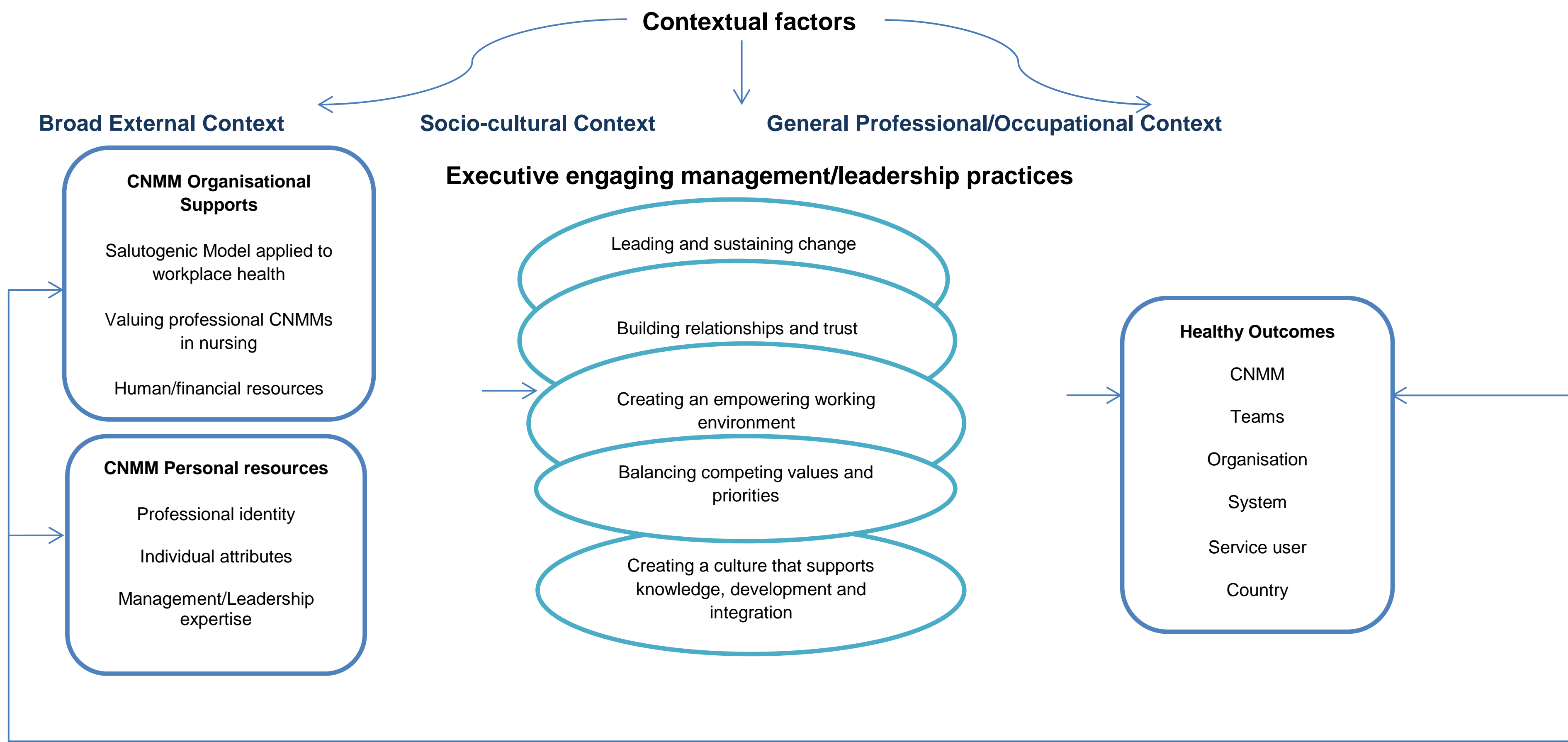
If the CNMM position is not adequately considered and supported it may result in loss for the NHS in terms of finance and wisdom via the exodus of this population at a time when their values, experience and expertise in managing and leading service change and acting as role models is essential if quality and care for service users is to be maintained for the future.

Therefore the recommendations in the following chapter should be considered for endorsement and action. These suggestions have the potential to contribute to retaining the current pool of experienced CNMMs through the introduction of explicit mechanisms designed to support the role. In addition this may encourage future

nurses to identify a positive and clear career pathway leading to the CNMM role, if the vibrancy of community nursing is genuinely valued highly enough not to be lost.
A conceptual model to develop and sustain CNMM management/leadership is offered based on the concept of salutogenesis and adapted from Registered Nurses' Association of Ontario (2006) (see Figure 15). An explanation of Figure 15 now follows.

The figure outlines the three contextual factors that could contribute to influencing the development and sustaining of CNMM management/leadership. The left hand side of the figure outlines two broad external factors which comprises of organisational and personal supports. Organisational factors include application of the salutogenic model to workplace health in the NHS, valuing the profession of community nursing middle managers by ensuring adequate human and financial resources backed by information that contributes to decision making on CNMM numbers. Personal resources incorporate professional CNMM identity, individual attributes and the identification of management /leadership expertise of CNMMs. The middle of the diagram incorporates the socio-cultural context of those who supervise CNMMs and encourages adoption of engaging management/leadership practices in leading and sustaining change, by building relationships and trust, creating an empowering working environment, supporting the balance of competing values and priorities, and creating a culture that supports knowledge, development and integration. The right hand side of the diagram delineates the general professional/occupational context of improved health outcomes for CNMMs, teams, the NHS organisation and system, service users and the country as a whole.

Figure 15: Conceptual model underpinned by salutogenisis to develop and sustain CNMM management/leadership



Adapted from: Registered Nurses' Association of Ontario (2006).

In the challenging times we face for the foreseeable future we need community nurse managers throughout the CHP structure who have knowledge and behaviour that contributes to positive health effects on staff and therefore patients. Floyd and Woolridge (1992) consider the implementation role of middle management as the most important. They are key actors in the way they carry out continuous interventions driven by political and executive priorities and how they adjust to emergent events and reduce the impact of resultant problems. Like other public sector professionals there is the need for CNMMs to be encouraged to:

“Express their professional selves within the context of their profession: to be the type of nurse, teacher, social worker or youth worker that they feel to be most effective in carrying out their role; to exhibit and manifest the qualities and traits that they believe will make a difference to the public that they serve” (Apesoa-Varano 2007).

CNMMs will need to be well-educated and motivated to be productive. Supporting and investing in this group would ultimately be cost effective to the tax payer and public sector in the longer term, strengthening NHS CHPs. CNMMs will then have increased ability to develop the way care is delivered in the community, by being advocates for the nursing profession and ultimately advocates for quality patient care.

9.7 Coda

This chapter started by taking stock of the recent literature to view the findings in contemporary context. It finishes on a similar note by highlighting a very significant and very recent scoping study of middle managers in Scotland's social services. Using primarily survey research methods, Patterson and George (2014) looked at the role and functions of middle managers in the local authority and voluntary/independent sectors. Both the literature review and the responses from their 153 participants yield very similar themes to my study. Indeed it is worth reproducing in full the box of comments from the survey that Paterson and George present:

Table 27: Themes from scoping study of middle managers in Scotland's social services

Taken from: Patterson and George (2014 p.26)

" The role of the manager is the proverbial squeezed middle"
"…Eventually it will become evident as staff stop working within the sector because it has become so onerous"
"The management structure around me has dramatically cut and much social work experience is lost. It is very pressurised and potentially unsafe and unsustainable"
"Expectations of the role increasing significantly due to financial pressures. Significantly increases stress levels"
"I am employed as an operational manager but more and more my time is spent supporting strategic change within the Service whilst still expected to undertake the tasks of my operational post"
"As an operational manager in my organisation I find it difficult to influence the strategic direction of my service. It is difficult to influence this in a large organisation.

My job is so focused on operational delivery it's difficult to get time to do anything else or even time to reflect on where we are now. It is also difficult to influence decisions about spend and procedural development such as review of database, processes and the barriers to effective and efficient operational delivery."

"Middle managers have to be in the front line offering support on a continual basis however, middle managers are not always offered support. There could be better support when new in role, as supports tend to be for front line staff from different agencies".

" To be all things to all people – a manager is expected to know and fix everything"

Moreover, similar patterns with developmental needs were also found:

"It was recognised that managing staff was a significant part of the middle management role but that, often, development of self was not prioritised. Participants highlighted the potentially unmet development needs of middle managers whose remit was varied and often demanding. They frequently were expected to take on additional responsibilities as a result of economic pressures and "delayering" but few were offered opportunities to develop themselves prior to taking on these roles" Patterson and George (2014 p.26).

At time of writing, the Scottish Social Services Council (SSSC) has put out a tender for "Identification of middle manager leadership learning needs in Scotland's social services".

Some of the learning needs of CNMMs have already been identified in my study, such as education to and beyond first degree: management of both strategic and operational change; organisational development/business planning; human resource management and policies; financial management; and coaching and mentoring opportunities. However there is a need for a larger study looking at CNMMs similar to that being commissioned by SSSC.

The SSSC report is valuable given that some of Patterson and George's participants are exactly some of the middle managers working in partnership with CNMMs through CHPs. Nevertheless it is important to highlight that although there are similarities my study goes deeper by yielding insights into how CNMMs navigate complex issues adding significant understanding of their work world.

Furthermore, this investigation in part confirms the assertion by Scotland's Chief Nursing Officer in 2012 that:

"Community nursing has always been a vibrant area of practice characterised by diverse roles and practice settings, a strong sense of identity, pride in its roots in evolving progress for the good of patients and the wider society"
(Scottish Government 2012).

However I argue that this requires strong community nurse leadership and management especially from the middle. In a recent article by the Nursing Times UK nursing champion Baroness Audrey Emerton cautioned that nurse leadership is lacking from the ward right up to the House of Lords, asserting that the quality of nursing care often comes down to the quality of leadership. Revealingly she indicated that this is due to lack of training or support "particularly in middle middle management making it "weak" (http://www.nursingtimes.net/opinion/2014).

"The bottom line is that an organisation as large and complex as the NHS cannot be run without high quality management and leadership. This will happen only through a commitment of time and resources and a willingness to value the role of managers whatever their background" (King's Fund 2012).

The findings of this exploration concur with these statements. In addition, they show that in order to thrive, the CNMM population needs to be invested in, valued, and supported to be courageous leaders. This will strengthen and maintain the unique and important role CNMMs perceive they have in contributing to the delivery of quality care to service users.

CHAPTER 10: CONCLUSION AND RECOMMENDATIONS

10.1 Conclusion

The overriding purpose of this study was to explore CNMMs experiences of role enactment in managing change within CHPs, so that the CNMM voice could be heard. It took place across three regions of Scotland from 2008-2011. My thesis has addressed six central questions by immersion into the work and life world of CNMMs through IPA. The nature and form of the CNMM role was captured by focusing on their life world as related by them. This has provided a detailed and rich account of CNMM role enactment and role related behaviour. During the investigation it was a time of considerable SG policy change and an economic recession which gives added dimension and depth to the subject. While many common themes emerged in terms of CNMM experiences, there were also areas of difference. Exemplar illustrations were used to explain these further. This highlighted elements that may support CNMMs to thrive or otherwise in their work world, providing further significant facets to the study. This is important and may prove an interesting route for further research.

The main conclusions from this IPA investigation are that in general CNMMs perceive that they hold a wide range of responsibilities, whilst keeping day to day services running. They manage the challenges of driving change within a hierarchy and professional bureaucracy. Their jobs have become more complex, responsibilities wider and the pace and intensity of work has increased. Many feel absent from decision-making in terms of targets etc., and feel disempowered, isolated and controlled. They see their working hours as having lengthened and their performance in achieving SG targets as being monitored more closely. Opportunities for education and learning were felt to have reduced despite the population being aware of training needs. They tended to struggle to enact their role optimally, with some citing an absence of adequate support, and some fearing that quality is being compromised by financial pressures. Small but significant proportions either left or were considering leaving the NHS service.

A primary motivation for CNMMs in carrying out the role was in maintaining an implicit and meaningful connection with service users, summed up as *"Nursing by the long stretch of the arm".* They were guided by the values of their occupational professional grouping of nursing and associated ethics espoused service user advocacy. CNMMs were proud to be members of the nursing profession and aligned their identity and moral compass in general, with their career history as opposed to that of management. This was in turn perceived by CNMMs to influence their management and leadership style. In overcoming some of the personal challenges they faced, they identified protective factors or "assets" to counteract stress. The application of a salutogenic perspective emerged as important in supporting this.

It is vitally important that the complexity of CNMM role enactment through change is understood. Being in the middle of the organisation CNMMs are in a unique position to influence the successful implementation of SG change. They carry out multiple roles through change, engaging and managing diverse teams and acting as conduits for vertical and horizontal communication between both the operational and strategic planes of the NHS and partner agencies. Many suggested that they are barometers of quality, service delivery and employee relations, influencing retention, stimulating job satisfaction and developing services. In addition they manage budgets in a high pressure sector with high expectations from government. Crucially, they make decisions and judgements affecting nursing teams that can have an effect not only on the resiliency of teams but more importantly patient safety (Shirey 2009).

10.2 Value of the investigation

The research literature on this subject and specifically in the context of community nursing middle management within NHS CHPs was found to be deficient. To my knowledge, there is limited awareness of such challenges for this particular study population. Hewison (2002 p.18) supports this notion asserting that "little is known about the realities of health management and middle management work in the NHS is obscured". The majority of management research in healthcare has concentrated on management at board level (Hyde et al 2011).

Significantly my thesis provides a valuable addition to existing literature in several domains. Firstly it contributes to middle management and change literature in general. Secondly it adds to NHS, CHP, change, middle management and community nursing literature in particular. Thirdly it explores a role not previously examined, to my knowledge. Fourthly the link between management style, workplace health, engagement and the retention or otherwise of experienced CNMM staff, has been explored to a degree and contributes to public health and HR literature. In addition it enhances understanding of the challenges of change and how the translation of government and local change policies and directives are determined and influenced from the middle to stimulate action and facilitate NHS CHP service delivery. In the process participant voices have been forefronted and each participant will receive a summary report as soon as the project is completed. Findings may also resonate with NHS allied health professionals partner public agencies, higher education, the voluntary sector and private sector middle managers. Importantly it has the potential to influence practice and policy at both local and government level.

Use of qualitative methodology and IPA specifically proved fitting in eliciting the detailed accounts of how participants made sense of their work world, the meanings they attributed to their particular experiences, and to events and states. This investigation has been true to the underpinning principles of IPA in its subscription to the four criteria of quality IPA studies (Smith 2010). The IPA thread is consistent,

flowing through each step of the methodology from the iterative literature search, to the RI, followed by the iterative phased approach over a time span and the sharing of initial findings with participants. In addition it offers an in-depth analysis of a specific topic with a specific population over a specific period of time. Reporting of analysis features sufficient sampling from the transcript corpus to show the density of evidence for each theme. Narrative extracts point to both convergence and divergence by demonstrating patterns of similarity and by highlighting the uniqueness of the individual experience. To capture particulars in more depth further the two exemplars provide added focus. Smith (2010 p.24), asserts that “this nuanced capturing of similarity and difference, convergence and divergence is the hallmark of good IPA work.” It will therefore add value to the existing body of IPA literature.

In terms of value and originality use of the RI introduced a novel aspect to the overall methodological design. This maximised the reflexive method of research in a way that turned back upon, and took account of, itself (Hardy et al 2001).

However, all research has limitations and it is acknowledged that this investigation is no different. In keeping with the authenticity of this thesis the limitations follow.

10.3 Acknowledgement of limitations of the research

The study is based on CNMMs working exclusively in three regions of Scotland and may therefore not be representative of the views of CNMMs in all parts of Scotland. All of the Community Nurse Managers interviewed were middle managers. Being both investigator and CNMM could be considered a potential limitation but active, early steps were taken to address this in the design. This was supported by the reflexive thread running through the methodology, and the RI in particular.

Due to time and resource limitations the scope of the investigation did not provide the opportunity to explore the views of CNMM role enactment from senior & junior managers to identify any differences between grades of mangers or teams. The sample size is fairly small; however it was on the larger scale for an Interpretative Phenomenological Analysis study (Smith et al 2009). In IPA research broad generalisation is not possible (Reid et al 2005). Nevertheless commonalities have been identified across narrative accounts supported by 'analytic commentary' providing useful insights which may have wider implications. 'Theory' with a capital 'T' is not the purpose or remit of IPA studies, but, findings can influence and contribute to theory in a broader 'lower case' sense (Caldwell 2008).

It is important to bear in mind that IPA does not seek to find one single answer or truth, rather a coherent and legitimate account that is attentive to the words of the participants. Accordingly this thesis has presented their shared perceptions through my respectful interpretation.

10.4 Recommendations

Based on the findings of this thesis I offer several recommendations for policy, education research and practice and which are now presented in sequence. Given that the evidence in this thesis suggests that CNMMs are nurses *"by the long stretch of the arm"* and are a pivotal link in the successful delivery of SG change, it would be useful to consider the importance and advantage of having a strong CHP community nursing middle management workforce. This could be supported by:

10.4.1 Policy, education and research

Scottish Government

- Considering inclusion of management as an important component of the Modernising Nursing in the Community Model. (This is currently and notably absent).
- Establishing a mapping exercise which looks at CNMM job analysis and quantifies CNMM numbers across Scotland.
- Commissioning a scoping study of CNMMs in Scotland (similar to that of the SSSC).
- Involving CNMMs in power sharing activities to design appropriate and affordable initiatives to contribute to the retention of staff and safe service user care.

NES and Professional Bodies

- Developing a national structured CNMM programme to degree level and beyond, with a formal management programme designed, established, and funded with in-built flexibility e.g. learning modules, that are tailored to need. (Specific nurse middle manager certification in addition to professional certification should be a requirement of the CNMM job description).

10.4.2 Practice

NHS and CHP

- Reviewing current CHP nursing management structures to ascertain whether they are fit for purpose with a clear line of professional support throughout the system.
- Applying healthy work practices taking into account employee needs and positively intervening in distribution of workloads and the pace of work.
- Reviewing CNMMs role to ensure realistic configuration for individual CNMMs so that they thrive in the workplace and deliver quality services.
- Providing accurate CNMM job descriptions so that they are more clearly understood and CNMM workload is more manageable.

CNMMs as a group

- Developing local and national networks to share best practice and reduce feelings of isolation.

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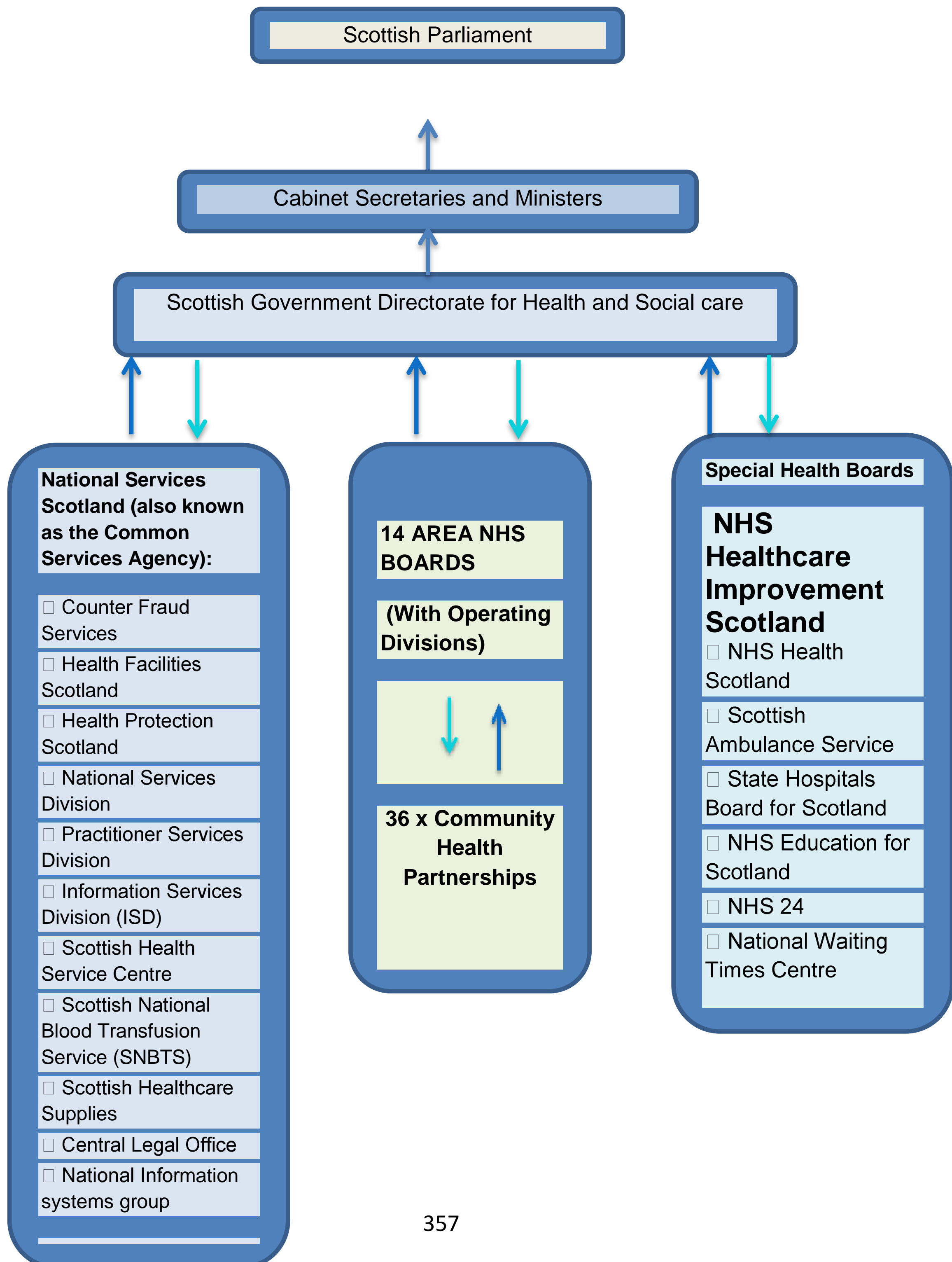
APPENDICES

Appendix 1:

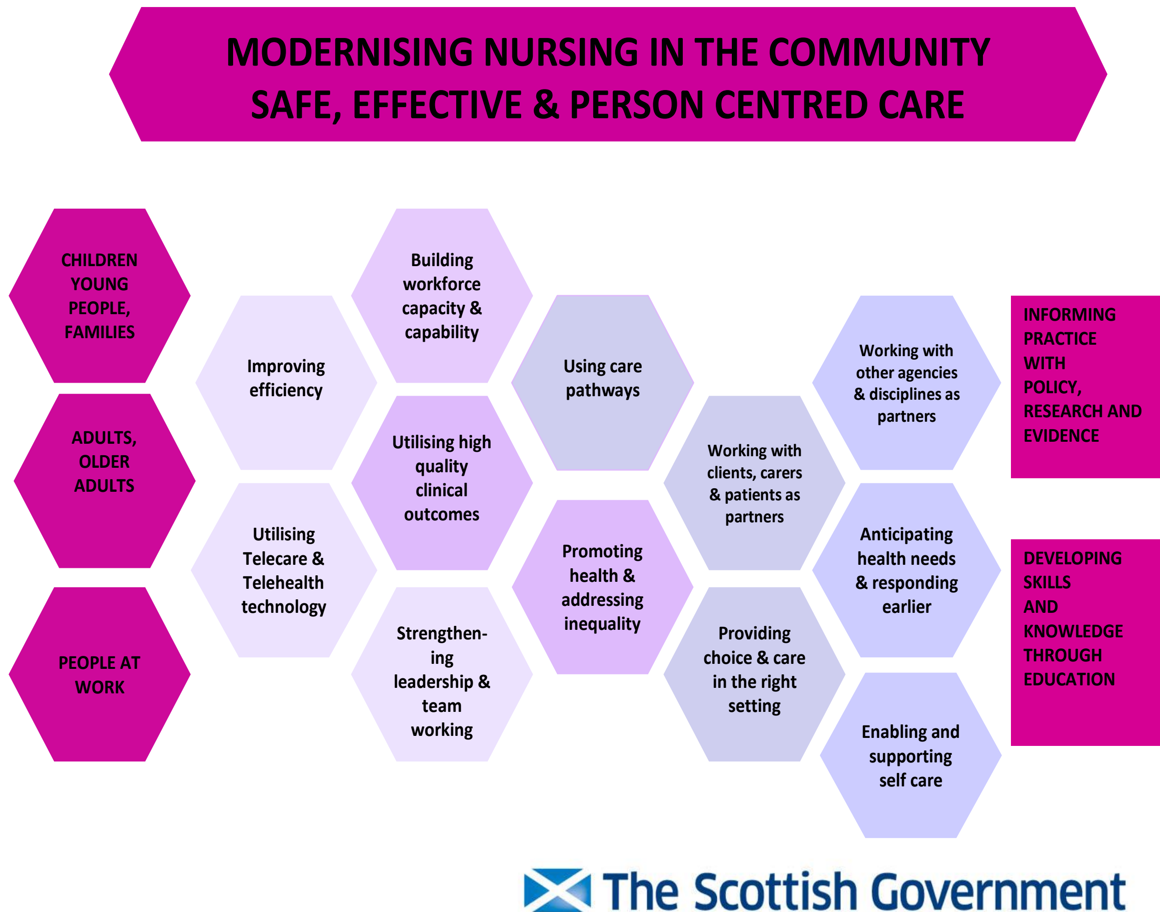
CURRENT ORGANISATION OF THE NHS IN SCOTLAND

Accountability → *Funding* →

(Modified from Robson 2011)



Appendix 2: Modernising nursing in the community



Taken from: Scottish Government website: www.scotland.gov.uk (2012)

Appendix: 3

CHP key policies, inter-linked frameworks, priority areas & health improvement Scottish Government directives

Key Policy context	Inter-linked Frameworks	Priority Areas	Health Improvement
National Strategy for the Development of the Social Service Workforce in Scotland: a plan for action 2005-2010 (Scottish Executive 2005)	Achieving our Potential: A Framework to tackle poverty and income inequality in Scotland (Scottish Government 2008)	Shifting the Balance of Care – Overview of Evidence Relating to Shifting the Balance of Care: A Contribution to the Knowledge Base. (Scottish Government September 2008)	The Potential Contribution of the Voluntary Sector to the Scottish Government's Health Improvement Performance Management Framework (NHS Health Scotland October 2008)
Changing Lives: Report of the 21st Century Social Work Review (Scottish Executive 2006)	Equally Well: Report of the Ministerial Task Force on Health Inequalities (Scottish Government June 2008)	Long Term Conditions – Improving the Health and Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan (Scottish Government June 2009)	Health Improvement & Community Health Partnerships – Advice Note (CHP Health Improvement Group June 2009)
Better Health, Better Care: Action Plan (Scottish Government 2007)	Early Years and Early Intervention: A Scottish Government and COSLA policy statement (March 2008)	Community Care outcomes – National Outcomes For Community Care (Scottish Government April 2007)	
Mental Health in Scotland: closing the gaps – making a difference (Scottish Government 2007)			
A Force for Improvement: The Workforce Response to Better Health, Better Care (Scottish Government 2009).			

Adapted from Watt et al (2010)

Appendix 4: Middle management literature

Pessimistic literature	**Optimistic literature**
Occupation under siege, targeted by de-layering and downsizing. (Scarborough and Burrell 1996)	Ideally placed to capitalise on changes in organisational structures and processes, empowered and enriched role. (Idema et al 2008)
Perceived as resistant to change, bureaucratic. (Kanter 1983, Peters 1992)	Contribute to strategic change, business planning processes, be innovative and entrepreneurial assuming greater responsibility for management and leadership of human resources. (Floyd & Wooldridge 1997, Kanter 1989)
Job insecurity and redundancy. (Dopson & Newman 1998, Hecksher 1995, Newell and Dopson 1996)	Vanguard of attempts to establish enterprise based management – particularly in the public sector.
Blurring of role. (Scarborough 1998)	
Erosion/changing of role. (Floyd and Woolridge 1997) “We are all managers now” (Grey 1999)	
Increase senior management’s control of the organisation. (Townley 1994, Willmott 1993)	

Adapted from Ainsworth et al (2009)

Appendix 5: Interview Schedule Foundational Phase

	Core Structure *Introductions* *Check consent and understanding of purpose and format of the interview.* *Explain that the study is being undertaken within the context of reform*	
Prompts (examples) Can you tell me more about that?	How long have you been in management? How and why did you come into management? What are the present expectations of your role and remit?	**Probes (examples)** Can you tell about any educational preparation?
What was that like? What happened then? Getting back to your experience of change etc... Go on	Can you share some of your **past** experiences of managing change? What team work issues do you recall? What leadership issues do you recall? Why do you think that things happened the way they did? What did you learn from this?	Have you experienced any conflict within nursing in being in management? Are there any particular experiences that stand out? Can you give me an example of what made you feel that way? I would like to hear about any unexpected outcomes.

Can you expand on that? What impact does it have? Tell me how that affects you?	In relation to the **present** can you share some of your experiences of managing change? What team work can you recall? What leadership issues can you recall?	How do you communicate change? With respect to change do you use any formal tools to help? Are there any coping strategies you use? What else do you have in your toolkit?
Can you elaborate? Can you give me an indication of why you think that?	If you **project your thoughts forward** what changes can you see developing over the next few years in relation to managing change? What are the implications for leadership? What if any are the implications for your role and other Community Nurse Middle Managers? What are the implications for education and practice development? Finally is there anything that you would like to add?	How does the business of every day service delivery continue?

Appendix 6: Interview schedule recursive and expansive phases

Core Structure

Introductions

Check consent & understanding of purpose of the interview. Explain format: the interview will use the diagram of the main phase one themes as a basis for discussion, but will also seek fresh perspectives from interviewees and explore some other issues that have emerged as potentially important

1. Role

New interviewees: Can you tell me about your role in terms of its purpose and main activities? Who do you mostly work with and what are the boundaries on your role (geographic/professional)

Follow-up interviewees*:* Has there been any change regarding your middle management function since we last spoke? If so, please explain *(explore nature and meaning of this)*

2. Instrumental Strategies for Managing Change

Looking at these strategies, to what extent do they reflect your own experiences of managing change as a CNMM? *(work through each exploring meaning and relevance, if any, for interviewee)*

Is there anything missing here that is important from your own experience of managing change?

Thinking about your own role and the way you manage change, why do you take the approach that you do?

3. Contingent Conditions and Tensions

The three things listed under this theme emerged as important aspects of working conditions and often there were tensions involved.

Can you say something about the relevance of each of these to your work role and whether tensions are a significant factor?

Is there anything missing here that is important from your own experience of working conditions within the CHP?

Thinking more broadly, what meaning do you feel your work has to others within the CHP?

I'm also interested in how you see yourself in terms of professional identity – can you tell me something about this?

How has this developed and changed in working as a CNMM?

Thinking of the CHP as an organisation, what does it mean to you?

I'm interested in your bases, spaces and places within the CHP – can you say more about your role and territory?

Can you tell me more about how power is exercised in terms of your effect on others and others effect on you?

Can you say more about why it works in the way it does?

4. Contingent professional/personal consequences

The three things listed under this theme emerged as important professional and/or personal consequences for CNMMs.

Can you say something about the relevance and meaning of each of these to your own experience?

Why do you think it affects you in the way that it does?

Is there anything missing here that is important from your own experience?

You'll see that I've depicted a kind of balancing act for CNMMs between adverse impacts and positive factors. Please

take a minute or two to look at a more detailed picture of this *(give time to consider)*

Can you say something about the relevance and meaning of this to your own experience and that of other CNMMs you know?

Is there anything missing here that is important?

I'm particularly interested in what sustains you in your role – can you tell me about this?

How might CHP CNMMs be better prepared for the role?

5. Reflections and projections

Looking back, what are the main things that you have learned from being a CNMM in a CHP?

Looking ahead, what does the future hold for CNMMs?

Finally is there anything that you would like to add?

Appendix 7: Example of an analysis of a foundational interview - based on Smith et al (2009)

Integrating nursing values

Emergent themes (clustering around values)	**Original transcript**	**Exploratory notes**
Applying nursing values to enacting CNMM role Identity entrenched in the nursing profession.	*Emmm… I suppose as a manager I still think of myself as someone who is helping patients which is what nursing is all about and I do that or how I explain it to myself is that I do that via helping the nurses who are at the front line to deliver that care to the best of their ability.*	Identity linked to nursing, Seeing role through caring lens. Emphasising connection with nursing as a profession as opposed to that of management.
Keeping CNMM role centred around patient care Patient centred values integrated into CNMM role	*I think that is the best way that I can put it, so, so I still think that I'm helping nursing **mmhh**, through helping the front line nurses and helping them to work with the people they are supposed to be working obviously with, like local authority staff, helping to iron out any difficulties there.*	Belief in putting the patient at the centre of providing services/maintaining the link with nursing values, partners and service users.
Maintaining underpinning nursing values	*So I think that's, I'm protecting the nurses and I'm working with the nurses but I am also very much acting on the interests of those patients that they're looking after and who maybe can't speak very well on behalf of themselves.*	Drawing on nursing experience/ identity to guide current role and maintain a link with and act as advocate for patients. Utilising nursing values to support staff and act as patient advocate
Maintaining integrity in CNMM role by applying nursing ethics to change	*I can see that we absolutely have to change the system so that we don't have that because that's an awful lot of time wasted on travelling that really should be given over to patient care so it's necessary.*	*Acknowledging need for change but balancing that with benefitting service users*

Beliefs grounded in caring and patient/nurse relationship	*In years gone past those district nurses might have visited those people either continuously or with their own staff nurse that was attached with them at the practice, so they are maybe going to feel that they are going to, to, some extent lose something of their patient relation, patient nurse relationship*	Tension in enacting CNMM role when trying to balance change and potential loss for patient /nurse relationship.
Maintaining philosophical nursing stance	*…..because as nurses you're not driven financially.*	Reflecting on personal nursing values, finds tension between caring and financial element of role.
Opposing nurse based and finance based philosophies	*You're driven by wanting to do a good job for the patients and for the people who are looking after the patients, but finance has a huge part to play*	Emphasises tension in enacting CNMM role when trying to balance two differing philosophies within the NHS. Cognitive dissonance.
Finding it challenging to reconcile nursing values with managing finances	*obviously, if you don't have financial resource sufficiently, around that one of the ways around that, is giving less of something....* ***mmhh.....*** *stopping doing something...* ***mmhh*** *...or diluting your resource in some way by doing things with less staff and those are all really hard painful decisions to make.*	Appears to be cognitive dissonance, due to opposing values, emphasising the pressures of balancing the financial challenges within patient care. Uses the word "painful" to describe feelings associated with diluting resource implying that this is upsetting. Repetition about finances driving services and reflecting on the negative impact that may have on care.
Keeping patient care at the heart of enacting role	*Because you might, in fact you do, want to deliver a gold standard service but you are forced to recognise that at times you can only deliver bronze. Well it is hard and it's going to become even harder , I'm sure of that in the coming years.*	Shows commitment towards maintain her nursing values by linking them to patient care.

Appendix 8: Example of an analysis of a recursive interview - based on Smith et al (2009)

This interview extract was selected as being typical in reflecting the core nursing values of participant experiences and because it is rich with emotion.

Emergent themes (clustering around values)	Original transcript	Exploratory notes
Applying nursing values to enacting CNMM role	*... I remember like it is to actually nurse that patient, and for patients to be well cared for and I don't want to lose that*	Reflecting and drawing on nursing experience/identity to guide current role and maintain a link with patients.
Keeping CNMM role centred around patient care	*Yes, because again it's back for that particular thing ... it's patient safety, patient care. At the end of the day we are here, whatever job we're in, we are here for patients, our clients, or we should be.*	Belief in putting the patient at the centre of providing services/maintaining the link with nursing values and service users.
Patient centred values integrated into CNMM role	*Sometimes I feel that's a bit removed nowadays, ,…. I have to say. I often go to meetings and I never hear a client or a patient mentioned at a meeting. And that bothers me. And I say that openly um, that you know, where are the patients in this? At the end of the day we are here for them um, that's what we're paid for, whatever level or whatever we're doing, whether you're working in the office here um, in a clerical position, I remind the office staff, every day that we're here for the patients, we make an impact on patient care,*	Uncomfortable with the focus of some NHS colleagues, their values and motivation in terms of patient care. Their perceived lack of consideration of patient care induces emotive feelings "that bothers me" resulting in consciously and proactively maintaining the underpinning values of nursing to maintain integrity in acting as advocate. Strong belief that everyone in the NHS should be keeping their focus on patient care and trying to influence others values/motives to maintain links to patient need.
Maintaining underpinning nursing values	*... and I believe passionately ... I mean I feed that all the time here, that integrate the nursing values into every post within here um, and go to meetings and look at this openly, to speak about patients, because I do think that they are far removed sometimes at different levels, folk never think about them, it is all*	Emotionally attached to caring and quality in delivering NHS services as part of the nursing component of CNMM role. Concern expressed that the needs of service users may be being lost and coming second to meeting financial cuts. Tension in enacting CNMM role when trying to balance two differing

	about er, streamlining services, doing this, but a patient is never mentioned.	philosophies within the NHS.
Maintaining integrity in CNMM role by applying nursing ethics	*And that bothers me – really bothers me. So I do try and remind folk that we're here for patients. It bothers me because I suppose I've worked too long on the ground level to ... I remember like it is to actually nurse that patient, and for patients to be well cared for and I don't want to lose that because I do think that we are in danger of us going against ..., but what about the patients in all this?*	Thinking about the personal effects of opposing values – emphasis on "it bothers me", then stresses how uncomfortable this is by again stressing " really bothers me" and repeats "it bothers me" again. Again mentioning not wanting to lose integrity and advocating for patient centred care. Important within the context of role enactment.
Beliefs grounded in caring	*It's all about quality, I mean especially with the quality standards as well, you know come in last year, that I know people are speaking about quality, quality but a really good quality service you've got to have people in post to deliver that um, and as much as I say it, you know, I do think we should be very educated um, but I do think that we do need to look seriously at skill mixing so that patients are being cared for, because there's no point having four or five ... band five's running about in a community ward area for example and one band two to do that, running about the patient care, and the band fives writing up notes and stuff, you do need somebody in either, a few band twos or something in the middle to care for patients because at the end of the day you know, a patient's not caring if their plan is being written, they're caring that their mouth's dirty or they're soiled or whatever, they're ill, and so worrying about that. Um, so I do think that nursing values is important for every door in the organisation to remember that we're there for patients.*	Emotional investment in providing quality services expressing perception that some are paying "lip service" to quality. Seeing quality in nursing through a "caring" lens not just about being well educated. Concerns that skill mix has not been the answer. Concerns that paperwork has become more important than the comfort of the patient. Cognitive dissonance. Acting as advocate within CNMM role taking it back to the service user again.

Finding it challenging to reconcile nursing values with managing finances	*I think there is a tension. Um, I do think you're asked to do things that may go a wee bit against your nursing values. I suppose it is, it's the management stuff, you know, when looking at finance, again where we're looking at finances and we're looking at it, yes, but we're trying to think ... but we're looking at finances, we're looking at high level stuff and yeah, you can read all about that and then sometimes it's difficult for people to equate that back to the patients. Patients are always the commodity. They don't want ... do you know what I mean? It's always the costs, financial driven ... it's all become financially driven where instead it used to be patient driven. Um, and that's essentially hard.*	Appears to be cognitive dissonance, due to opposing values, emphasising the pressures of balancing the financial challenges within patient care. Again concerns expressed that at high level link to caring becomes more removed. Repeating concerns re changing emphasis on finance instead of patient need …using term commodity, (strong word to use – dehumanising) to describe how others view service users, which sits uncomfortably with underpinning nursing ethics.
Identifying importance of maintaining nursing ethics in role	*I suppose that's financially driven as well, as with safety – patient safety is another concern, that you know, if we can't supply a nurse to that area, whether it's a community hospital or a GP practice or whatever, um, I suppose patient safety comes into it as well.*	Repetition about finances driving services and reflecting on the negative impact that may have on care.
Keeping patient care at the heart of enacting role	*I worry – I do worry, I go home at weekends and worry if we have enough supply nurses you know, people say, "Oh, you'll get over that – you'll get over that um, after a while you've been in the job you'll get over that because it's not your fault, you're complimentary, you're..." But I don't, I do worry about patients, I've come in at weekends and wait for them, wait and see if we can get people to cover, especially some community hospitals where they're relying on, you know, maybe one or two nurses um, so I have done that. So I suppose it's integrating your nursing values there that you've kind of struggled um, getting people because you want the patients cared for.*	Outlining personal emotional cost to maintaining nursing integrity in CNMM role. Outlining personal cost in ensuring that adequate services are available. Working additional hours. Shows commitment towards maintain her nursing values by linking them to patient care.

Identifying the need for nurses to manage nurses	*I think it should be important that you are a nurse to manage a service um, because I think if you don't have that insight as to how busy areas are um, how busy the health visiting teams are, how busy, you know, then how could I actually emphasise and try my best for it? So again it's going back to your values. I think to be in this type of job if you weren't a nurse you wouldn't be able to empathise with what people need staff for and why they need them. And they aren't just here leading them and really I think it would be very ... a really bad move to have somebody in this job that wasn't a nurse*	Reflecting on the values perceived to be needed to manage nurses in order to be a strong nurse leader/manager. Feels that CNMMs need to have experience in the disciplines they are managing, the opposite of the general management ethos.
Values being a nurse more than being a manager		Reiterating the values perceived to be needed to manage nurses in order to be a nurse leader. (Indicates strong feelings about this.)
Identity entrenched in the nursing profession	*I do think to be a reasonable manager or a good manager, I still think you need to have the basis of ... or a nurse manager, you've got to have the basis that you're still a nurse. And it worries me if I see that people aren't like that.*	Expressing that her nursing identity defines her as a person. "Hard to get out of your system" implies a deep seated affinity with the nursing profession that supports professional identity.
Nurse values integral to CNMM role	*I very much see myself as being a nurse at the end of the day, whatever else, I'm definitely still a nurse. Er, if somebody asks what my job is I never say, "A manager." I probably would say a nurse and then what do you do then? And then I would probably say, "I manage a community nurse service." Because,…. it's hard to get out of your system.*	Reiterating attachment to nurse identity perceiving that people relate to nurses more than managers.
	I still very much see myself as that nurse. And I think a compliment to me is if somebody says, "You're normal" or "You're grounded" or to me, because people identify with you. And I feel that you get a lot more out of people if you're like that.	Emphasising again connection with nursing as a profession as opposed to that of management.
Being part of the nursing community/profession to maintain nurse values	*I've found that the managers that I've had less and least respect for are the people that really think that they are something else than a nurse. They forget*	Highly values and honours nursing identity and profession above management role.

Strong alignment with colleagues who maintain nursing values in enacting their role	*they're a nurse, they're a manager or you know, to me that's a poor reflection on that person, whereas I'd far rather say, "I'm a nurse"* *There's quite a lot of um, camarad- you know...Camaraderie? Camaraderie, and I do think that.you know if somebody said to me, "Right, you've two choices, you lose your nursing registration state or get a better job." I'd keep my registration. I would keep my registration. I'd rather forego the job. I was very proud of being a nurse because I felt it was a job that I wanted to do. And um, I'm still very proud of that part. The management bit, I enjoy the job but …er ,…. better being known as a nurse than a manager.* *I do really worry that folk are in those positions that are almost ruthless to the point that actually why are they doing this, it's certainly not the patients, it's actually for themselves. And that is just a side of management that I don't like, because I've got brilliant managers I work with, a lot of brilliant managers who are like myself, share the same nursing values. Um, but there are managers that you'll say, "I can't believe they were ever nurses." And that worries me as well because those are the people that are influencing what's actually going on.*	Concern about the motivation of some colleagues at high strategic level. Uses word "ruthless" indicating perception that some are callous and unfeeling. Expressing allegiance with "like-minded" nurse colleagues. Goes back again to express concerns/discomfort about colleagues in powerful positions who are not perceived as exhibiting nursing values when in a position of authority.

Appendix 9: Specific example of inter-case construction – role complexity as a Theme Cluster.

Example of development of a Theme Cluster	Narrative transcript excerpt examples Recursive Phase	CHP, page paragraph, participant code RW = region wide role	Present in Narratives?
ROLE COMPLEXITY (fluidity and widening span of control)	*"my role's developing I think. Um, I'm covering areas that are granting wide stuff now rather than um, just primarily focused on the job so I am covering things like newly qualified nurses and things like that. However um, the biggest change for me has been losing my line manager, um, which has been I suppose a bit difficult given that there's been so much different things going on within, um, my role. So I suppose for me I know of a more senior manager um, in the chain um, who actually kind of given the same support supervision as … so my middle management role's changing because I'm having to seek out more staff for myself to find support."*	*Marie, R., R.W.*	√
	*…..I think it's a role that evolves all the time without your realising, formally realising it's changed. ...**How do you mean then?** Well if I look back my job probably is slightly different this year than what it was last year. I mean if you looked at my job description I'm quite sure it doesn't really accurately describe what I do. Because of the changes, because of the drivers; you just have to adapt to what you're doing, em, and I suppose you just... I just don't know, you get better but you em, but I suppose it's around, you do your job differently don't you. I think em in this type of role that you're expected to take a job description and develop it the way you think is the best way to develop it. That would be my interpretation anyway. So, em...I couldn't actually put my finger on what was different, but probably because we're doing just probably different, there's different focus and different elements of it, would probably be a better way to describe it"..*	*Emma, R., S.M., CHP 1*	√

	"I have links with the GP practices, District Nurses, Health Visitors and other teams that would be involved in any form of immunisation. I attend the Steering Groups in Aberdeen and lead any changes or anything that's coming in, I'm the instigator in Moray.Em, I was heavily involved with GIRFEC, but that role has now been taken over by our Child Protection Liaison Nurse.Em, Gypsy travellers is the latest thing that em I'm involved in, and how that links into immunisation, and that was the link that I got involved with there. That's new; I don't know how much work it's going to generate at the moment. It's just been em me contacting everybody in Moray that's relevant, to say that the yellow handheld record's going to be re-launched, and to watch this space. Feedback I've got back from a lot of people is they don't know what the yellow handheld record is; they thought it was just for children and didn't realise it was for the adults as well, so obviously we need to do some education work with that.I'm involved with HEAT 3 Targets and that's through the school nursing perspective. There's quite a large group meet here to discuss HEAT 3 and how we can move that forward. So that's a monthly meeting as well.I'm involved in the Health and Wellbeing Curriculum for Excellence Group, which is separate from the Health and Wellbeing Project. That's em, meeting with education; there are some head teachers and em folk from the Public Health Team – not the Health Visiting Team, the proper Public Health Team – who are leading change in the Health and Wellbeing Curriculum. So I'm involved with that. Em..."	*Isla, R., L.N., CHP 3*	√
	"The CHP was becoming ever bigger and more complex and the management structure within the CHP wasn't growing because of financial constraints. So that resulted in managers and nursing staff, and very possibly wider staff too, although I can't speak for them, but with regard to nurses and managers, yes it did result far more work coming all of our way. And it didn't seem to me like we, as managers, had found a very good way of coping with that. We used to speak about it a lot but not really be able to come up with any solutions. We were just able to sound off to each other and empathise and sympathise but at the end of the day I felt that the workload was just becoming overwhelming…"	*Rosie, R., S.M., CHP 1*	√

<u>Present in Over 1/2 (66.6%) Narratives (Smith et al 2009)</u>	*" my role is, is, to co-ordinate and facilitate the work of the complete nursing team that is the GP attached community nurses, eh the HVS the DNs and their staff but also the practice nursing team who are employed directly by the GPs. I also have a clinical input which works out about on average 40% but I can choose when I do that, when I work with the patients and that might be surgery based or it might be going out and working with the DN team and I have also been known to help the team with the child health so that's the role in itself then.I suppose in a way I've got 2 sets of managers 2 sets of bosses because em this was a unique role in this area, it was negotiated between the GPs and NHSG and GPs put money into the post em, way back, Primary Care Investment Fund money, so in a way it is a joint post although completely administered and managed by the NHSG processes but , you know, I am also duty bound to report and act on the stuff the GPs want me to do as well so that's a wee bit different from others in the area.* *"Well, from my point of view just because of the time lapse between the last one I have actually retired from my middle management function.* *"The main issue purely being the amount of different components to the job".*	*Iona, R., S.M. CHP 2* *Mary, R., S.M., CHP 1*	√ √ **<u>YES</u>** **(Total of 9 interviews present in 6)**

Appendix 10: Specific example of inter-case construction: role complexity as a Superordinate Theme

Example of development from a theme cluster to a Superordinate Theme	Narrative transcript excerpt examples expansive phase	CHP, page paragraph, participant code RW = region wide role	Present in Narratives?
ROLE COMPLEXITY (fluidity and widening span of control)	*"…….we are the professional lead for nursing but we are not the managerial lead. Now I quite like that because erm it frees me up to do the professional things the advice, the leading on it and everyday things are picked up by the manager er so it does give me that bit of extra time to do these things. Each Senior Nurse Advisor has a double role. My dual role is I'm Senior Nurse Advisor, I'm also interested in and specialise in Professional Development so that's any kind of training, any kind of new clinical skills brought on etcetera". " all three of us have in our locality but our other halves stretch across to CHP which is Infection Control, Service Development and Re-design and the workforce and workload planning."*	*Diane, E., C.L., CHP 5*	√
	"I've got school nursing, district nursing, health visiting, and I manage integrated response team which is a multi-disciplinary team there's social work, rehab care assistants it's a joint team there's social work involved and health, so there's physio, OT ,and there's twelve rehab care assistants in the team, and their purpose is to support early discharge, or prevent admission. I also manage a community rehab which is a health team that's physio OT district nurse and level 3 carer…"	*Laura, E., W.G.M., CHP 5*	√
	" there are two components to the role, there's the Senior Nurse Advisor's part, which means that in each of our localities, and there's three in the CHP, there is a Senior Nurse Advisor there for strategic nursing input and advice and that can range from anything from complaints from family, friends, relatives and HR conduct things in relation to nurses that you take up and reply to or work with HR.	*Joy, E., C.L., CHP 4*	√

	Depending on how you work with the manager in that locality, you may well get some line management, more managerial issues that they don't pick up which are more nursing and that works differently across the three CH, the three localities".		
	"I have responsibility for community nursing services from district nursing, public health nursing, including schools and health visiting team, primary care nursing, treatment room nursing, evening nursing and potentially some of the specialist services."	*Fiona, E., G.M., CHP 7*	√
	"*GIRFEC, inequality, public health nursing, including schools and health visiting team, primary care nursing and how that links into accessing acute services."*	*Angela, E., G.M., CHP 6*	√
	"….I co-ordinate and facilitate the work of the complete nursing team that is the GP attached community nurses, eh the HVS the DNs and their staff but also the practice nursing team who are employed directly by the GPs. I also have a clinical input which works out about on average 40% but I can choose when I do that, when I work with the patients and that might be surgery based or it might be going out and working with the DN team and I have also been "I have to say over the past six months I have noticed that colleagues and myself, our workload has catapulted, exponentially, I was going to use that word but I don't know if that's the right word, just hugely and therefore, what people would have been able to manage and do, it's getting, that will have to wait because they're getting so much piled on them because other people's roles when they leave and retire aren't getting filled so then the roles get divvied up"	*Jill, E., G.M., CHP 6*	√
	Um, okay. Well responsibility for the services that are sat within that generic role in terms of the service development as they relate to the nursing disciplines that… you know that sit within that responsibility for the management of the staff, um within it. Um, in terms of the structure of the role, um I don't know how closely that vies up with other areas but within the CHP, um we have a … in the nursing structure we have a chief nurse who sits across two CHP areas, and then there's clinical nurse managers of which, um there's only one in the CHP area and then I have two team managers who support me in that role. One for the public health nursing side of things, school nursing health visiting and then the other for community nursing, um district nursing and treatment room. So I guess it's all…	*Kate, E., .C.L., CHP 8*	√

Present in 1/3-1/2 Narratives (Smith et al 2009)	*it's everything that sits within that, you know the partnership work and the working with the local authority in terms of, um delivering on joint futures, shared services agenda, the integrated children's services on the other side of the age spectrum. So I kind of in my head I see it that way, it's like this, you know the age spectrum from one, um extreme, if you like, to the other, and kind of in a sense everything that sits in between it. So it is broad".* *"... there is a focus on how we do things more efficiently and we reduce waste and we improve safety compared to also looking at all the other things around care and involvement, staff involvement and staff wellbeing. All of these things that we need to do and how you manage all of that has probably added a greater complexity to the role".*	*Grace, E., G.M., CHP 4*	√ **YES (Total of 8 interviews 100%)**

Appendix 11: Characteristics defining employee engagement

Definition Characteristics	Description	Sources
Drivers/inputs into engagement		
Two-way relationship between employee and employer	*"Similarity to the psychological contract – unwritten, underpinned by trust – easy to break."* *"Organisations have to work to engage employees – and may have to put in a lot to reach their goal of a committed, enthusiastic and engaged workforce"* *"An important point to note is that engagement is two-way; organisations have to work to achieve it."*	Robinson et al (2004) Robinson et al (2004) CIPD (2005)
Business appreciation & vision	*"Employees must understand the context in which the organisation operates. It is insufficient for employees to be committed to their organisation; they also need an element of business appreciation, so that any changes they make to their jobs could be seen to have business benefits."* *"Of course, when you have the right people you have the trouble of creating ways of letting them know what is going on in the business and where they fit in …'line of sight' – in regards to business goals and objectives."* *"Knowing what to do at work – understanding the organisation's vision of success and how the employee can contribute to achieving that vision…"*	Robinson et al (2004) Penna (2006) Christian, M. et al (2007)

	"We also have it confirmed here that communication – knowing what's going on, what's planned and why – is crucial. *"The report describes a group of people who receive a clear vision, are inclined to support the organisation's objectives, and who are also highly engaged."*	Segal/Sibson (2006) CIPD (2006a)
Employee involvement	*"Fundamentally, good internal communications should be about effective transfer of knowledge or meaning within the organisation, so that people understand and support the organisation's business goals – it's not just about 'broadcasting to the troops'."* *"We talk more about words like 'involve', 'participate' and 'respond' rather than 'engage'. That means creating shared meaning and understanding in a way that our people actively want to participate." (BBC case study)* *"These are interesting findings and can be taken to emphasise that people want a sense of involvement – or being to some extent in a partnership with their employer."*	Investors in People IIP UK (2006) Melcrum Publishing (2005) CIPD (2006a)
'Elbow room' / discretionary behaviour	*"….give them lots of opportunities to contribute…."* *"… people who have reasonable autonomy in doing their job, sometimes called 'elbow room', and who find their job challenging are likely to have high levels of job satisfaction…."*	Buchanan (2004) CIPD (2006a)

Effective Communication	*"…employees having a voice – being able to express their opinion upwards to their manager and beyond."* *Ref management style – "…keeps the person in touch with what is going on. Listening to suggestions."* *"The main drivers of employee engagement are: having opportunities to feed your views upwards; and feeling well informed about what is happening in the organisation…."* *"… challenges you to raise the level at which you communicate with your people, making the dialogue increasingly two-way and giving people a greater say and stake in decisions which affect them."*	CIPD (2006a) CIPD (2006a) CIPD (2006b) IIP UK (2006)
Management	*This points to the primacy of the quality of the relationship between employee and supervisor, sometimes called 'leader-member exchange'."* *"Managers themselves have to show commitment to the organisation, what we would call 'committed leadership'."* *"…engagement, which is influenced by …..management capability – reflected in professional, fair and impartial behaviour. It is possible to be motivated in one's job without necessarily feeling an attachment to the organisation or the management… however, a feeling of engagement requires a wider sense of supporting and being supported by the organisation."*	CIPD (2006a) CIPD (2006a) Sharpley (2006) (as cited in Harrad 2006)

Results of engagement/characteristics of an engaged workforce:		
Employee identification with the organisation	*"Employees need to believe in its [organisation's] products and services, and particularly its values"*	Robinson et al (2004)
Commitment	*"Wanting to do the work – obtaining a sense of satisfaction from the job and work content and being inspired by the organisation to perform the work."* *"Employee engagement, or 'passion for work', involves feeling positive about your job, as well as being prepared to go the extra mile to make sure you do the job to the best of your ability."*	Segal/Sibson (2006) CIPD (2006b)
Pride & advocacy	*"…people's commitment, pride and advocacy (what employees say about company products, services and brand)."* *"We believe that the pride taken in working for their employer, and their willingness to recommend their employer as a place to work to friends, are excellent barometers of engagement and meaning"* *"Engaged employees will help promote the brand and protect the employer from the risks associated with poor levels of service…..similarly, a strong employer brand will help in attracting and retaining employees"*	Right Management (2006) Penna (2007) CIPD (2007a)

Taken from: Scottish Executive Social Research (May 2007)

Appendix 12: Salutogenisis model