UNIVERSITY OF SOUTHERN QUEENSLAND

THE INFLUENCE OF FORMAL EDUCATION ON THE LEADERSHIP DEVELOPMENT OF HEALTHCARE EXECUTIVE LEADERS IN QUEENSLAND HEALTH

A thesis submitted by

Stephen Hart

Associate Diploma in Electrical Engineering, Graduate Diploma of Education,

Master of Organisational Development and Training

In partial fulfilment of the award of

Doctor of Education,

School of Linguistics, Adult and Specialist Education,

Faculty of Business, Education, Law and Arts,

University of Southern Queensland, Australia

February 2016

Abstract

The need to develop the leadership capabilities of clinicians to bring about necessary improvements in health systems is confronted by a number of challenges, including the adequacy of healthcare leadership frameworks and the quality of healthcare leadership development programs. This study focuses on the influence that formal education, as one strategy of leadership development, has had on the leadership development of healthcare executives in Queensland Health.

A qualitative research methodology, positioned within an interpretivist paradigm and using an Interpretative Phenomenological Analysis approach, was used to construct a conceptual model that explains how healthcare executive leaders develop leadership capability through formal education.

In the first instance, the nature of leadership was considered through a literature review before moving onto additional literature that explored existing leadership frameworks and leadership development. An interview survey was then used to discover healthcare executives within Queensland Health who could be identified as having specific leadership characteristics. These identified healthcare executive leaders became the participants for further enquiry.

Through two semi-structured interviews with each of five identified healthcare executive leaders, it was confirmed that leadership capability can be developed from insights gained through formal education experiences. These identified healthcare executive leaders reported that formal education experiences had the effect of raising their awareness that there were alternative ways of leading and operating. The formal educational experiences provided them with models of effective leadership and encouraged them to reflect upon and to compare these models to their current practice, leading to new understandings about themselves and their approaches to leadership. This personal insight motivated them to change their behaviour towards new practice. Based on these findings, a conceptual model that describes this relationship among leadership knowledge, educational process and leadership insight has been developed.

The significance of this study is that it provides evidence for the important role that formal education has as an effective strategy for the development of healthcare executives' leadership capability.

This study contributes to leadership theory through an extension of the understanding of pedagogy as it applies to leadership capability development. This study also contributes to leadership capability development practice by encouraging the designers of formal education approaches to consider how their instructional design elements interact to build a more systemic approach to leadership development.

Certification of thesis

I certify that the work contained in this thesis is my bona fide work, that the work has not been previously submitted for an award, and that, to the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due acknowledgement and reference are made in the thesis to that work.

_____ _____

Signature of Candidate Date

ENDORSEMENT

_____ _____

Signature of Supervisor Date

_____ _____

Signature of Supervisor Date

_____ _____

Signature of Supervisor Date

Acknowledgements

In any meaningful learning journey, the forming and reforming of relationships, the discovery of oneself and the discovery of new knowledge are all intertwined. So it has been in the conduct of this research and the development of this thesis. New, valuable relationships have been formed with the research participants, whose generosity of time and willingness to disclose their personal leadership education journeys make them the heroes of the thesis, my role being to bring out the richness of their stories and to interpret them in a useful way. The relationships formed with my supervisors have also been an incredibly valuable contribution to this work. They have stood beside me as I struggled with methodology, process and writing style, ever guiding me and helping me to discover my own path.

The reforming of relationships with my family has led to stronger, more resilient connections as my children, who were completing undergraduate degrees themselves whilst I was completing this work, saw their father in a different role as a lifelong learner. A wonderful, life-fulfilling relationship with my wife has become even stronger as we continue to share life's successes and challenges, ever growing closer.

Discovery of self has been a constant companion is this process. Can I do this? Should I do this? What meaning does this bring? What does this say about me? These are all questions that were continually asked, not by others but by myself. And, as we discover later in the body of the work, clearly the leadership journey is a relationship between new knowledge and self-discovery – a journey that for me does not conclude with this thesis.

And finally, I acknowledge the value of new knowledge, I know things now that I had not known before and this new knowledge has helped me both personally and professionally. But it is the intertwining of all these things that has enriched my experience and the combination of these elements is greater than the sum of the individual parts.

Table of contents

List of figures

List of tables

List of acronyms and abbreviations

A number of abbreviations and acronyms are used throughout the study and, in addition to being referenced in the text, the commonly used abbreviations and acronyms are listed here for convenience:

CEO	Chief Executive Officer
Framework (the)	the NHS Leadership Qualities Framework
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service (United Kingdom)
Review (the)	the Queensland Health Systems Review (Australia)
RQ	Research Question
Taxonomy (the)	the Taxonomy of Leadership Theory
WHO	World Health Organisation

1 Chapter 1: Introduction

1.1 Introduction

This study was an enquiry into the influence that formal education has had on the leadership development of healthcare executive leaders in Queensland Health. This chapter provides the reader with an introduction to the study, the background to the research problem, the identification of the research problem itself and its associated research questions. It sets the scene for the study and provides compelling evidence of the need for research into the important identified area of effective pedagogical approaches to the development of leadership capability for healthcare executive leaders.

This chapter also presents a high level overview of the methodology used to provide responses to the research questions and includes a brief autobiography of the researcher - my background, influences and insights into my worldview. In addition, the chapter outlines the significance of the study and the limitations and delimitations of the approach used to conduct the research. Finally, the chapter concludes with an outline of the work, providing the reader with an introductory guide to the structure of the thesis.

1.2 The context of the research

This study is situated within a context of health services in countries throughout the world that are under ever-increasing pressures to deliver improved services in a climate of increasing demands from and expectations of patients and communities, ageing populations and fiscal constraints. The availability and accessibility of improved transportation and movements of populations have meant that healthcare systems require new, more efficient and faster responses to potential, and real, epidemics and pandemics. This increased requirement for preparedness and responsiveness adds further and continuing pressures on national and international health systems (Deloitte, 2014; World Health Organisation, 2014b).

It has been identified that skill shortages and leadership deficiencies in healthcare workforces are intensifying the challenges facing healthcare systems and the

implementation of national health plans (World Health Organisation, 2006). In its *2008 World Health Report* (World Health Organisation, 2008), the World Health Organisation (WHO) identified improved leadership as a key requirement of delivering continuing advancements in healthcare. WHO has continued to call for improved leadership capability throughout global healthcare systems (World Health Organisation, 2014b) and placed leadership priorities at the centre of its *Twelfth General Programme of Work* (World Health Organisation, 2014a), which is WHO's high-level strategic vision of work for the period 2014–2019.

Health services in Australia are also confronted with increasing healthcare pressures and issues that are cause for concern and that call for a response. Armstrong, Gillespie, Leeder, Rubin and Russell (2007) have identified a number of challenges confronting Australian healthcare, including an increase in chronic illness, increasing healthcare costs, workforce supply and distribution, and equity in health. Knowles, O'Dowd, Hewett, Schafer and Wilkinson (2012) have called for a healthcare leadership response in Australian healthcare systems, stating that changes in modern healthcare's provision, complexity, and workforce demand an increasing emphasis on leadership development within the Australian medical profession.

When under the types of pressures outlined above, some health systems experience extreme breakdowns in performance. Public inquiries have uncovered serious adverse outcomes resulting in mortality and direct harmful impact on patient care as a result of these systemic breakdowns. The literature produced through these public inquiries, usually in the form of official reports, has recommended improvements in the leadership development of clinicians in the respective healthcare systems as they have found that deficiencies in leadership have been identified as factors that have contributed to the breakdowns in the healthcare systems reviewed (Forster, 2005; Kennedy, 2001; Wallace, 2015).

In the specific context of the Australian State of Queensland, the Queensland Health Systems Review (Forster, 2005) was commissioned by the then Premier of Queensland as a result of community concerns over health service issues such as surgery practices, waiting lists, clinical workforce shortages, service quality and public accountability. Queensland Health employees interviewed as part of the

Queensland Health Systems Review (Forster, 2005) reported a number of perceived deficiencies in the skills of Queensland Health leaders and managers.

In response to these challenges and recommendations, Queensland Health had adopted the NHS Leadership Qualities Framework (National Health Service, 2006) as its model of leadership to guide the development of its healthcare executives.

1.3 The conceptual background relevant to the research

Although inquiries and reviews have recommended improvements in the leadership development of clinicians (Forster, 2005; Kennedy, 2001), many clinicians have viewed engaging in hospital management as a waste of their highly developed skills and training and better left to others (Eastman & Fulop, 1997). Eastman and Fulop (1997) have also reported that clinicians fear that their collegial relationships with their peers will be compromised if they are seen to be aligning with management and taking on management responsibilities. Those clinicians who do try to take on management responsibilities often try to apply a medical paradigm and to utilise a scientific approach to management. When confronted with the political nuances and ambiguity of organisational management, they find that their skills are ineffective, which, according to Eastman and Fulop (1997), has led to these clinicians feeling frustrated.

Buchanan, Jordan, Preston and Smith (1997) have reported that doctors do not find managerial posts attractive, given their commitment to patient care, their lack of management skills and the lack of career benefit. Nurses, according to Harris, Huber, Jones, Manojlovich and Reineck (2006), as with other clinical groups, separate nursing practice from nursing administration and also do not see nursing administration, including management and leadership, as part of advanced nursing practice.

It was found from the literature that there are many definitions of leadership (Bass & Bass, 2008; Yukl, 2013). It was further found from the literature that researchers usually define leadership according to their individual perspectives and the aspects of the phenomenon of most interest to them (Yukl, 2013). A taxonomy of leadership

theory, hereafter referred to as the Taxonomy, was necessarily created in Chapter 3 to bring together some of the major leadership theories into theory clusters and to provide a commentary overview of the themes of the clusters. The purpose of the Taxonomy was its use as a point of reference when considering different leadership frameworks. The Taxonomy that has been created in this work is a significant contribution to theoretical knowledge in this field.

Leadership frameworks more generally, and healthcare leadership frameworks specifically, that were available from the literature were reviewed against the Taxonomy to determine the theoretical influences of those frameworks. It was found that the healthcare leadership frameworks were dominated by qualities, behaviours, competencies or characteristics that reflected a view of leadership as a process of influencing colleagues and health networks within the context of the health system, whilst managing the day-to-day realities of delivering a service. There was little to no evidence from the frameworks that they were influenced by more contemporary leadership theory such as Uhl-Bien and Marion's (2008) complexity leadership theory or Pearce and Conger's (2003) shared leadership theory.

A review of the literature relating to healthcare leadership development programs found that there were various descriptions of the content covered by these programs or the workshop designs employed but that there was little or no description of the learning processes employed or of the learning experiences of the individual participants in the programs. The literature was very much program-centred rather than learner-centred in its focus.

1.4 The research problem

The preceding section provided evidence that it is useful to raise questions about the approach to leadership development adopted by Queensland Health and, in particular, to consider the influences that educational approaches may have had on the development of the leadership capability of Queensland Health leaders. In this study, a specific focus was on the influences that formal education has had on the development of the leadership capability of Queensland Health leaders who were from a clinical background. The focus on Queensland Health leaders who were from

a clinical background, rather than including Queensland Health leaders more generally who were from either clinical or non-clinical backgrounds, was deliberate and was in direct response to the call from the literature that has recommended improvements in the leadership development of clinicians (Forster, 2005; Kennedy, 2001; Wallace, 2015).

In an organisation the size of Queensland Health, with more than 75,000 employees, over 48,000 of whom are clinical staff (Queensland Health, 2011), it should be expected that some clinicians have successfully moved into healthcare leadership roles, are exhibiting effective leadership behaviours and are making a positive difference in the delivery of improved services. Who are these healthcare executive leaders and what can be learnt from them? How did these healthcare executive leaders develop their leadership capability and what can be learnt from their experiences that may be applicable to others?

The aim of this study was to identify these healthcare executive leaders and to examine their educational experiences to determine the influence that those experiences may have had on the development of their leadership capabilities. It was recognised that these leaders would have had a broad range of experiences, including formal, informal and non-formal learning (Colley, Hodkinson, & Malcom, 2003; Organisation for Economic Co-operation and Development, 2009), which would have contributed to their leadership development and therefore, in order to provide focus to the study, the particular influence of formal educational experiences was explored as a primary consideration.

Therefore the problem addressed in this research was:

> What is the influence of formal education on the leadership development of healthcare executive leaders in Queensland Health?

1.4.1 The research questions

In order to provide a response to the research problem, three questions were put forward (definitions of the terms used in the research questions can be found in Section 1.4.2):

RQ1. How does the NHS Leadership Qualities Framework (National Health Service, 2006) adopted by Queensland Health compare with the leadership characteristics required of its healthcare executives?

RQ2. What is the influence that formal education has had on the leadership development of the identified healthcare executive leaders in Queensland Health?

RQ3. What conceptual model of pedagogical approach can inform the development of leadership capabilities for healthcare executives?

1.4.2 Definitions of terms

Healthcare executives. Healthcare executives within the scope of this research are defined as medical (e.g., doctors, surgeons), nursing (e.g., nurses, midwives) and allied health (e.g., physiotherapists, psychologists, dieticians, etc.) professionals who are in senior executive roles in Queensland Health. Typical roles/titles include: Divisional CEOs, District CEOs, District Executive Directors, Senior Medical Administrators and Directors of Nursing.

Formal education. The study defines formal education as:

- education that is engaged in through institutions such as universities and professional colleges and that typically results in some form of recognised professional qualification; or
- workplace training that is organised and structured and that has learning objectives.

1.5 Methodology

This study was concerned with issues of leadership, leaders and learning. A methodology was required that enabled theory to be constructed that explained how healthcare executive leaders develop leadership capabilities through formal education. The research methodology chosen to achieve this outcome was positioned within an interpretivist paradigm using qualitative methodology. Interpretative Phenomenological Analysis (IPA) was chosen as the research approach for this study as it best suited the nature of the research questions, it was congruent with the paradigm within which I was operating and it had characteristics that suited my

preferences of how I wanted to engage with the research and to interact with the participants in the study. Appropriate methods were used to obtain the data needed to facilitate the interpretative analysis and to answer each specific question.

The consequent research design consisted of three phases:

Phase 1. Phase 1 was concerned with conceptualising leadership from a theoretical perspective to enable the NHS Leadership Qualities Framework (National Health Service, 2006) to be positioned within a theoretical construct.

Phase 2. Using the outputs of Phase 1, the next phase was concerned with identifying healthcare executive leaders in Queensland Health, the participants in the study, and interviewing them to obtain data relating to their formal education experiences.

Phase 3. The final phase consolidated the outputs from the phases above to construct a conceptual model explaining how pedagogical approaches have contributed to healthcare executive leaders developing leadership capability through formal education.

Research Question 1 was explored through a literature review and analysis that firstly explored the nature of leadership before moving onto literature that explored existing leadership frameworks and leadership development. The literature review and analysis then considered the particular framework of leadership chosen by Queensland Health, the NHS Leadership Qualities Framework (National Health Service, 2006), and compared this framework to the evidence and understandings gained from the broader review and the analysis of the literature. The purpose of this methodological approach was to provide a clear context of leadership within which to explore the leadership capabilities and leadership development of Queensland Health healthcare executives.

A response to Research Question 2 was obtained by firstly identifying healthcare executives within Queensland Health who could be considered as having leadership characteristics that most strongly aligned with the NHS Leadership Qualities Framework (National Health Service, 2006), these identified healthcare executive

leaders being the participants in further enquiry. The identified healthcare executive leaders were interviewed and asked to share their formal education experiences and to explain how those experiences had contributed to their leadership development. Coding techniques were used to enable understanding and reconstruction to develop through inquiry with the identified healthcare executive leaders whilst still allowing more informed and sophisticated new constructions to be explored.

The reconstruction of the data from the identified healthcare executive leaders' interviews allowed a conceptual model to be developed that explained how healthcare executive leaders develop leadership capability through formal education, drawing from literature and the findings from the interviews. This conceptual model of pedagogical approach enabled a response to the overall research problem.

1.6 The autobiography of the researcher relevant to the research problem

IPA deals not only with participants' interpretations of their experience but also with the researchers' interpretations of participants' interpretations (VanScoy & Evenstad, 2015). It is useful, therefore, to describe my own personal and leadership journey and educational influences here in recognition of the proposition that my experiences will have contributed to the IPA interpretative analysis presented in this study.

I am from a white Anglo-Saxon heritage and am the youngest of five children with two brothers and two sisters as siblings. I was born in 1961 and I could be considered to have been part of a 'traditional family' of the 1960s and the 1970s in Australia. I recognise that my heritage, background, gender and upbringing have all contributed to my worldview and perspective, having come from what would be considered to be, certainly from a global perspective, a somewhat 'privileged' background. The cultural influences of the 1960s and the 1970s during my childhood would have also contributed strongly to my worldview. My childhood was characterised by relatively carefree days followed by, through television each night, images of some of mankind's greatest achievements (such as the moon landings) and some of our darkest periods of extreme violence (such as the Cold War, the Vietnam War, Middle Eastern terrorism and assassinations). It was also a period of great hope with human

rights movements and equality (particularly women's rights) movements active in society.

Owing to my father's work, our family moved frequently as I was growing up. This required the development of adaptation qualities as I needed to adjust to new educational environments in different States of Australia, each State having different curricula and approaches to pedagogy. After I graduated from secondary school, I immediately began work with Australia's telecommunications provider, Telecom. Whilst with Telecom, I commenced and completed an apprenticeship, which required the successful completion of a formal in-house education program. Soon after completing my apprenticeship I commenced and completed an Associate Diploma of Electrical Engineering with the Queensland Institute of Technology through part-time study. The completion of this qualification enabled me to 'fast-track' from being a Technician to becoming a Technical Officer, my first formal leadership role. This experience demonstrated, for me at least, that formal education can have a positive impact on career progression. I moved from a technical maintenance role to a technical training role as a Principal Technical Officer in my mid-20s, one of the youngest to do so. From this technical training role, in the early 1990s I moved to a personal development training role, facilitating and teaching in the areas of leadership (including organisational change), management development and personal development. This was a period of significant change in Telecom as it transitioned from a Government owned monopoly to a private enterprise publically listed company. During this time I completed a Masters of Organisational Development through Southern Cross University part-time. After over 20 years with Telecom (which had been rebranded to Telstra during that time), I joined the Queensland State Government, taking on leadership roles in learning and development and strategic human resources functions. During that time I led the development and implementation of a number of leadership programs across large, complex government agencies. I commenced a professional doctorate with the University of Southern Queensland (a component of which is this study) whilst I was with Queensland Health. I am currently the Associate Director of Human Resources (Organisational Development) with the University of Queensland. I continue to develop and implement organisational leadership programs.

I recognise that my background and experiences will have contributed to the IPA interpretative analysis presented in this study. During my career I have benefitted personally and professionally from undertaking formal education linked to my profession. I have also experienced, and I have seen my colleagues experience, participation in formal learning experiences that have not translated to any meaningful improvement in my own or their capability. I see the world that I grew up in, and continue to experience, as a world that is imperfect, that truth is often found to be a concept that is open to interpretation and where meaning is found through shared experience. My worldview is post-positivist, whereby I consider that the world is complex, with dynamics that are shaped by social, cultural and gender values and that, where realities do exist, they are co-constructed by myself and others within the contextual framework of our experiences and dispositions (Bunniss & Kelly, 2010; Creswell, 2009; Guba & Lincoln, 2005).

1.7 The significance of the study

Based on their review of research and literature, Bass and Bass (2008) concluded that the evidence indicates that leadership and management training, education and development are effective. Burgoyne, Hirsh and William (2004) and Yukl (2013) contended, however, that there is relatively little research in the area of leadership development when compared to the amount of leadership training that occurs and assert that further evidence of effectiveness is required. This requirement for further research is particularly the case with regard to formal leadership training for healthcare executives, which is still seen as a relatively recent addition to the healthcare practitioner's educational armamentarium (Sonnino, 2013). Deficiencies in the leadership capability of healthcare executive leaders have been found to have contributed to adverse outcomes for patients, including increases in mortality (Forster, 2005; Kennedy, 2001; Walshe & Offen, 2001).

The significance of this study is that it has explored the important area of formal leadership development for healthcare executives as called for by Burgoyne, Hirsh and William (2004), Yukl (2013) and Sonnino (2013). This study has contributed to the body of evidence available to further understanding of the influence that formal

education has on the development of the leadership capability of healthcare executives.

1.8 The delimitations and limitations of the study

A number of limitations and delimitations of the study are highlighted. Firstly, the theoretical understanding of leadership is evolving and is contested (Yukl, 2013). The differing perspectives of the participants and my own views of 'what leadership is' had the potential to cloud the study, particularly in a study using an IPA approach where there are the participants' interpretations of their experience and there are also the researchers' interpretations of participants' interpretations (VanScoy & Evenstad, 2015). This delimitation was minimised through the use of a consistent benchmark of 'what leadership is' by using the NHS Leadership Qualities Framework (National Health Service, 2006) as the common point of understanding.

A limitation was the sample size of the respondents to the interview survey used to identify the healthcare executive leaders as the participants in the qualitative interview phase of the study. A nonprobability sample (Creswell, 2009) of 3% of the population to be studied was used based on convenience and availability. It was recognised that this sampling technique is less desirable (Creswell, 2009; Groves, 2004) and therefore an additional validation process was put in place whereby confirmation in the form of 360^0 feedback data was requested from the identified healthcare executive leaders.

Another limitation was the number of participants in the qualitative interview phase of the study. My goal of interviewing only healthcare executive leaders in Queensland Health who were identified as having leadership qualities, rather than simply interviewing people who were in leadership roles, limited the pool of possible participants. A purposeful selection of participants that results in a small number of interviews being conducted is, however, consistent with an IPA approach (J. A. Smith, Flowers, & Larkin, 2009; J. A. Smith & Osborn, 2007).

A further limitation was the use of a single researcher and hence the individual perspective inclusive of possible bias and filtering from that particular perspective. I

utilised open-ended questioning and objective data capture to minimise the effect of individual bias and filtering.

A delimitation of the study was the focus on the leadership of healthcare executive leaders. Leadership of other cohorts in other contexts was not extensively explored. Another delimitation of the study was the focus on formal education. Whilst tentative exploration into aspects of informal education and learning were made, they were done so with full acknowledgement that this was not an area of focus for the study and that further research was required to illuminate the interrelationships fully.

The data that emerged through the study had depth and richness that, despite the recognised limitations outlined above, empowered fruitful analysis and legitimate inductive interpretation. This consequently led to the development of a strong conceptual model that illuminates the influence of formal education on the development of leadership capability. This newly proposed conceptual model was shown to have a solid foundation in established literature and it is expected that organisational development and learning and development practitioners will find the insights presented through this model useful when designing future leadership development initiatives.

1.9 The thesis outline

This chapter, Chapter 1, outlines the study and includes the background to and the context of the research problem, the research problem itself and an overview of the methodology as a lead in to the work. Chapter 2 reviews literature related to the context of the study providing a solid contextual foundation from which the conceptual framework is explored through the literature in Chapter 3. Chapter 3 analyses concepts in the areas of leadership, leadership frameworks, leadership development and aspects of pedagogy. A leadership taxonomy was developed in Chapter 3 from these concepts for use when considering the theoretical influences that have informed the healthcare leadership frameworks presented in the chapter.

The full methodology of the study is presented in Chapter 4, where a review of the ontological and epistemological considerations provides a rationale for the selection of the research paradigm, methodology, approach and methods.

The focus of Chapter 5 is on providing a response to the first research question by reviewing the NHS Leadership Qualities Framework (National Health Service, 2006) and comparing it with the leadership characteristics required of Queensland Health's healthcare executives.

Chapter 6 identifies the healthcare executives in Queensland Health who were considered to be 'leaders' and then presents data, in the form of narrative reconstructions, from the semi-structured interviews with the identified healthcare executive leaders. These data are presented in the broad clusters of the leadership journey of each of the identified healthcare executive leaders and the influences, as identified by them, of formal education on their leadership development.

The data obtained from the identified healthcare executive leaders are analysed and interpreted in Chapter 7 and a conceptual model emerges that helps to describe more effectively how the influences of formal education contribute to the leadership development of healthcare executives.

Finally, Chapter 8 provides an overall response to the research problem and the associated research questions. This final chapter also considers the implications and significance of the study for the leadership capability development of healthcare executive leaders, as well as the theory, policy and practice that inform that capability development. Additionally, Chapter 8 points the way to further research in this important area of leadership capability development.

1.10 Conclusion

Issues of leadership and leadership capability development are important concerns upon which to focus attention if there is to be improved positioning of healthcare services to meet current and emerging challenges more effectively. This chapter has defined one aspect of these healthcare leadership issues as a research problem:

What is the influence of formal education on the leadership development of healthcare executive leaders in Queensland Health?

This chapter has also provided the reader with an overview of the methodology that was used to provide a response to the research problem and the associated research questions.

The next chapter is a review of the literature to provide a fuller picture of the contextual framework within which the study is situated.

2 Chapter 2: Contextual framework

2.1 Introduction

This chapter identifies and explores literature to provide an account of the contextual framework within which the study is situated. Literature that illuminates the issues, challenges and complexities of the provision of healthcare services in a global context are firstly explored in the chapter. The issues, challenges and complexities of the provision of healthcare services in the Australian context and the Queensland context are then explored more explicitly. Whilst somewhat brief, this contextual chapter provides an important background from which the conceptual underpinnings of the research can be explored. The conceptual framework is presented in Chapter 3.

2.2 The international context

Health services in countries throughout the world are under pressure to deliver improved services in a climate of ageing populations and the increasing demands and expectations of patients and communities. The ever present spectre of epidemics - for example, Ebola Virus Disease (EVD), Human Immunodeficiency Virus (HIV), Severe Acute Respiratory Syndrome (SARS), Avian Influenza ('Bird Flu') and other potential influenza pandemics (such as the 2009 H1N1 'Swine Flu' pandemic) - add to continuing pressures on health systems (Deloitte, 2014; World Health Organisation, 2014b).

These pressures are exacerbated by issues related to skill shortages and leadership deficiencies in healthcare workforces. The World Health Organisation (WHO) (2006) has identified the shortage of human resources as having replaced financial issues as the most serious obstacle to implementing national health plans. In the 2008 World Health Report, WHO identified improved leadership as a key requirement of delivering continuing improvements in healthcare (World Health Organisation, 2008). In the *World Health Report 2013* (World Health Organisation, 2014b), WHO identified that building and strengthening global research capacity required "a skilled and self-confident workforce with strong leadership" (p. 102). WHO's continuing focus on issues of leadership in healthcare is evidenced by the placement of

leadership priorities at the centre of its *Twelfth General Programme of Work* (World Health Organisation, 2014a), which is WHO's high-level strategic vision of work for the period 2014–2019. Deloitte (2015), a leading international consultancy firm, have also identified that:

> Mitigating the human resource crunch at all levels of the health care value chain is not the only staffing challenge facing hospitals and health systems in 2015. Organisations will need to source, recruit, and retain executives with new leadership skills and professionals trained to meet the needs of 21st-century health care models. (p. 10)

When under the types of systemic pressures identified above, some health systems experience extreme breakdowns in performance. One example of a systemic breakdown that has occurred was at the Bristol Royal Infirmary, Bristol, England. In the late 1980s and into the early 1990s staff at the Bristol Royal Infirmary began to raise concerns about the quality of paediatric cardiac surgery undertaken at the hospital and the resultant deaths and complications arising from this surgery (Walshe & Offen, 2001). There was continuing conflict at the hospital between surgeons, anaesthetists, cardiologists, and managers about the issues that were contributing to the high mortality rates. Walshe and Offen (2001) have reported that the General Medical Council (GMC) opened an investigation into the events at Bristol following complaints from parents of some of the children. This investigation found three doctors guilty of serious professional misconduct. Following the GMC investigation, a full public inquiry began hearing evidence in October 1998. The report from the public inquiry, the Kennedy report, was published in July 2001 and contained recommendations for the National Health Service (NHS) to consider for all healthcare services across the United Kingdom (Kennedy, 2001; Walshe & Offen, 2001).

Kennedy (2001) found that the issues at the Bristol Royal Infirmary, when taken together, "led to around one-third of all the children who underwent open-heart surgery receiving less than adequate care" (p. 2). He also found that "staff were not encouraged to share their problems or to speak openly and that those who did try to raise concerns found it hard to have their voices heard" (Kennedy, 2001, p. 5).

The report highlighted a lack of leadership at the Bristol Royal Infirmary, "poor teamwork demonstrates a clear lack of effective clinical leadership. Those in positions of clinical leadership must bear the responsibility for this failure and the undoubtedly adverse effect it had on the adequacy of the service" (Kennedy, 2001, p. 4).

Kennedy(2001) made five recommendations that specifically related to improving the quality of leadership in the NHS, including the recommendation that "The highest priority still needs to be given to improving the leadership and management of the NHS at every level" (p. 14).

The events at the Bristol Royal Infirmary unfortunately highlighted that the combination of a healthcare system under pressure and poor leadership capability within the system can lead to increased mortality and poor patient outcomes.

2.3 The Australian context

Health services in Australia are not immune to healthcare issues and pressures. Armstrong, Gillespie, Leeder, Rubin and Russell (2007) identified a number of challenges confronting Australian healthcare, including an increase in chronic illness, increasing healthcare costs, workforce supply and distribution and equity in health - especially for Indigenous Australians.

Australian healthcare systems are also not immune to systemic breakdowns. Wallace (2015), investigated a significantly higher than average perinatal mortality rate at Bacchus Marsh and Melton Regional Hospital in Victoria, Australia. McArthur and Johnston (2015) have reported that the deaths of seven babies may have been avoidable but had resulted from a multi-system failure and that the hospital had failed to adjust or update its practices to respond to rapid population growth in the region. It was further reported by McArthur and Johnston (2015) that some midwives, and possibly doctors, had raised concerns with management and left the service in frustration when their concerns were not addressed. Wallace (2015), found that, among other contributing factors, "There has been a lack of high quality

staff education" (p. 1). These reports sadly echo the findings of the Bristol Royal Infirmary inquiry from some decades ago.

The healthcare leadership response required in Australia to face the issues and pressures identified by Armstrong, Gillespie, Leeder, Rubin and Russell (2007) are summed up by Knowles, O'Dowd, Hewett, Schafer and Wilkinson (2014b), who, when discussing a medical leadership program developed by The University of Queensland's School of Medicine, stated that: "Changes in modern healthcare's provision, complexity, and workforce demands provide a compelling rationale for an increasing emphasis on leadership development at all levels of training within the medical profession" (p. 344).

Windsor et al. (2015) have identified a well-trained medical workforce, including training and development in leadership, as a key criteria required to meet the quality, safety and cost effectiveness challenges of modern healthcare systems in Australia.

2.4 The Queensland context

Queensland is the second largest, by land mass, and third most populous state of Australia. The population of Queensland is over 4.7 million people (Queensland Government Statistician's Office, 2015) and is mostly concentrated in the South-East corner of the state and the Eastern seaboard. It has been estimated that Queensland's population will increase to 6.1 million people by 2026 (Queensland Health, 2013).

Queensland's growing population is living longer than previous generations and it is estimated that by 2026 1.1 million people in Queensland will be aged over 65 - an 83 percent increase on 2011(Queensland Health, 2013). Queensland's growing population and the increasing burden of preventable chronic disease, including diabetes and heart disease, is placing increasing pressure on the Queensland healthcare system (Queensland Health, 2013).

The Queensland healthcare system has also experienced breakdowns in performance and has been the subject of governmental inquiry. The Queensland Health Systems Review (Forster, 2005), hereafter referred to as the Review, was commissioned by

the Premier of Queensland as a result of community concerns over health service issues including surgery practices, waiting lists, clinical workforce shortages, service quality and public accountability. The Review was centred on mortality and surgical issues identified at the Bundaberg Hospital in Queensland but also had broader terms of reference that allowed the consideration of systemic concerns.

Queensland Health employees interviewed during the Review reported a number of perceived deficiencies in the skills of Queensland Health leaders and managers. Areas of managerial concern included dealing with difficult and often complex problems, encouraging staff contribution in the resolution of problems, engaging effectively with staff and dealing with staffing problems - particularly staff who were troubled, disaffected or not performing.

The Review described Queensland Health's structure as "a bureaucratic, mechanistic structure characterised by highly centralised formal authority and hierarchical layers of decision making" (Forster, 2005, p. 124).

A major emphasis of the Review was a focus on the clinical workforce, recommending increases in the number of clinicians to address demand for health services and increasing the quality and availability of clinical education. The Review recommended that Queensland Health appoint a senior executive leadership team able to demonstrate positive leadership behaviours and also that existing senior managers should demonstrate required leadership behaviours supported through leadership development programs. The Review also recommended that clinical leadership should be fostered and encouraged and progressively relied upon to be responsible and accountable for many of the functions currently performed by executives in the Corporate Offices and district hierarchies. In considering issues relating to developing the future workforce, the Review concluded that one of the primary casualties of the overburdened system was education and training.

One of the organisational responses by Queensland Health to the Review was the development of the *Queensland Health Strategic Plan 2007-12* (Queensland Government, 2007). In addition to defining an organisational purpose, mission and values, the *Queensland Health Strategic Plan 2007-12* (Queensland Government,

2007) identified organisational challenges, a desired future and key initiatives in the four strategic areas of:

1. Improving access to safe and sustainable health services
2. Better meeting people's needs across the health continuum
3. Enhancing organisational work processes and systems to support service delivery and business effectiveness
4. Developing our people in a way that recognises and supports their role in the delivery of health services

A key initiative of the *Queensland Health Strategic Plan 2007-12* (Queensland Government, 2007) was to "Fully implement the Queensland Health Leadership Program" (p. 11).

The Review also made a number of recommendations relating to Queensland Health's structure. A new organisational unit, the Workplace Culture and Leadership Centre, was formed in early 2006 and located in the Reform and Development Division. One of the roles of the Workplace Culture and Leadership Centre was to lead the administration and analysis of a cultural survey, the Better Workplaces Survey, in partnership with the University of Southern Queensland. The other major role of the Workplace Culture and Leadership Centre was to lead the development of leadership capability in Queensland Health.

Queensland Health, through the Workplace Culture and Leadership Centre, adopted the NHS Leadership Qualities Framework (National Health Service, 2006) as the leadership development framework for the organisation.

From 2006 to 2010, the Workplace Culture and Leadership Centre's Queensland Health Leadership Development Program had delivered over 574 workshops with a total of 14,807 participants (Crethar, Phillips, & Brown, 2011). The leadership program included a range of initiatives aimed at improving the leadership capability of Queensland Health executives, managers and supervisors.

2.5 Conclusion

This chapter has explored literature to provide the contextual framework within which the study is situated. It has been found from the literature that healthcare systems internationally, within Australia and within Queensland are under increasing pressures to provide services in an environment of high demand, ageing populations, increasing community expectations and fiscal constraints. Under these pressures, some healthcare systems have been the subject of systemic breakdown, resulting in increased patient mortality and poor quality patient outcomes. Inquiries that have investigated these breakdowns in healthcare services have found that a contributing factor has been poor leadership and have recommended a focus on the leadership development of healthcare professionals.

This chapter has established the importance of conducting research that contributes to a better understanding of approaches to the development of leadership capability within a healthcare context and more specifically the importance of effecting research focussed on the leadership development of healthcare executive leaders in Queensland Health. The outcomes of research in this area can translate to improved leadership practice and consequential improvements in healthcare provision and responsiveness to systemic pressures.

3 Chapter 3: Conceptual framework

3.1 Introduction

The previous chapter provided the context within which the research was conducted and established the importance of the research as a contribution to improved leadership practice and consequentially to improvements in healthcare systems. This chapter provides the conceptual framework for the study. In a study where leadership was at the centre of the research questions, it was prudent to discuss and explore the conceptual nature of leadership and the development of leaders. This chapter first reviews and discusses the literature relating to leadership theory to set the foundation for a better conceptual understanding of 'what leadership is'. Following the review of the leadership theory literature, the chapter reviews leadership frameworks in use in organisations. Finally the chapter reviews literature relating to leadership development and provides a conceptual overview of adult learning literature and theory.

3.2 Leadership theory

Library bookshelves (and electronic library catalogues) are full of books and journals where authors have put forward their definitions of leadership and have made their case for the conclusive proclamation of what leadership is. We are confronted with many variations of the theme, each author proposing a 'new' definition of leadership or, more commonly, an old definition dressed in new clothes. Bennis (1989), writing over 20 years ago, captured the essence of the challenge of defining leadership through his use of an analogy of leadership to beauty - something that is hard to describe but that you know it when you see it.

More recent literature views leadership as a shared phenomenon (Pearce & Conger, 2003) related to context and situation (Mayo & Nohria, 2005) with Mayo and Nohria (2005) finding that leadership success was not derived from the possession of certain personal characteristics but by the application of them within unique contextual settings.

Yukl (2006) has reviewed leadership definitions that have been put forward over the past 50 years and has concluded that "Most definitions of leadership reflect the assumption that it involves a process whereby intentional influence is exerted by one person over other people to guide, structure, and facilitate activities and relationships in a group or organisation" (p. 3).

Bass and Bass (2008) contended that we must continue to live with many possible ways to define leadership and that definitions used, both broad and narrow, should depend on the purposes to be served, making sure that we understand which definition is being used in any particular analysis.

Bass (1990) concluded that "There are almost as many definitions of leadership as there are persons who have attempted to define the concept" (p. 11). Yukl (2013) contended that "researchers usually define leadership according to their individual perspectives and the aspects of the phenomenon of most interest to them" (p. 2). Yukl (2013) then went on to join the assemblage of authors who have provided their definitions of leadership: "Leadership is the process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives" (p. 7).

Leadership theory continues to evolve. Dinh, Lord, Gardner, Meuser, Liden and Hu (2014), in their review of leadership theories of the new millennium, concluded that:

> Our review has also shown that since the start of the new millennium, we have witnessed the growth of emerging leadership theories such as neurological perspectives on leadership, and the continued proliferation of theories relating to leading for creativity and innovation, toxic/dark leadership, and strategic leadership. Several established leadership theories continue to capture the interest of the field including neo-charismatic, information processing, trait, and leader–follower exchange theories. However, other leadership theories have not witnessed significant growth, including behavioral approaches, contingency theory, and path-goal theory. Overall, the growth and development of the leadership field presents both exciting new possibilities and challenges that confront scholars as they

> navigate the complexities of a field that has become increasingly diverse and rich in theoretical insight. (p. 55)

Whilst the conclusive definition of leadership remains somewhat elusive, there is some consensus in the literature on the evolution and categorisation of leadership theory. A taxonomy of leadership theory has been developed in Table 3.1 to bring together some of the major leadership theories into theory clusters and provide a commentary overview of the themes of the clusters. The purpose of developing the taxonomy was for use as a point of reference when considering different leadership frameworks which are used by organisations to operationalise leadership theory. The taxonomy enabled a consideration of a framework and a determination to be made as to which leadership theory construct/s the framework most aligned with. The taxonomy was developed mainly from the work of Van Seters and Field (1990), Bolden, Gosling, Marturano and Dennison (2003), Bass and Bass (2008), Avolio, Walumbwa and Weber (2009), Yukl (2006, 2013) and Dinh, Lord, Gardner, Meuser, Liden and Hu (2014). In developing the Taxonomy of Leadership Theory (please refer to Table 3.1), necessary decisions were made by the researcher as to which theories best clustered together. These decisions were made based on the affinity of the ideas and propositions represented by each of the theories. Decisions were also made regarding the naming of each theory cluster. It is acknowledged that the use of singular explicit adjectives to name a cluster of rich theory is contentious.

Table 3.1:Taxonomy of leadership theory - adapted from Van Seters and Field (1990), Bolden, Gosling, Marturano and Dennison (2003), Bass and Bass (2008), Avolio, Walumbwa and Weber (2009), Yukl (2006, 2013), and Dinh, Lord, Gardner, Meuser, Liden and Hu (2014)

Taxonomy of Leadership Theory	
Theory Clusters and Theorists	**Commentary**
Great Man Theories (Bowden, 1927; Carlyle, 1841; Galton, 1869; James, 1880; Metcalf, 1931; Sun Tzu, c400$_{B.C.;}$ von Clausewitz, 1833; Woods, 1913)	Great Man theories have at their conceptual centre the belief that leaders are born with innate leadership qualities that predispose them to be successful in leadership roles – that they are 'born to rule'. The theory is primarily built upon ideas of male, military and Western constructs of leadership and hence the use of the term 'man' was intentional (Bolden et al., 2003). Although today we may consider the Great Man theories simplistic and sexist, they were based on some of the earliest formal research in what has now become an expanding field of interest in leadership. These early researchers focused their studies on promulgating the notion of 'born to rule' through attempts to show that "a man's natural abilities are derived by inheritance" (Galton, 1869, p. 1) or, in the case of Borgatta, Bales and Couch (1954) demonstrating the positive impact great men had on group performance. Bass and Bass (2008) state that "Without Moses, according to these theorists, the Jews would have remained in Egypt; without Winston Churchill, the British would have given up in 1940; without Bill Gates, there would have been no firm like Microsoft" (p. 49). Attempts were made to equate leadership with personality, however such propositions were frustrated when it became apparent that many effective leaders had widely differing personalities (e.g. Lincoln, Hitler, Gandhi, King, Thatcher). Furthermore it was found that personalities are extremely difficult to imitate, thereby providing little value to enhancing the leadership capability of practising managers (Van Seters & Field, 1990). Although we may consider 'Great Man' theory to be passé, biographies of organisational and political leaders still sell well and at the time of writing, biographies on Thomas Jefferson, Steve Jobs, and Winston Churchill were all in the current Top 100 Best Sellers biographies list on Amazon.com (2013) perhaps indicating that many people still believe there is something to be learnt by studying 'Great Men'.
Trait Theories (Bernard, 1926; Bingham, 1927; Bird, 1940; Jenkins, 1947; Page, 1935; H. L. Smith & Krueger, 1933; Stogdill, 1974; Tead, 1929)	Trait theories differ from Great Man' theories in that they attempt to separate the link between specific individuals and the characteristics or 'traits' that leaders possess. The aim of the theory is to develop lists of traits that, if adopted, enhance leadership potential and performance. These lists can then be used to recruit and select people with such traits into leadership positions (Bolden et al., 2003; Van Seters & Field, 1990). Despite empirical studies revealing no single trait or group of characteristics that can be consistently associated with good leadership, "The lists of traits or qualities associated with leadership exist in abundance and continue to be produced. They draw on virtually all the adjectives in the dictionary which describe some positive or virtuous human attribute, from ambition to zest for life" (Bolden et al., 2003, p. 6). Pure trait theory has fallen into disfavour as it fails to give attention to intervening variables in the casual chain that could explain how traits affect group performance or leader advancement and Stogdill (1948) concluded that both person and situation had to be included to explain the emergence of leadership (Bass & Bass, 2008; Yukl, 2006). Traits have, however, been added to later theories as explanatory variables and researchers have made progress in discovering how leader attributes are related to leadership behaviour and effectiveness, an example being that Bass and Bass (2008) list Transformational Theory and Servant Leadership under the general theory heading of Trait Theories (those theories have been separated out from Trait Theory in this taxonomy). Traits are still considered by many authors as being of great importance in the study of leadership (Bass & Bass, 2008; Van Seters & Field, 1990; Yukl, 2006). Bolden, Gosling, Marturano, and Dennison's (2003) review of Leadership Frameworks currently in use in organisations showed that these frameworks are still heavily influenced by Trait Theory.

Table 3.1:Taxonomy of leadership theory - adapted from Van Seters and Field (1990), Bolden, Gosling, Marturano and Dennison (2003), Bass and Bass (2008), Avolio, Walumbwa and Weber (2009), Yukl (2006, 2013), and Dinh, Lord, Gardner, Meuser, Liden and Hu (2014)

Taxonomy of Leadership Theory	
Theory Clusters and Theorists	**Commentary**
Behaviour Theories (Argyris, 1976; Bass, 1960; Blake & Mouton, 1964; Fleishman, Harris, & Burtt, 1955; Likert, 1961; McGregor, 1960, 1966)	Behaviour theories differ from Trait Theories in that they emphasise what leaders do, as opposed to their traits or source of power. Different patterns of behaviour are observed and categorised as 'styles of leadership' (Bolden et al., 2003; Van Seters & Field, 1990). In behaviour theory, leadership is defined as a subset of human behaviour (Hunt & Larson, 1977). Behaviour theory was a major advancement as it enjoyed strong empirical support (Fleishman & Harris, 1962) and because it could easily be implemented by practising managers to improve their leadership effectiveness. Some of the best known behaviour theories used for managerial application were the Managerial Grid Model (Blake & Mouton, 1964, 1978) and Theory X and Y (McGregor, 1960, 1966). Behaviour research falls into two general categories: (1) how managers spend their time and the typical pattern of activities, responsibilities, and functions for managerial jobs; and (2) research that is focused on identifying effective leadership behaviour and examining correlations between leadership behaviour and indicators of leadership effectiveness (Yukl, 2006). Bass and Bass (2008) position some behaviour theory, including McGregor's (1960, 1966) Theory X and Theory Y, and Blake and Mouton's (1964, 1978) Managerial Grid within their Leadership of Organisations theories.
Influence Theories (Belbin, 1993; French, 1956; French & Raven, 1959; Greenleaf, 1977; Hollander, 1958, 1980; Jacobs, 1970; Katzenbach & Smith, 1994; Schenk, 1928)	Influence theories address aspects of power and influence by recognising that leadership is a relationship between individuals and not a characteristic of the solitary leader. Initially attempts were made to explain leader effectiveness in terms of the source and amount of power the leader commanded and how it was used, a leader-centred perspective that assumes power and influence is unidirectional – that leaders act and followers react (Van Seters & Field, 1990; Yukl, 2006). While power influence is certainly prevalent in today's leaders (Pfeffer, 1981), the dictatorial, authoritarian and controlling nature of this type of leadership is no longer considered effective (French, 1956) and more attention is directed towards concepts of influence. Most modern definitions of leadership include assumptions of intentional influence (Yukl, 2006), influence that can be exercised by the leader, followers, peers and/or teams. The notion of Servant Leadership (Greenleaf, 1977) emphasises the leaders' desire to be influenced by their followers, with power being shared by empowering followers. The trading of favours among peers is a form of influence commonly used in organisations to achieve task objectives and research suggests it is important for the success of middle-level managers (Yukl, 2006). Katzenbach and Smith (1994) contend that leaders must follow the team if the team's purpose and performance goals demand it and, in self-managed work teams, much of the responsibility and authority usually vested in a manager's position is turned over to the team members (Bass & Bass, 2008). Research into influence often bridges both Influence theory and Behaviour theory, for example, participative leadership research is concerned with power sharing and empowerment of followers, but is firmly rooted in Behaviour theory as well (Yukl, 2006).

Table 3.1:Taxonomy of leadership theory - adapted from Van Seters and Field (1990), Bolden, Gosling, Marturano and Dennison (2003), Bass and Bass (2008), Avolio, Walumbwa and Weber (2009), Yukl (2006, 2013), and Dinh, Lord, Gardner, Meuser, Liden and Hu (2014)

Taxonomy of Leadership Theory	
Theory Clusters and Theorists	**Commentary**
Contingency Theories (Adair, 1973; Evans, 1970; Fiedler, 1964; Hersey & Blanchard, 1969, 1977; Hook, 1943; House, 1971; Stogdill, 1959; Tannenbaum & Schmidt, 1958; Trist & Bamforth, 1951; Vroom & Jago, 1988; Vroom & Yetton, 1973)	Contingency theories acknowledge the importance of factors beyond the leader and the subordinate, seeing leadership as related to the situation in which it is being exercised, for example, whilst some situations may require an autocratic style, others may need a more participative approach (Bolden et al., 2003; Van Seters & Field, 1990). Situational factors include the type of task, the social status of the leader and subordinates, the relative position power of the leader and subordinates, the type of organisation, and the nature of the external environment (Van Seters & Field, 1990; Yukl, 2006). Those situational aspects then determine the kinds of leader traits, skills, influence and behaviours that are likely to cause effective leadership. Contingency theory represented an evolution of leadership theory as it recognised that leadership was not found in any of the pure, one-dimensional forms discussed above, but rather was contingent or dependent on one or more of the factors of behaviour, personality, influence, and situation (Van Seters & Field, 1990).
Transactional Theories (Dansereau, Graen, & Haga, 1975; Graen & Cashman, 1975; C. N. Greene, 1975; Hollander, 1958, 1979; Jacobs, 1970)	Transactional theories are based on the suggestion that perhaps leadership resides not only in the person or the situation, but also and rather more in role differentiation and social interaction, focusing on the mutual benefits derived from a form of 'contract' through which the leader delivers such things as rewards or recognition in return for the commitment or loyalty of the followers (Bolden et al., 2003; Van Seters & Field, 1990). Van Seters and Field (1990) put forward the idea that Transactional theories are essentially Influence theories revisited since they continue to addresses the influence between the leader and subordinate, only elevated to acknowledge the reciprocal nature of the influence and the development of the relative roles of subordinate and leader over time. Transactional theories of leadership have survived well and still have a strong place in current leadership theory (Van Seters & Field, 1990). Transactional theories are often used as a foil against which to compare the characteristics of Transformational theories and the two are often presented side by side for comparison.
Transformational Theories (Bass, 1985; Burns, 1978; Eden, 1984; Field, 1989; Hooper & Potter, 1997; House, 1977; Tichy & Devanna, 1986)	Transformational theories have as their central concept organisational change and the role of leadership in envisioning and implementing the transformation of organisational performance. The goal of transformational leadership is to 'transform' people and organisations in a literal sense – to change them in mind and heart; enlarge vision, insight, and understanding; clarify purposes; make behaviour congruent with beliefs, principles, or values; and bring about changes that are permanent, self-perpetuating, and momentum building (Bolden et al., 2003). In the 1980s and 1990s Transformational theories were seen as a dramatic improvement over previous theories in that they were based on intrinsic, as opposed to extrinsic factors, and, in comparison with transactional theories, leaders must be proactive rather than reactive in their thinking; radical rather than conservative; more innovative and creative; and more open to new ideas (Van Seters & Field, 1990). Despite the great hope held for Transformation theories by Van Seters and Field (1990) and others, Transformation theories have not held the test of time, particularly through world-wide events such as the Global Financial Crisis and, for example, Bass and Bass (2008) have relegated Transformation theory to a sub-theory within their broader categorisation of Trait theory.

Table 3.1:Taxonomy of leadership theory - adapted from Van Seters and Field (1990), Bolden, Gosling, Marturano and Dennison (2003), Bass and Bass (2008), Avolio, Walumbwa and Weber (2009), Yukl (2006, 2013), and Dinh, Lord, Gardner, Meuser, Liden and Hu (2014)

Taxonomy of Leadership Theory	
Theory Clusters and Theorists	**Commentary**
Culture Theories (Manz & Sims, 1987; Mendenhall, 2001; Ouchi & Jaeger, 1978; Pascale & Athos, 1981; Peters & Waterman, 1982; Van Dyne & Ang, 2006)	Culture theories propose that leadership is not based on relationships between leaders and followers, individuals or teams, but is a function of the culture of the organisation or environment. These theories also change the leadership focus from increasing the quantity of work accomplished through productivity and efficiency, to increasing quality through expectations and values (Van Seters & Field, 1990). Formal leadership is needed only when the existing culture is changed and a new culture must be created (Van Seters & Field, 1990). Cross-cultural theories of leadership are recognition that most leadership theory and research has been developed and tested within a Western context and extend Culture theory from organisational culture to societal culture. Leaders are increasingly required to work globally across a diverse set of locations, or are required to lead multi-cultural teams as part of a multi-national workforce (Avolio et al., 2009; Yukl, 2006). A global perspective on leadership requires that any new or emerging theory of leadership needs to be validated in cultures that differ to the one in which the theory is developed as some aspects of a leadership theory may be relevant to all cultures but other aspects may only apply to a particular type of culture (Yukl, 2006).
Organisational Leadership Theories (Boal & Hooijberg, 2014; Day, Gronn, & Salas, 2004; A. Harris & Spillane, 2008; Hazy, Goldstein, & Lichtenstein, 2007; Heifetz, 1994; Ogawa & Bossert, 1995; Pearce & Conger, 2003; Raelin, 2003; Uhl-Bien & Marion, 2008)	Organisational leadership theories view leadership as a property of the whole organisational system, leadership effectiveness being an outcome of the connections or relationships within the system rather than the function of leader-follower (Avolio et al., 2009). These leadership theories have emerged due to a growing sense that the leadership models and literature of the past century may not fully capture the leadership dynamic of today's knowledge driven organisations (Avolio et al., 2009). Complexity theory originated in the physical sciences and has been adapted by the social sciences to explain how random effects and futures can develop from seemingly disparate organisational factors such as networks, structures and relationships (Bass & Bass, 2008). These theories view leadership as a process that occurs throughout an organisation, the emphasis shifts from developing 'leaders' to developing 'leaderful' organisations with a collective responsibility for leadership (Bolden et al., 2003). Leadership is viewed as an interactive system of dynamic, unpredictable factors that interact with each other in complex networks, which then produce adaptive outcomes such as knowledge dissemination, learning, innovation, and further adaptation to change (Avolio et al., 2009). Shared and distributed theories put forward the perspective that the collective leadership provided by many members of an organisation is more important than the individual actions of formal leaders (Yukl, 2013). The most widely cited definition of shared leadership (Avolio et al., 2009) is that of Pearce and Conger (2003): "a dynamic, interactive influence process among individuals in groups for which the objective is to lead one another to the achievement of group or organisational goals or both. This influence process often involves peer, or lateral, influence and at other times involves upward or downward hierarchical influence" (p. 1). The most prolific of the emerging Organisational Leadership theories, as identified by Dinh, Lord, Gardner, Meuser, Liden and Hu (2014), is Strategic Leadership theory, which has been described by Boal and Hooijberg (2014) as 'the capacity to learn, the capacity to change, and managerial wisdom' (p. 515).

Each of the authors whose work was drawn upon to develop the taxonomy, Van Seters and Field (1990), Bolden, Gosling, Marturano and Dennison (2003), Bass and Bass (2008), Avolio, Walumbwa and Weber (2009), Yukl (2006, 2013) and Dinh, Lord, Gardner, Meuser, Liden and Hu (2014), have organised leadership theory in different ways. Van Seters and Field (1990) and Bolden, Gosling, Marturano and Dennison (2003) used time based approaches to present what is essentially their respective views on the evolution and development of leadership theory. Yukl (2006, 2013) and Bass and Bass (2008) did not use time based approaches to present leadership theory, choosing to organise theories into 'approaches' (see Yukl, 2006, 2013) or 'sources' (see Bass & Bass, 2008). Avolio, Walumbwa and Weber's (2009) work was focused on recent and emerging leadership theory, including new theory not considered in the other works, whilst emphasising the shift from 'leader-based' theory to 'leadership' theory. Dinh, Lord, Gardner, Meuser, Liden and Hu (2014) conducted an extensive qualitative review of leadership theory across 10 top-tier academic publishing outlets to identify the frequency of publication of established and developing theories since the beginning of the new millennium. Dinh, Lord, Gardner, Meuser, Liden and Hu's (2014) review identified 66 "leadership domains" (p. 55) of established and emerging leadership theory.

The Taxonomy of Leadership Theory (please refer to Table 3.1) has been necessarily created to contribute to a response to Research Question 1. Research Question 1 was concerned with exploring the NHS Leadership Qualities Framework (National Health Service, 2006) adopted by Queensland Health and comparing that framework with the leadership characteristics required of Queensland Health's healthcare executives. The taxonomy was used in the study as a point of reference when considering leadership frameworks. Leadership frameworks were reviewed against the taxonomy and a determination made as to the frameworks theoretical alignment.

It was identified earlier in the chapter that Bass and Bass (2008) recommended that, due to the many possible ways to define leadership, we should make sure that we understand which definition is being used in any particular analysis. In this study, leadership is defined as the set of qualities described by the National Health Service (NHS) Leadership Qualities Framework (National Health Service, 2006), hereafter referred to as the Framework. The Framework was chosen not because it is the

conclusive definition of leadership but because the Framework allowed a conversation of leadership to occur with the study population using a definition of leadership in context (Mayo & Nohria, 2005). The study population within Queensland Health was familiar with the Framework and most had attended some development activities based on the Framework and/or had participated in a 360^0 feedback process that used the leadership qualities in the Framework (360^0 feedback is a process where the participants in the process ask their peers, subordinates and manager for behavioural feedback through a questionnaire. The participants also typically self-rate). Thus the use of the Framework as a foundation for conversations about leadership provided a means through which to establish a common understanding of the definition of leadership being used, as was recommended by Bass and Bass (2008).

3.3 Leadership frameworks

This section of the chapter reviews leadership frameworks. Leadership frameworks are used by organisations to operationalise leadership theory by providing practising managers with guidance on how to become better leaders. This guidance is often given in terms of sets of qualities, behaviours, competencies or characteristics that, if adopted by people within an organisation, will lead to improved leadership and enhanced organisational performance. Earlier in the chapter, when reviewing the leadership literature, it was found that there were "almost as many definitions of leadership as there are persons who have attempted to define the concept" (Yukl, 2013, p. 2). It was also found when reviewing the literature on leadership frameworks that there are also almost as many leadership frameworks as there are major organisations.

Bolden, Gosling, Marturano, and Dennison's (2003) review of leadership frameworks in organisations provides a solid foundation upon which to build a further understanding of leadership frameworks (a list of the Frameworks that they reviewed can be found in Appendix A). Bolden, Gosling, Marturano, and Dennison (2003) conducted their review for Chase Consulting and the Management Standards Centre to assist in the development of the new National Occupational Standards in Management and Leadership in the United Kingdom. In their review they discuss

seven private-sector, nine public sector and eight generic frameworks and provide web links to the full frameworks where available.

Bolden, Gosling, Marturano, and Dennison (2003) concluded from their review that most frameworks promoted a "somewhat limited" (p. 37) version of transformational leadership theory. Their analysis of the frameworks led them to the view that most of the frameworks go beyond simple definitions of behaviours and include some cognitive, affective and inter-personal qualities of leaders, although the role of followers was usually expressed in a simplistic, unidirectional manner:

> Leadership, therefore, is conceived as a set of values, qualities and behaviours exhibited by the leader that encourage the participation, development, and commitment of followers. The 'leader' (as post holder) is thus promoted as the sole source of 'leadership'. He/she is seen to act as an energiser, catalyst and visionary equipped with a set of tools (communication, problem solving, people management, decision making, etc.) that can be applied across a diverse range of situations and contexts. Whilst contingency and situational leadership factors may be considered, they are not generally viewed as barriers to an individual's ability to lead under different circumstances (they simply need to apply a different combination of skills). Fewer than half of the frameworks cited refer directly to the leader's ability to respond and adapt their style to different circumstances. (p. 37)

Bolden, Gosling, Marturano, and Dennison (2003) also noted the emphasis in the frameworks on the importance of values such as honesty, integrity, empathy, trust, ethics and valuing diversity noting that "The leader is expected to show a true concern for people that is drawn from a deep level of self-awareness and personal reflection" (p. 37). They considered that such an almost evangelistic notion of the leader as a multi-talented individual with diverse skills, personal qualities and a large social conscience represents almost a return to the trait theory of leadership.

Bolden, Gosling, Marturano, and Dennison's (2003) work will be built upon in Chapter 5 where leadership frameworks in use specifically in healthcare organisations will be reviewed and analysed as part of the response to Research Question 1.

As stated in the introduction to the chapter, the aim of this chapter was to explore leadership literature from three perspectives: firstly a review and discussion of the literature relating to leadership theory, secondly a consideration of leadership frameworks in use in organisations, and now thirdly, attention is turned to a review and discussion of the literature relating to leadership development.

3.4 Leadership development

Most large organisations have leadership development programs (Yukl, 2013) with a 1997 survey (Bass & Bass, 2008) of 540 organisations showing that 93% of large organisations engaged in management and supervisory skills training and 63% in executive development, with the healthcare industry having the highest rate of employee training at 82% (Bass & Bass, 2008).

Both Bass and Bass (2008) and Yukl (2006, 2013) devoted significant chapters of their texts to commentary on leadership development and it is not the intention of this paper to replicate that work, however it is worthwhile to summarise some key points:

- leadership development is influenced by a number of early environmental factors such as family influences and opportunity in childhood and adolescence (Bass & Bass, 2008)
- leadership development can occur through both formal (universities, consulting companies, internal organisational training) and informal (on-the-job experience, informal coaching and mentoring) processes (Bass & Bass, 2008; Yukl, 2013)
- a wide variety of leadership development activities are undertaken by organisations and individuals including: lectures and discussions; role playing; simulations and games; behaviour modelling; leadership skills training; sensitivity training; learning from experience; action learning; job rotation; coaching; mentoring; giving and receiving feedback; development assessment centres; developmental assignments; personal

growth programs; problem based learning (Bass & Bass, 2008; Yukl, 2013)

Bass and Bass (2008) contended that based on the research that is available, leadership and management training, education and development is effective. When compared to the amount of leadership training that occurs, however, there is relatively little research and further evidence is required (Burgoyne et al., 2004; Yukl, 2013). Day, Fleenor, Atwater, Sturm and McKee (2014) supported this call for further research and evidence and have concluded that, despite the significant advances in understanding leadership development made over the past 25 years, the field is still relatively immature and is "replete with opportunities for researchers and theorists" (p. 80).

A number of authors have described specific healthcare related leadership development programs. Eastman and Fulop (1997) described a residential management program for clinician managers in Australian hospitals. They claimed that the Management for Clinicians Program promoted increased understanding and acceptance of the role of clinicians as managers. Owen and Phillips (2000) explored the Trent program, an interdisciplinary program for doctors and managers which explores roles and relationships, values, agendas for change, and barriers to joint working, resulting in closer collaboration in practice.

Wolf, Bradle, and Greenhouse (2006) explored three levels of programs for developing healthcare leaders. The programs were designed for: nurses transitioning into their first leadership roles (level 1); nurses experienced in managing others and who are counted on to drive change and impact staff performance (level 2); vice-president level or aspiring executive level leaders (level 3). It was claimed that graduates of the programs have contributed to $500,000 in savings to the system with more than $38 million identified in potential future savings for strategic initiatives.

McAlearney, Fisher, Heiser, Robbins, and Kelleher (2005) critiqued an internal physician leadership program, the Medical Leadership Program, at the Columbus Children's Hospital, Ohio. The program was designed to support an organisational

transformation change effort and to involve physicians in organisational leadership. The program was considered to be successful in achieving those objectives.

Not all the literature described success stories. Currie (1999) described a program where there was resistance to a management development program due to the designer's failure to adequately consider the health context. Crofts (2006) described a leadership program for clinicians involved in critical care which was conducted across six NHS hospitals in the UK. Whilst participants were primarily nurses, other health professionals also participated in the program. The program had mixed success with organisational culture and organisational endorsement cited as being influencing factors.

Hewison and Griffiths (2004) critiqued a number of NHS leadership development programs including the Royal College of Nursing Clinical Leadership Program, the NHS Leading Empowered Organisations Program and the NHS National Nursing Leadership Program. Hewison and Griffiths (2004) found that in addition to development activities, healthcare organisations need to create conditions which support and enhance new models of leadership.

All of the programs reviewed from the literature had a face-to-face traditional workshop or session component, one qualification based program reported by Loan-Clarke (1996) also had distance learning, tutorial and assessment components. The program described by Wolf, Bradle and Greenhouse (2006), in addition to face-to-face workshops, had on-line assessment as an entry component and work-based projects post workshops. Whilst in the literature reviewed there were various descriptions of the content covered, or the workshop design employed, there was little to no description of the learning processes employed or the learning experience of the individual participants of the programs.

Thus far, the study has endeavoured to establish evidence that health systems need to engage health professionals with leadership and management capabilities to enable more effective and efficient use of resources. Further, this chapter has established that policy and practice in the form of leadership capability frameworks and leadership programs have been, and continue to be, developed to build these

capabilities. However, in the introduction to the study, it was also identified that clinicians remain reluctant to engage with these management and leadership capability development opportunities.

The issue of engagement of clinicians with leadership development can be viewed through the perspective of learner engagement with reference to theories of learning and models of pedagogy.

3.5 Pedagogical considerations

The term pedagogy is derived from the Greek words paid (meaning child) and agogus (meaning guide) and thus pedagogy was defined as the art and science of teaching children (M. Knowles, 1977). Knowles (1977) popularised the concept of adults as learners and the term andragogy, aner meaning adult in Greek thus andragogy being defined as the art and science of helping adults. In this study, adult learning, andragogy, is positioned within a broader interpretation of pedagogy as the art and science of teaching and learning.

Knowles, Holton and Swanson's (2015, pp. 90-96) pedagogical principles as they apply to adult learners can be summarised as follows:

1. Adults need to know why they need to learn something before learning it
2. The self-concept of adults is heavily dependent upon a move towards self-direction
3. Prior experiences of the learner provide a rich resource for learning
4. Adults typically become ready to learn when they experience a need to cope with a life situation or to perform a task
5. Adults' orientation to learning is life-centred; education is a process of developing increased competency levels to achieve their full potential
6. The motivation for adult learners is internal rather than external

These principles relate to optimal factors that should be evident in learning design to engage the adult learner. Each of these principles is considered in the following sections as they apply to health professionals and their engagement, as reported in the literature, with leadership and management development.

3.5.1 Adults need to know why they need to learn something before learning it

It appeared from the literature that little attention has been paid to exploring the need for health professionals as individual adults to learn leadership and management capabilities. Whilst the organisational benefits are clear from the literature (Armstrong et al., 2007; Forster, 2005; Kennedy, 2001), what is less well understood is why *individual* clinicians need to, or should bother to, learn about leadership and management.

3.5.2 The self-concept of adults is heavily dependent upon a move towards self-direction

The self-concept of health professionals, doctors and nurses as examples, are strongly linked to their profession. Leadership, in their view, is most often seen within the context of their professions and their desire to be leading clinicians in their fields of practice and expertise (Eastman & Fulop, 1997; K. Harris et al., 2006). However, organisational leadership and management, is not associated with their view of their own self-concept.

3.5.3 Prior experiences of the learner provide a rich resource for learning

Clinical experience is not necessarily a resource that can be drawn upon for building leadership and management capability. Eastman and Fulop (1997) posited that the application of clinical skills to leadership and management problems can create poor outcomes and lead to frustration.

3.5.4 Adults typically become ready to learn when they experience a need to cope with a life situation or to perform a task

Health systems have their origins in early models of military organisation and military hospitals and often have highly mechanised authoritarian models of control and management (Forster, 2005). Within such organisational structures, roles and responsibilities are clearly defined and professional boundaries and cultures are quite distinct. The opportunities and need for clinicians, particularly doctors, to perform organisational management tasks are few.

3.5.5 Adults' orientation to learning is life-centred; education is a process of developing increased competency levels to achieve their full potential

Clinicians' orientations are towards achieving their full potential as clinicians, becoming specialists in their fields. Their focus is on increasing competency within their specialities (Buchanan et al., 1997). They are less oriented to increasing their competency as leaders.

3.5.6 The motivation for adult learners is internal rather than external

Although Buchanan, Jordan, Preston and Smith (1997) proposed that there is little evidence of doctors engaging in management with any sense of purpose or ambition, they have identified six factors that motivate doctors to assume management responsibilities: power; ability to play a shaping role; influence; being 'in the know'; status and prestige; and career progression.

The need to develop the leadership capabilities of clinicians to bring about improvements in health systems is confronted with issues relating to the engagement of these clinicians as adult learners. Organisational leadership is not currently associated with their view of their self-concept or potential. A better case needs to be made to individual clinicians so that they can see why they should bother to engage with learning about leadership.

The above review of Knowles, Holton and Swanson's (2015) pedagogical principles as they apply to health professionals and their engagement with leadership and management development exposes further need to better understand and explore these issues through research.

3.6 Conclusion

There is strong evidence from the literature that developing leadership capability has value, that theoretical constructs and an increasing and evolving understanding of leadership exists and that leadership frameworks and programs are available to clinicians. There are questions that remain, however, about both the theoretical

constructs and the pedagogical principles underpinning healthcare executives' leadership capability development.

The review of literature on leadership theory has enabled the development of a Taxonomy of Leadership Theory (please refer to Table 3.1). In Chapter 5, the Taxonomy of Leadership Theory will be used to consider healthcare leadership frameworks and determine their theoretical underpinnings, including the theoretical underpinnings of the NHS Leadership Qualities Framework (National Health Service, 2006) and thus provide a response to Research Question 1.

The review of literature on leadership development for clinicians reveals development approaches that are very content and program-centred with a heavy emphasis on describing capabilities, qualities, and competencies and little focus on clinicians and their educational experiences and the pedagogical constructs of those experiences. This study, which seeks to understand the influence that formal education, as one strategy of leadership capability development, has had on the development of leadership capabilities with healthcare executives in Queensland Health addresses a gap in the existing literature.

4 Chapter 4: Methodology

4.1 Introduction

The preceding chapters gave focus to the research problem and context, provided an introduction to the study, and reviewed current literature in the areas of leadership and leadership development. This chapter provides clarity about the research paradigm, methodology, approach, design, methods, ethics, validity and limitations evident in this study as a precursor to the examination of the data and the articulation of the study's results.

This chapter firstly considers research paradigm and methodology in relation to how we know the world, or gain knowledge of it, and what is the nature of the approach to the research (Bunniss & Kelly, 2010; Denzin & Lincoln, 2005; Nicholas & Hathcoat, 2014). The research design of the study is then outlined and presented as being characterised by three main phases, each phase being focused around a research question. The output of phases one and two became the inputs to phases two and three respectively until finally a response to the research questions can be proposed. The research techniques used for each research phase are presented in the chapter as part of the presentation of the design.

The chapter concludes with a discussion of the ethical considerations that apply to the research, positioning the researcher in the study, how the research was validated and the limitations of the study.

4.2 Research paradigm

As discussed in Chapter 1, my early career and training was in electrical telecommunications engineering. Electrical circuitry is mostly characterised by polarity, that is, a circuit is either switched on or switched off, there is either voltage present or no voltage present and there is either current flowing or no current flowing. Even in advanced semi-conductor technology there is binary logic that is applied to the design and operation of the circuitry. The design language at the micro level of semi-conductor circuitry is Boolean algebra which was conceived as a calculus suitable for the mathematical analysis of logic in a language of absolutes

(Givant & Halmos, 2009). As I progressed in my career and as I became more focussed on human behaviour and learning, I found that my early training was deficient. Absolute rules no longer applied as I found that the human experience was characterised by more organic and non-absolute concepts. I found that, although I might deliver a particular training course on a specific topic following a common format, that each participant would make their own meaning from that experience. As I then moved into more strategic roles, I found that I was co-creating knowledge with colleagues through conversations and shared experiences. It is against this background of my own experience and journey that I now elucidate the identification of research paradigm, research methodology and the approach that I have taken to the research presented in this thesis.

The concept of research paradigms was popularised by Kuhn in his work *The Structure of Scientific Revolutions* (1970), first published in 1962 (R. L. Greene, 2014). Kuhn (1970) considered that paradigms had the characteristics of being: "sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific activity [and] sufficiently open-ended to leave all sorts of problems for the redefined group of practitioners to resolve" (p. 10).

Kuhn's (1970) views on research paradigms were from the perspective of the physical sciences but the concept of research paradigms has translated across into the social sciences. Greene (2007) provided the following definition of research paradigms in the social sciences: "Paradigm in this discussion refers to an integrated set of assumptions about the nature of the social world, about the character of knowledge we have about the social world, and about what is important to know" (p. 15).

Kuhn (1970) linked paradigms to research communities in that the "group of adherents" (p. 10) were the research community that aligned with a new paradigm. Research communities (Kuhn, 1970) have, over time, become clustered as groups of adherents around a number of different research paradigms associated with research in the field of education. Research paradigms such as positivism, post-positivism, critical theory, advocacy/participatory, interpretivist, constructivism and pragmatism (Creswell, 2009; Denzin & Lincoln, 2005; J. C. Greene, 2007; Guba & Lincoln,

2005) have each attracted adherents and have established levels of legitimacy with the educational research community.

Researchers make choices in the way they define the research problem and approach the research task starting with, as Creswell (2009) has described, the philosophical worldview assumptions that are brought to the study. As a new researcher beginning the journey of entry into the educational research community, questions arose for me as to which group of adherents to join, on what basis and consequently, the paradigm to adopt.

In Chapter 1 of this thesis, the choices I made when defining the research problem were made explicit and now in this chapter the choices I made regarding the research paradigm, methodology and research techniques are also made explicit in the discussion that follows.

Theoretical researchers such as Guba and Lincoln (2005) have provided new researchers with guidance towards the consideration of which paradigm to adopt by providing insight into the basic beliefs that underpin alternate inquiry paradigms through the lenses of ontology and epistemology and the positions that each paradigm adopts on issues such as the nature of knowledge, values and ethics. The differences and distinctions between paradigms can be illuminated through the consideration of the ontology and epistemology associated with each paradigm (please refer to Table 4.1).

Table 4.1: Ontology and epistemology associated with research paradigms - adapted from Guba and Lincoln (2005), Creswell (2009) and Bunniss and Kelly (2010)

	Research Paradigms				
	Positivism	**Post-positivism**	**Critical Theory**	**Interpretivism**	**Participatory**
Ontology What kind of being is the human being? What is the nature of reality?	Naïve realism – "real" reality but apprehend-ible (sic)	Critical realism – "real" reality but only imperfectly and probabilistically apprehendible (sic)	Historical realism – virtual reality shaped by social, political, cultural, economic, ethic, and gender values; crystallised over time Reality may be objective but truth is continually contested by competing groups	Relativism – local and specific co-constructed realities Meanings are constructed by human beings as they engage with the world they are interpreting	Participative reality – subjective-objective reality, co-created by mind and given cosmos Research enquiry is intertwined with politics and a political agenda
	Reality is static and fixed. The world is ordered according to an overarching objective truth				
Epistemology What is the relationship between the inquirer and the known? What is the nature of knowledge?	Dualist/ objectivist; findings true Objective, generalisable theory can be developed to accurately describe the world Knowledge can be neutral or value-free	Modified dualist/ objectivist; critical tradition/ community; findings probably true Objective knowledge of the world is not necessarily fully accessible Seeks to establish 'probable' truth Knowledge is conjectural (and antifoundational) – absolute truth can never be found	Transactional/ subjective; value mediated findings Knowledge is co-constructed between individuals and groups Knowledge is mediated by power relations and therefore continuously under revision	Transactional/ subjectivist; co-created findings Humans engage with their world and make sense of it based on their historical and social perspectives The basic generation of meaning is always social, arising in and out of interaction with a human community	Critical subjectivity in participatory transaction with cosmos; extended epistemology of experiential, propositional, and practical knowing; co-created findings Focus of inquiry is on helping individuals free themselves from constraints

Ontology is concerned with questions such as: What kind of being is the human being? and What is the nature of reality? (Bunniss & Kelly, 2010; Denzin & Lincoln, 2005). Epistemology is concerned with questions such as: What is the relationship between the inquirer and the known? and What is the nature of knowledge? (Bunniss & Kelly, 2010; Denzin & Lincoln, 2005).

When considering the ontology and epistemology of different paradigms, I was drawn to three of the five paradigms described, the post-positivism, critical theory

and interpretivism research paradigms. I was drawn to these research paradigms as the world that I was exploring was a world of imperfect reality. It had complexity and dynamics that were shaped by social, cultural and gender values; in addition, the realities that existed were co-constructed by myself and the participants in this study within the contextual framework of our experiences and dispositions. Each of the paradigms that I was drawn to had attracted adherents and had established levels of legitimacy within the educational research community. Notably, however, in alignment with Kuhn's (1970) definition of paradigm, all were sufficiently open-ended and left all sorts of problems to be resolved for the researcher, not least of which was their appropriateness as lenses through which to view the world I was exploring.

Whilst the post-positivism, critical theory and interpretivism research paradigms initially appealed from the perspective of the nature of the world I was exploring, I recognised that when aligning with a paradigm I also needed to consider the research problem and research questions which formed the foundation of the study.

The research problem and associated questions focused on the experiences and perceptions of the identified healthcare executive leaders, the participants in the research, as they described the influence that formal education has had on their leadership capability development. The interpretivist paradigm where "Meanings are constructed by human beings as they engage with the world they are interpreting" (Creswell, 2009, p. 8) was therefore considered as an appropriate paradigm through which to consider the research problem and questions. This exploration was to be made by engaging in conversation with the participants about their historical journey of leadership development and this aligns with Creswell's (2009) view of interpretivism, being that "Humans engage with their world and make sense of it based on their historical and social perspectives" (p. 9). It was important for me to note that in the context of the interpretivist paradigm, one of the 'humans' referred to was the researcher themselves and in this study the participants and I were constructing meaning from the experiences we were interpreting. Creswell (2009) highlighted that interpretivist researchers need to acknowledge how their interpretation flows from their own personal, cultural and historical experiences.

The participatory paradigm was also considered as there was an element of "Participative reality – subjective-objective reality, co-created by mind and given cosmos" (Guba & Lincoln, 2005, p. 195). The participatory research paradigm, however, is more often associated with political agenda and marginalised individuals in our society (Creswell, 2009). Healthcare executives, the individuals who were participants in the study, could not be considered to be marginalised and, although healthcare issues are often politicised, there was no political agenda in the study that aligned with the definition as described for the participatory research paradigm.

The research paradigm adopted for this study, therefore, was interpretivism.

4.3 Research methodology

Paradigm guides the selection of methodology for the study such that quantitative methodology is most often associated with positivistic paradigms whereas qualitative methodology is most often associated with paradigms that include post-positivist, critical theory, interpretivism and participatory. Greene (2007) provides a distinction between the two methodologies:

> In quantitative methodological traditions, controlling for bias of all kinds is of vital importance to the quality of the study and is in fact a driving force underlying methodological advancements. In qualitative traditions it is method that protects the data and thus the inquiry findings from the idiosyncrasies of the inquirer. (p. 39)

Qualitative research is a form of inquiry where researchers make an interpretation of what they see, hear and understand, often from data collected in the field where the participants experience the issue or problem under study (Creswell, 2009). Qualitative research uses multiple sources of data, including case studies, personal experiences, life stories and interviews that describe moments and meanings in individuals' lives (Creswell, 2009; Denzin & Lincoln, 2005). Qualitative researchers use a wide range of interconnected interpretive practices to gain a better understanding of problems of interest, with each practice making the world visible in different ways (Denzin & Lincoln, 2005) and then, through inductive analysis, organising the data to build patterns, categories and themes (Creswell, 2009).

Qualitative methodology, therefore, was identified as the most appropriate methodology to adopt for this study.

Having positioned the study as being interpretivist and as using qualitative methodology, the research approach and design used in the study are now presented.

4.4 Research approach

Tashakkori and Teddlie (2009) contended that research questions drive research and consequently the research approach used. The nature of the research questions for this study were such that the individual formal education experiences of the participants, the identified Queensland Health healthcare executive leaders, needed to be explored and interpreted to illuminate the contribution that formal education may have had on the development of their leadership capability. The questions were broad and open and were designed to explore the area of interest, not to test a predetermined hypothesis. I needed to adopt a research approach that suited the nature of the questions, was suitable for qualitative research and that was appropriate for a study situated within an interpretivist paradigm. I chose Interpretative phenomenological analysis (IPA) as the research approach for this study as it best suited the nature of the research questions, it was congruent with the paradigm that I was operating within and it had characteristics that suited my preferences of how I wanted to engage with the research and interact with the participants in the study.

IPA is an approach to qualitative inquiry which enables the examination of how people make sense of their life experiences (J. A. Smith et al., 2009). IPA has been described as having three characteristics from which its procedures are derived: it is phenomenological, interpretative, and idiographic (VanScoy & Evenstad, 2015). IPA is phenomenological in that it is concerned with exploring and seeking to understand the participants' experience in its own terms however it is unique in its focus on the participants' experience of a phenomenon (J. A. Smith et al., 2009; VanScoy & Evenstad, 2015). IPA is interpretative in that it deals with participants' interpretations of their experience and also the researchers' interpretations of participants' interpretations (VanScoy & Evenstad, 2015). IPA is idiographic, which, when used by IPA researchers is meant to convey the approach's focus on individual

experience and, consequently, “appropriate research questions for IPA focus on understanding individual experience within a given context” (VanScoy & Evenstad, 2015, p. 341).

Whilst the biggest use of IPA is for research related to illness experience (J. A. Smith, 2011), Smith (2011) examined 293 papers that used IPA as the research approach and found that the key terms used in 4 papers related to education and 14 related to health professionals’ experiences. Examples of the use of IPA as the research approach to enquiry into experiences related to leadership include dissertations by Whittred (2008), who studied the leadership experiences of senior police women, and Lee (2013) who explored executive leadership experiences. Published journal articles that describe the use of IPA as the research approach to enquiry into experiences related to leadership are those by Sherman (2010), who interpreted the experiences of clinical nurse leaders, and Heard (2014) who described the experiences of those in leadership roles in the discipline of occupational therapy.

The characteristics of IPA aligned with the nature of the questions and inquiry associated with this study and therefore IPA was identified as an appropriate research approach to adopt.

An overview of the research design is shown by Figure 4.1, showing the research questions at the centre of each design phase. The full research design and methods for each phase are detailed in Sections 4.4 - 4.6, including a description of the practical application of the IPA approach.

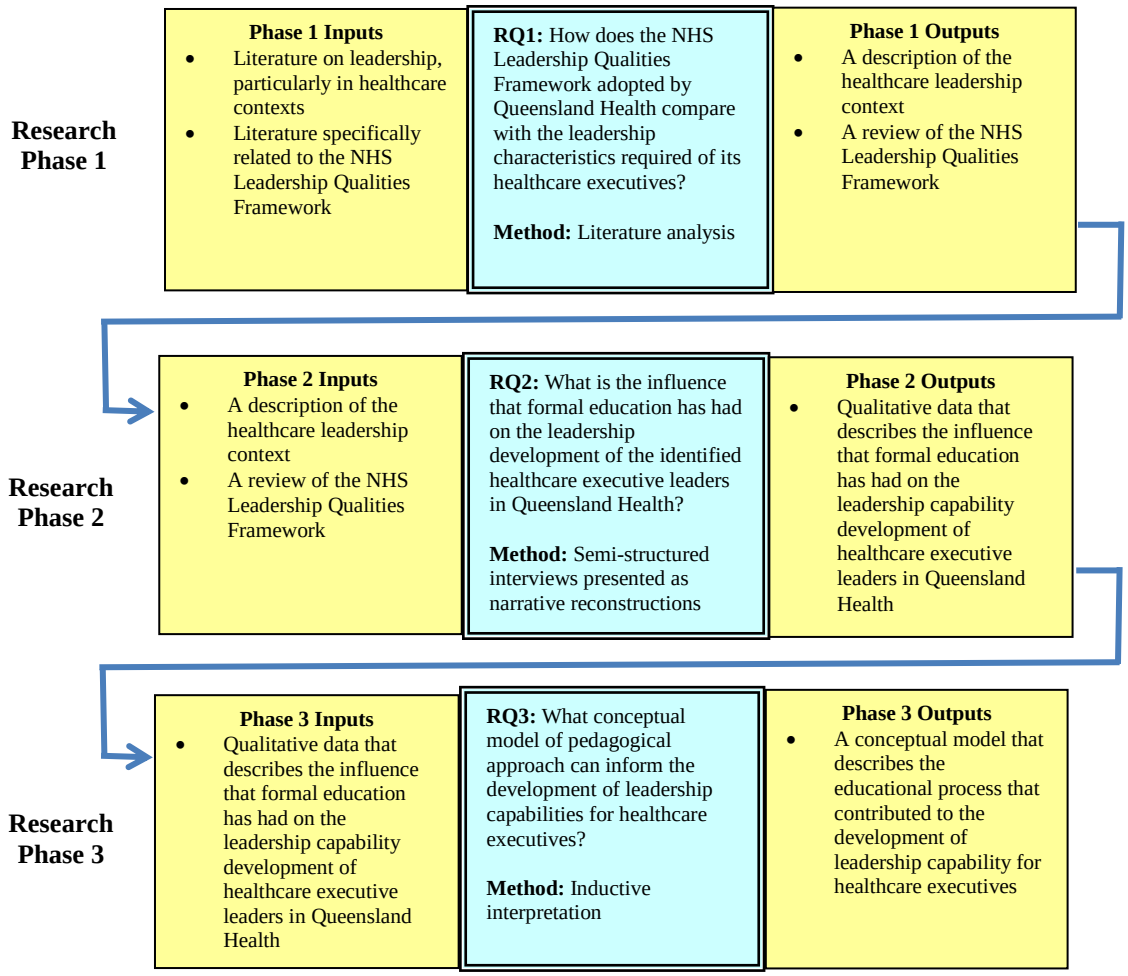

Figure 4.1: Research design phases - inputs, research questions, methods and outputs

The purpose of the design strategy for Research Phase 1 was to provide a clear context of leadership within which to explore the leadership capabilities and leadership development of Queensland Health healthcare executive leaders. The method for exploring Research Question 1 was a literature analysis. The literature analysis considered evidence of leadership capability characteristics that have been determined to be required of healthcare executives. The review considered the themes and threads emerging from the literature and then explored different directions guided by the realisations and understandings of that literature (University of Southhampton, 2011). The review compared the particular leadership framework chosen by Queensland Health, the National Health Service (NHS) Leadership

Qualities Framework (National Health Service, 2006), with the realisations and understandings gained through the analysis of the literature.

Research Phase 2 was centred on Research Question 2. The assumption underpinning this question was that there are healthcare executives in Queensland Health who align more strongly with the characteristics of leadership than others and in fact may be considered to be exemplary leaders within the leadership context understood through Research Question 1. The identification of these exemplary healthcare executives in Queensland Health was important for this study as Research Question 2 was predominantly concerned with illuminating the influence that formal education has had on the leadership development of the aforementioned identified healthcare executive leaders.

Research Phase 3 was centred on Research Question 3. The data obtained from Phase 2 were interpreted to construct a conceptual model that describes the pedagogical approach that contributed to the development of leadership capability for the identified healthcare executive leaders.

A more detailed description of the research design and method relating to each question is now presented.

4.5 Research design and method relating to Research Question 1

The desired outcomes for Phase 1 of the research were to provide a description of the healthcare leadership context within which the study participants operated and to review the leadership framework chosen by Queensland Health, the NHS Leadership Qualities Framework (National Health Service, 2006).

In order to achieve these outcomes, a qualitative literature analysis was undertaken. Creswell has provided a number of options for using literature in a qualitative study. The first option is that it can be used to frame the problem in the introduction to the study. The second is that it can be presented in a separate section, and this option is

an approach "most familiar with the traditional postpositivist approach" (p. 27). The third option presented by Creswell is that literature is presented at the end of the study, to compare and contrast findings. In this study, literature was used in the three ways described by Creswell (2009), to frame the study (Chapters 1, 2 and 3), as a separate section as part of the literature analysis approach to Research Question 1 (Chapter 5), and at the end to assist in comparing and contrasting the findings from the interviews with the identified healthcare executive leaders (Chapters 7 and 8).

The literature analysis method that was used for Phase 1 of the research to provide a response to Research Question 1 was described by Machi and McEvoy (2009) and consisted of six steps: selecting a topic; searching the literature; developing the argument; surveying the literature; critiquing the literature; and writing the review.

Table 4.2 shows the literature analysis method used to obtain a response for Research Question 1.

Table 4.2: Overview of the use of Machi and McEvoy's (2009) literature analysis method for Research Question 1

Method Step	Comments
Select a topic	The topic was the adequacy of the NHS Qualities Framework (National Health Service, 2006) adopted by Queensland Health to describe the leadership characteristics required of healthcare executives.
Search the literature	Literature that specifically related to the NHS Qualities Framework (National Health Service, 2006) was previewed, selected and organised.
Develop the argument	A body of evidence from the literature was formed and presented to present the case logically as to whether the NHS Qualities Framework (National Health Service, 2006) adopted by Queensland Health describes adequately the leadership characteristics required of healthcare executives.
Survey the literature	The data from the literature were assembled, synthesised and analysed to form an argument about the current knowledge about the topic, leading to conclusions and claims.
Critique the literature	The current understanding of the topic was critiqued to determine how previous knowledge answers the research question.
Write the review	The review was written for others, as a work that conveys the research accurately and that can be understood by the intended audience.

The response to Research Question 1, elucidated through the method described above, is presented in Chapter 5.

4.6 Research design and method relating to Research Question 2

The inputs into this phase of the research were the outputs from the previous phase - that is, a description of the healthcare leadership context and a review of the NHS Leadership Qualities Framework (National Health Service, 2006).

The output required for Phase 2 of the research was qualitative data that describes, from the experiences of the participants, the influence that formal education has had on the leadership capability development of healthcare executive leaders in Queensland Health.

An interpretative phenomenological analysis (IPA) approach was used to inform the research design and method used for Research Question 2. The design for Phase 2 included purposeful participant selection of a small sample size and data collection through face-to-face semi structured interviews (Quinn & Clare, 2008; J. A. Smith et al., 2009).

4.6.1 Participant selection

One of the characteristics of the research approach chosen for this study, IPA, is the use of purposeful participant selection which has been described by Smith and Osbourne (2007):

> IPA researchers usually try to find a fairly homogeneous sample. The basic logic is that if one is interviewing, for example, six participants, it is not very helpful to think in terms of random or representative sampling. IPA therefore goes in the opposite direction and, through purposive sampling, finds a more closely defined group for whom the research question will be significant. (p. 56)

For this study, I was most interested in the formal education experiences of healthcare executives in Queensland Health who were considered to be exemplary leaders within the leadership context understood through Research Question 1. A qualitative survey was used to identify these exemplary leaders. Healthcare

executives in leadership positions in Queensland Health were asked to identify those of their peers whom they believed exhibited behaviours that were strongly aligned to the NHS Leadership Qualities Framework (National Health Service, 2006) used by Queensland Health. Potential participants to interview for the study emerged as those who were most frequently identified by their peers. The peer referrals were confirmed through analysis of the candidates' 360^0 leadership feedback reports, 360^0 feedback being an assessment of a person's behaviour (Morgan, Cannan, & Cullinane, 2005). Queensland Health healthcare executives whose leadership credentials were identified through this process were invited to participate further in the study.

The purposeful method used for the selection of participants is now presented in more detail. Healthcare executives with leadership characteristics that aligned with the NHS Leadership Qualities Framework (National Health Service, 2006) were identified through surveys with a sample (3%) of the survey population of 500 executives from Queensland Health. Respondents to the survey were invited to list healthcare executives from within Queensland Health who they considered had leadership characteristics that aligned most strongly with the NHS Leadership Qualities Framework (National Health Service, 2006). Names that emerged consistently through the survey process were those whom the respondents recognised, through interactions or observations, or whose reputations identified them, as being healthcare executive leaders who demonstrated the desired leadership characteristics.

A simple survey design was chosen as it provided a description of the opinions of a population by studying a sample of that population. I was then able to make claims about that population (Creswell, 2009). In this case, I was interested in making a claim from the population of healthcare professionals as to who amongst them was a leader who exhibited leadership characteristics that aligned with the NHS Leadership Qualities Framework (National Health Service, 2006).

The survey method enabled the rapid identification of the leaders in an economical way and had the following characteristics: it produced descriptions of an aspect of the study population; the information was collected by asking people questions –

their answers constituting the data to be analysed; and information was collected from only a fraction of the population (Creswell, 2009; Fowler, 2009).

Survey methodology seeks to identify the principles of design, collection, processing and analysis of surveys (Groves, 2004) and includes details such as: the collector; the purpose; the timeframe; the target population; the sampling frame; the sample design; the sample size; and the mode of administration. An overview of the survey method is shown in Table 4.3.

Table 4.3: The survey method used for Research Question 2

Collector	The researcher
Purpose	To identify healthcare executives within Queensland Health who have leadership characteristics that align with the NHS Leadership Qualities Framework (National Health Service, 2006)
Timeframe	Cross sectional February to April 2010
Target Population	Queensland Health executives
Sampling Frame	Researcher access, convenience and availability
Sample Design	Single stage non-probability sample
Sample Size	14
Mode of Administration	Face to face interviews

There were 500 executives of Queensland Health who potentially made up the population of the survey component of the study. I considered the issues of access to this total population and also that the survey activity was only one part of a broader study. A single stage sampling procedure (Creswell, 2009) was used as I had access to the population and could sample people directly.

A nonprobability sample (Creswell, 2009) was used based on convenience and availability. I had, through my day to day work, access to a broad cross-section of the population of Queensland Health executives and used the opportunity of convenience

and access to invite people from the population to participate in the survey. The sampling frame was, therefore, sampling from a set of people who go somewhere or do something that enables them to be sampled (Fowler, 2009) - in this case, a set of people with whom I came into contact during the survey period. It was recognised that this sampling technique was less desirable (Creswell, 2009; Groves, 2004) and therefore an additional step was put in place whereby confirmation in the form of 360^0 feedback data was requested from the identified healthcare executive leaders. Data obtained from the survey process was also monitored to determine if there were clarity and agreement forming on the candidates who were being identified.

Although full stratification was not performed, I gave consideration when approaching potential respondents that the sample had representation of the population and included, males, females, metropolitan staff, regional staff, and medical, nursing and corporate characteristics.

Fowler (2009) describes good survey design as having the characteristics of: questions that meet the research objectives; testing to make sure that the questions can be asked and answered as planned; and putting the questions in a form that maximises ease of administration.

The survey instrument used was specifically designed for this research to meet the research objective of identifying the healthcare executive leaders with the desired characteristics. The initial survey question was as follows:

> "Who do you consider are exceptional healthcare leaders in Queensland Health?"

This question was tested with three people who would form part of the survey population and feedback was obtained that indicated two main deficiencies in the question:

1. Lack of clarity around the term exceptional leader. Questions were asked such as "Is an exceptional leader one who does an exceptional job at achieving budget outcomes but is not a good communicator?".
2. Lack of clarity as to who was considered a healthcare leader. Questions were asked such as "Could this be anyone in Queensland Health or just

executives? Are healthcare leaders only those with clinical backgrounds or does that include anyone?".

To address the first concern, a context of leadership was provided - that is, leadership that aligns with the NHS Leadership Qualities Framework (National Health Service, 2006). To address the second concern, the definition of leaders was clarified to be healthcare executives with a clinical background.

The survey instrument then became:

1. Are you familiar with the NHS Leadership Qualities Framework? (A copy of the NHS Leadership Qualities Framework (National Health Service, 2006) was shown to the survey respondents to assist with their recognition of the framework).
2. When you consider leadership within the context of the NHS Leadership Qualities Framework, which healthcare executives with a clinical background do you identify as having leadership characteristics that align with the Framework?

The instrument was tested once more and no further concerns were raised. In the literature, there is some opinion that people "know leadership when they see it" (Bennis, 1989; Paterson, 2005; Principals Australia, 2011) and this was somewhat evident from people's comfort and readiness in their responses to the questions.

The instrument was administered in 14 one-on-one interviews. An overview of the study was provided and people were invited to respond. The potential survey respondents were advised that participation was entirely voluntary. A copy of the NHS Leadership Qualities Framework (National Health Service, 2006) was shown to respondents and they were asked the first question. In the event that people were not familiar with the framework, the survey would have ended. The NHS Leadership Qualities Framework (National Health Service, 2006), however, is well established in Queensland Health and all those who were approached were familiar with the framework. When asked Question 2 of the survey, survey respondents were able to list as many leaders as they thought was justified.

Candidates who were identified by their peers through this survey process were invited to participate in the study as identified healthcare executive leaders. The identified healthcare executive leaders who agreed to participate in the research were asked to provide their 360^0 feedback as confirmation of their leadership qualities. 360^0 feedback, sometimes also referred to as multi-rater feedback, is a process where the participants ask their peers, subordinates and manager for feedback through a questionnaire. The participants also typically self-rate. The 360^0 feedback questionnaires are compiled by a third party into a report that provides the participants with insight into their behaviours and characteristics as observed and perceived by others. Most Queensland Health executives had completed a formal 360^0 feedback instrument that was designed specifically for the NHS Leadership Qualities Framework (National Health Service, 2006).

The identified healthcare executive leaders were then interviewed to obtain qualitative data that described the influence that formal education has had on their leadership capability development. This data collection method is now described.

4.6.2 Data collection

An IPA approach was used for this study and therefore an appropriate data collection method was required that was aligned with IPA. Smith and Osbourne (2007) have recommended the use of semi-structured interviews as a suitable data collection instrument:

> While it is possible to obtain data suitable for IPA analysis in a number of ways – such as personal accounts, and diaries – probably the best way to collect data for an IPA study and the way most IPA studies have been conducted is through the semi-structured interview. (p. 57)

Two semi-structured interviews were conducted with each of the identified healthcare executive leaders. The first interviews focused on the identified healthcare executive leaders' leadership journey and their educational influences. The second interviews focused on the identified healthcare executive leaders perceptions of the influence(s) that formal education has had on the development of their leadership

qualities. The two interviews were held approximately four to six weeks apart, subject to the participants' and interviewer's availability.

The identified healthcare executive leaders were invited to participate in the study via email. The email included an overview of the study, a research fact sheet (please refer to Appendix E) and a research consent form (please refer to Appendix F). A schedule was prepared for each interview, however, as recommended by Smith, Flowers and Larkin (2009), the schedules were used as "a guide, which can incorporate ideas about how best to phrase the questions, and how best to move from general issues to more particular ones" (p. 64).

The first interviews commenced with an explanation of the purpose of the research and ensuring that the requirements of informed consent (Australian Government, 2007) were met. The identified healthcare executive leaders were informed that the study was entirely voluntary and they were assured that they could withdraw from the study at any time. Time was spent with the identified healthcare executive leaders at the commencement of the interviews developing rapport as suggested by Smith, Flowers and Larkin (2009), "The most important thing at the beginning of the interview is to establish a rapport with the participant" (p. 64).

The focus of the first interviews with each of the identified healthcare executive leaders was on their leadership journey and the influences of their formal educational experiences. The identified healthcare executive leaders were invited to share their journey and experiences through an initial open question that flowed from the explanation of the purpose of the research, informed consent and rapport building. The question was not identical for each of the identified healthcare executive leaders, which is acceptable as part of an IPA approach (J. A. Smith et al., 2009), however each opening question was of the nature of:

What I would like to do in this interview is to capture your leadership journey and some of the educational influences that have had an impact on that journey. I'm particularly interested in your formal educational experiences, these could be from Universities and may have resulted in some form of recognised professional qualification or they could be educational experiences that were run in-house within

an organisation. As long as the educational experience had some kind of formal structure to it, so that there were learning objectives or that there was some kind of program or course attendance, whether that be online or face to face.

I'm not as interested in, however still happy to have a conversation about, informal learning such as mentoring or on the job learning. I recognise those experiences may have also had an influence in building leadership capability; however that is not necessarily the focus of the study. So please talk me through your leadership journey, you can go back as far as you want that you think is relevant, and also the formal educational experiences that you've had that may have influenced the building of your leadership capability.

Each interview participant's journey was unique and therefore the clarification and probing questions for each interview participant were different. An example of a clarification question was: *Did that experience occur after you'd completed your A Levels part time?* and a probing question example was *Were you attracted to roles that involved interaction with people?*

The focus of the second interviews with each of the identified healthcare executive leaders was on their perceptions of the influence(s) that formal education has had on the development of their leadership qualities. The NHS Leadership Qualities Framework (National Health Service, 2006) was used as a point of reference for this interview and a copy of the Framework was provided to the participants. The identified healthcare executive leaders were invited to consider each quality and to comment on whether they considered that there were any aspects of their formal educational experiences that may have influenced the development of that quality. An example of the nature of those questions is presented below:

The area of my research interest is the influence that formal education has had on the development of your leadership qualities. So that we've got a common language and construct of leadership to use, we're using the NHS leadership qualities framework, as that's the framework that we've adopted in Queensland Health. Could you reflect upon those formal educational experiences we've previously discussed and talk about the contribution those experiences may have made to

building some of these qualities. As a starting point, the personal quality of Self-Belief, were there any aspects of your formal educational experiences that may have influenced the development of this quality.

IPA requires the collection of 'rich' data, which Smith, Flowers and Larkin (J. A. Smith et al., 2009) have suggested can be obtained when participants "have been granted an opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns at some length" (p. 56) and I ensured I provided sufficient time for the identified healthcare executive leaders to tell their stories. The data that were collected during Phase 2 of the research are presented as narrative reconstructions, which is consistent with an IPA approach (J. A. Smith et al., 2009), in Chapter 6.

4.7 Research design and method relating to Research Question 3

Research Question 3 was intended to discover the relationship between the formal educational experiences of the identified healthcare executive leaders and the contribution these experiences have had on their development as leaders. Illuminating these relationships was achieved through analysis of the data that were collected in Phase 2 of the research. IPA does not prescribe a single method for data analysis (J. A. Smith et al., 2009), however Smith, Flowers and Larkin (2009) highlight that the essence of IPA lies in its analytic focus, "In IPA's case, that focus directs our analytic attention towards our participants' attempts to make sense of their experiences"(p. 79). Whilst not prescribing a method, Smith, Flowers and Larkin (2009) have provided strategies that can be drawn upon as part of an iterative and inductive cycle of analysis. Table 4.4 documents those strategies and provides examples of how the strategies were applied in this study.

Table 4.4: IPA inductive analysis strategies and examples

Analysis Strategies (J. A. Smith et al., 2009, pp. 79-80)	Examples of Application
The close, line-by-line analysis of the experiential claims, concerns and understandings of each participant	Line coding (Charmaz, 2006) was used to summarise and account for the data. The method used is described in Section 4.7.1 and practical evidence of the use of line coding is provided in Chapters 6 and 7
The identification of the emergent patterns (i.e., themes) within this experiential material emphasizing both convergence and divergence, commonality and nuance, usually first for single cases, and then subsequently across multiple cases	Focused coding and axial coding (Charmaz, 2006) was used to identify emergent patterns within the experiential material. Focused coding enabled the identification of emergent themes whilst axial coding gave coherence to the emerging analysis. The method used is described in Section 4.7.2 and evidence is provided in Chapter 7
The development of a 'dialogue' between the researchers, their coded data and psychological knowledge, about what it might mean for participants to have these concerns, in this context, leading in turn to the development of a more interpretative account	Chapter 7, the chapter that details the interpretation of the data, provides extensive evidence of this strategy having been used.
The development of a structure, frame or gestalt which illustrates the relationships between themes	A conceptual model that illustrates the relationships between the themes of analysis is developed and presented in Chapter 7
The organisation of all of this material in a format that allows for analysed data to be traced right through the process – from initial comments on the transcript, through initial clustering and thematic development, into the final structure of themes	This thesis in its entirety provides the evidence of the application of this strategy
The use of supervision, collaboration, or audit, to help test and develop the coherence and plausibility of the interpretation	The study has been undertaken under supervision and was the subject of examination
The development of a full narrative, evidenced by detailed commentary on data extracts, which takes the reader through this interpretation, usually theme-by-theme, and is often supported by some form of visual guide (a simple structure, diagram or table)	Chapter 7, the chapter that describes the interpretation of the data and describes the development of a conceptual model that contributes to theoretical knowledge in the area of enquiry, provides evidence of the application of this strategy
Reflection on one's own perceptions, conceptions and processes	Throughout the study, but particularly in Chapter 8 there are reflections on my own perceptions, conceptions and processes

The data coding and analysis method is described in more detail in the following sections.

4.7.1 Data coding and analysis

Coding is a means by which segments of data are categorised, usually with a short name, that simultaneously summarises and accounts for each piece of data. Coding enables sorting of data to begin an analytic accounting of them (Charmaz, 2006).

Charmaz (2006) suggests line coding as a beginning point in the coding process. Line coding, as the name suggests, uses each line of data as the segment for coding. The lines of data collected through the semi-structured interviews with the identified healthcare executive leaders were reviewed and categorised by naming the data. An example of the line coding technique that was used is shown in Table 4.5.

Table 4.5: Line coding example

Data	Line Codes
I remember the computers were the size of rooms and you had those cards with holes in them. It was really interesting, but what I found about the job is that I spent a lot of time on computers and not very much time interacting with people. But because I didn't do my A Levels, I started doing an Ordinary National Certificate in business studies, which was in the evening. That sort of almost set the tone for the rest of my educational life, really, because every single - the last time I studied full time was when I was 16 at school. The rest of my professional life, it's all been part time.	Worked with leading technology of the time Work was interesting Wanted to work more with people Studied while working Identified an "educational life" Identified a "professional life"

Line coding commenced following the first interview which was the first capture of data. As data collection continued through further interviews, a rich source of line coding emerged. The second major phase of coding used was focused coding (Charmaz, 2006). Focused coding used the most significant line codes to make analytic decisions that categorised the data more decisively and completely.

An example of focused coding based on the same data sample as used above is shown in Table 4.6.

Table 4.6: Focused coding example

Data	Focused Coding
I remember the computers were the size of rooms and you had those cards with holes in them. It was really interesting, but what I found about the job is that I spent a lot of time on computers and not very much time interacting with people. But because I didn't do my A Levels, I started doing an Ordinary National Certificate in business studies, which was in the evening. That sort of almost set the tone for the rest of my educational life, really, because every single - the last time I studied full time was when I was 16 at school. The rest of my professional life, it's all been part time.	Education is a strategy to enhance career Education and profession are separate but complimentary

Line coding and focused coding are not linear but iterative as shown by Figure 4.2. As interviews progressed and data were collected, line coding and focused coding started to guide me to avenues of enquiry that were explored in subsequent interviews. Coding is flexible (Charmaz, 2006) and I was able to return to the data to make fresh coding decisions as the interviews progressed and as new avenues of enquiry emerged.

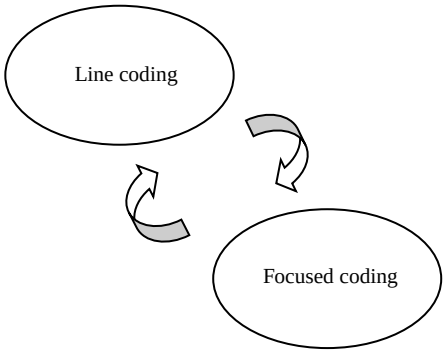

Figure 4.2: The iterative nature of line and focused coding

The coding process generated large quantities of coded data, gathered over time, from different sources, and from multiple interactions with the identified healthcare

executive leaders. As the study progressed, the line coding and focused coding 'fractured' (Bryant & Charmaz, 2007) the data into separate pieces and distinct codes and a method was required to bring it back together into a coherent whole. As themes emerged, categories were identified and explored and core categories emerged. Axial coding (Charmaz, 2006) enabled the relation of categories to subcategories and the reassembling of the data that had been fractured during earlier coding. Axial coding gave coherence to the emerging analysis. Figure 4.3 shows how the data was reassembled around core categories (or axes).

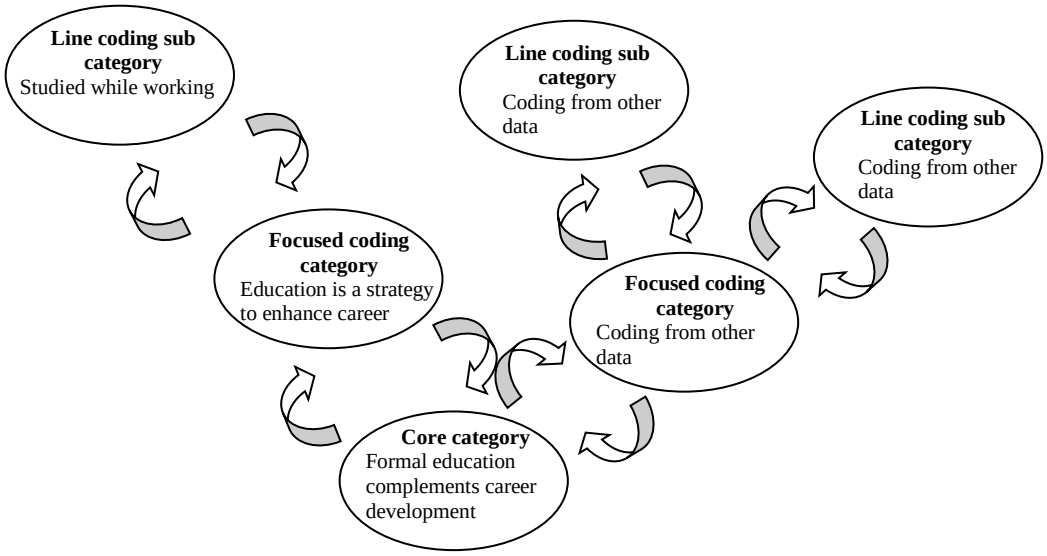

Figure 4.3: Axial coding process

Theoretical coding (Charmaz, 2006; Hernandez, 2009) was used to identify the relationships between categories, thus enabling the development of an integrated and explanatory interpretation to be generated. Hernandez (2009) has described theoretical coding as "detecting the relationships between two or more categories" (p. 54). Smith, Flowers and Larkin (2009) have described interpretation in IPA as "a form of amplification or illumination of meaning, which is cued or sparked by close engagement with the data, and which requires creativity, reflection and critical awareness for its full development" (pp. 204-205). The analysis of the data through coding and the consequent inductive interpretation of that analysis enabled illumination, from the data collected in the field, of the participants' experience of the research question under study (Creswell, 2009).

The data collection and analysis method described above is consistent with qualitative approaches to research where, through inductive analysis, data is organised to build patterns, categories and themes using interconnected interpretive practices to gain a better understanding of problems of interest (Creswell, 2009; Denzin & Lincoln, 2005). Further support for the method comes from Berger and Luckmann (1991) who contend that "reality is socially constructed and that the sociology of knowledge must analyse the process in which this occurs" (p. 13), the process in this case being the process of formal educational influence on the development of leadership qualities with Queensland Health healthcare executives.

4.8 Positioning of the researcher in the study

At the time of conducting the research, I was employed as the Director of Capability with Queensland Health. In this role, I had some limited professional responsibilities that required interaction with the healthcare executives who were participating in the study. Neither the participants nor I, however, were subordinate to one another nor had a direct power influence on one another. At all times the research and my professional role were differentiated and clearly separated when interacting with participants.

The worldview of the researcher was that the world has imperfect reality and any truth to be found is only probably so. Further, I consider that the world has complexity and dynamics that are shaped by social, cultural and gender values and the realities that exist are co-constructed by myself and others within the contextual framework of our experiences and dispositions.

IPA deals not only with participants' interpretations of their experience but also with the researchers' interpretations of participants' interpretations (VanScoy & Evenstad, 2015).

4.9 The participants

When considering the participants in the study, I am referring to the healthcare executives who were identified through the second area of inquiry described by

Research Question 2 - that is, the healthcare executive leaders within Queensland Health who were identified as having leadership characteristics that most strongly aligned with the NHS Leadership Qualities Framework (National Health Service, 2006).

At the time of the study, Queensland Health had 15 Health Service Districts and eight Corporate Divisions and a staff of approximately 60,000 (full time equivalent) people nearly two thirds of whom were healthcare practitioners (Queensland Health, 2010). Of these, approximately 500 employees were considered healthcare executives and senior leaders and it was from this group of 500 employees that the participants for the study were drawn.

My goal of interviewing only healthcare executive leaders in Queensland Health who were identified as having leadership qualities, however, rather than simply interviewing people who were in leadership roles, necessitated the use of the interview survey to identify healthcare executives who were identified as having leadership characteristics that aligned with the NHS Leadership Qualities Framework (National Health Service, 2006), this purposeful selection limited the pool of possible participants.

4.10 Ethical considerations

As the research involved interviews with human participants, the National Statement on Ethical Conduct in Human Research (Australian Government, 2007) was adhered to. Application for ethics clearance was made to the University of Southern Queensland (USQ) Human Research Ethics Committee, which is the USQ body responsible for reviewing the ethical acceptability of human research and for advising of any ethical considerations for those proposals and ensuring compliance with regulatory and legislative requirements relating to human research (University of Southern Queensland, 2008). Full ethics approval was granted by the USQ Human Research Ethics Committee on 22 January 2010; Ethics Approval Number H09REA144 refers (please see Appendix D).

Approval for the study was also obtained from the Queensland Health Executive Director of People and Culture and, where documents were required to be obtained, approval was sought from the relevant areas.

Ethical considerations towards the participants were primarily focused on informed consent, voluntary participation and the ability to withdraw at any time. The following steps were undertaken to ensure informed consent of the participants:

- Participants were given full written information about the study (including the aims, use and storage of data and confidentiality) before deciding voluntarily whether to participate (please refer to Appendix E).
- Participants were verbally briefed by me prior to the conduct of the interviews.
- Participants were asked to sign a written consent form (please refer to Appendix F).
- Participants were informed that the study was entirely voluntary and they were assured that they could withdraw from the study at any time.

The identities of the participants were protected through the coding of data and the use of fictitious names, hospitals, Health Districts and locations. The data collected will be safely retained for a period of five years on secure servers and hard drives and the files are password protected. Participant identification was coded and the keys have been stored separately.

The findings, and the methodology of the research, will be shared with relevant organisations and the broader research community. Papers that describe the research and the subsequent findings will be submitted for peer review to encourage debate about the methodology and transparency of the research.

4.11 Research validity and quality

Traditional categories of validity (for example, concurrent validity, predictive validity and convergent validity) are based on positivist assumptions that the world is ordered according to an overarching objective truth and that knowledge can be

neutral or value-free (Bunniss & Kelly, 2010; Guba & Lincoln, 2005; Maxwell, 1992). Qualitative research requires different approaches to validity that do not depend on the existence of absolute truth or reality to which an account can be compared. Qualitative validity refers primarily to the accounts themselves, not to data or methods (Maxwell, 1992). Hammersley and Atkinson (2007) have stated that "data in themselves cannot be valid or invalid; what is at issue are the inferences drawn from them" (p. 177).

Maxwell (1992) has provided five categories of validity to consider for qualitative studies: descriptive, interpretive, theoretical, generalisability and evaluative. He considered that the first three are the ones most directly involved in assessing qualitative accounts as they pertain to the actual situations on which the account was based.

Descriptive validity is concerned with the factual accuracy of the account - that is, that the researcher is not making up or distorting the things that they saw or heard. Threats to this validity are whether the researcher misheard, mistranscribed, or misremembered the account. Maxwell (1992) considers this to be the primary aspect of qualitative validity. For this study, I took notes during the interviews and audio-recorded interviews and made transcripts. Statements attributed to the participants were taken either directly from the notes taken at the time of the interviews or from the transcripts of the recordings.

Qualitative researchers are not concerned solely with providing a valid description of the physical accounts of the settings that they study; they are also concerned with what these accounts mean to the people engaged in and with them (Maxwell, 1992). Interpretive validity is grounded in the language of the people studied; however, unlike descriptive validity there is no access to data that would address threats to validity. For this study, I attempted to establish a common language of 'what leadership is' by using the NHS Leadership Qualities Framework (National Health Service, 2006) as a commonly understood point of reference as one measure to address interpretive validity threats. Other measures included asking clarifying questions and ensuring data collection was rich and sufficient (Charmaz, 2006; J. A. Smith et al., 2009).

Theoretical validity (Maxwell, 1992) addresses the theoretical constructions that the researcher brings to the study, "theoretical understanding refers to an account's function as an explanation, as well as a description or interpretation, of the phenomena" (p. 291). Maxwell (1992) contends that theoretical validity is concerned with problems that do not disappear with agreement about the 'facts'. For this study, I generated a contribution to theoretical knowledge from multiple sources of data and linked this contribution to established literature to address the threats to theoretical validity.

Yardley (2000) has described four characteristics of quality qualitative research which have been supported by Smith, Flowers and Larkin (2009) as being suitable for assessing the quality of IPA. Yardley's (2000) four characteristics are: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Smith, Flowers and Larkin (2009) have argued that the strongest context that a good piece of IPA research will be sensitive to is the data. They have made this argument as they considered that great care should be taken with the collection of data from participants and with grounding analytic claims in the data obtained. Such an approach, they have claimed, is demonstrating sensitivity to the raw material being worked with. Smith, Flowers and Larkin (2009) have provided guidance on how to demonstrate context and sensitivity in an IPA study:

> A good IPA study will always have a considerable number of verbatim extracts from the participants' material to support the argument being made, thus giving participants a voice in the project and allowing the reader to check the interpretations being made. (pp. 180-181)

In this study, care has been taken to ensure that there are extensive verbatim extracts from the participants' material to support the arguments and to ground any analytic claims that have been made.

Yardley's (2000) second characteristic of quality qualitative research was commitment and rigour which she has related to thoroughness in data collection,

analysis and reporting in the research. Smith, Flowers and Larkin (2009) have provided guidance on the demonstration of commitment and rigour in an IPA study in so far as commitment relates to the degree of attentiveness to the participants during the interviews and the care with which the analysis is undertaken. Their guidance on rigour relates to the appropriateness of the sample, the quality of the interviews and the completeness of the analysis.

In this study, great care was taken to ensure that the identification of the participant sample was appropriate and thorough. The quality of the interviews has been demonstrated by the quality of the data obtained and the completeness of the analysis has been demonstrated through the findings that have been concluded.

Yardley's (2000) third characteristic of quality qualitative research was transparency and coherence. Yardley (2000) has stated that transparency refers to the degree to which all relevant aspects of the research process are disclosed and that transparency can be achieved by detailing the data collection process, disclosing the rules used to code the data and by presenting excerpts of the textual data in which the readers can themselves discern the patterns identified by the analysis. Yardley (2000) has described coherence as "the fit between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken" (p. 222).

For this study, this chapter discloses all relevant aspects of the research process and also provides examples of excerpts of the coding process. Further details of analysis and excerpts of data are provided throughout the analysis chapters of this study. This chapter has also described the 'fit' between the research question and the philosophical perspective adopted.

Yardley's (2000) fourth characteristic of quality qualitative research was impact and importance which she has described as "The decisive criterion by which any piece of research must be judged" (p. 223). Yardley further has suggested that: "the ultimate value of a piece of research can only be assessed in relation to the objectives of the analysis, the applications it was intended for, and the community for whom the findings were deemed relevant" (p. 223).

The impact and importance of this study are extensively discussed in the final chapter of this thesis.

4.12 Summary

This study was focussed on questions associated with issues of leadership, leaders and learning. A methodology was required that generated a contribution to theoretical knowledge to be constructed that explained how healthcare executive leaders develop leadership capability through formal education. The qualitative research methodology chosen to achieve this outcome was positioned within an interpretivist paradigm. Appropriate methods were used to obtain the outcomes sought for each specific research question.

The consequent research design consisted of three phases:

Phase 1. Phase 1 was concerned with the conceptualisation of leadership from a theoretical perspective to enable the NHS Leadership Qualities Framework (National Health Service, 2006) to be positioned within a theoretical construct.

Phase 2. Using the outputs of Phase 1, the next phase was concerned with the identification of healthcare executive 'leaders' in Queensland Health, the participants in the study. Phase 2 also consisted of semi-structured interviews with the identified healthcare executive leaders to obtain insight into their formal education experiences and how those experiences have contributed to their leadership development.

Phase 3. The final phase consolidated the outputs from the phases above to generate a contribution to theoretical knowledge explaining how healthcare executive leaders develop leadership capability through formal education.

In Chapter 5, Research Question 1 is explored through a literature analysis and interpretation that is focused on the particular framework of leadership chosen by Queensland Health, the NHS Leadership Qualities Framework (National Health

Service, 2006). The purpose of this approach is to provide a clear context of leadership within which to explore the leadership capabilities and leadership development of Queensland Health healthcare executives.

5 Chapter 5: Review of the NHS Leadership Qualities Framework

5.1 Introduction

The previous chapter described the methodology for the study, including the research design and method for Research Phase 1 which was the research phase that had as its output the response to Research Question 1. The purpose of this chapter is to provide the response to Research Question 1 using the method that was described in Chapter 4. Research Question 1 is re-stated here for convenience:

> RQ1. How does the NHS Leadership Qualities Framework adopted by Queensland Health compare with the leadership characteristics required of its healthcare executives?

It was established in Chapter 4 that an appropriate method for considering Research Question 1 was a literature analysis. This chapter commences with an analysis of literature available on healthcare leadership frameworks more generally prior to focusing more specifically on an analysis of the literature available on the NHS Leadership Qualities Framework (National Health Service, 2006), the leadership framework that had been adopted by Queensland Health.

5.2 A review of healthcare leadership frameworks

In Chapter 3 of this study, leadership frameworks reviewed by Bolden, Gosling, Marturano, and Dennison (2003) were discussed. Only one of the frameworks reviewed by Bolden, Gosling, Marturano, and Dennison (2003), the NHS Leadership Qualities Framework (National Health Service, 2006), was a healthcare framework. As this was a study of leadership in a healthcare context, 10 additional healthcare leadership frameworks were sourced from the literature for comparison. The healthcare leadership frameworks reviewed are presented in Appendix B.

Examination of the literature available on these 10 additional healthcare leadership frameworks provided clarity around the theoretical influences that informed their design. Using the leadership taxonomy created in Chapter 3 and shown in Table 3.1, the elements (competencies/qualities/characteristics) of each of the 10 additional

healthcare leadership frameworks sourced from the literature were analysed to determine to which cluster of leadership theory they most strongly aligned. This was achieved through an analysis of the respective elements of each healthcare leadership framework, a sample of this analysis is shown in Table 5.1 and described below.

Table 5.1: An example of the analysis of the healthcare leadership frameworks

Healthcare Leadership Framework A: The NSW Health Leadership Framework (Australia)		
Domain	**Capability**	**Theoretical Alignment**
Achieving outcomes	• Building a common vision for future health outcomes	Transformational Theory
	• Using outcomes for patients and clients as well as service agreements to drive performance	Transactional Theory
	• Focusing on what makes a difference to results	Transactional Theory
	• Being accountable for performance and resources	Transactional Theory

The method of analysis of the New South Wales (NSW) Health Leadership Framework (Health Education and Training Institute, 2013) is presented here as an example of the approach to the analysis of the frameworks. The NSW Health Leadership Framework (Health Education and Training Institute, 2013) consists of five domains. Each domain has four associated capabilities, with each capability having three behavioural descriptors. The '*Achieving outcomes*' domain, for example, has four capabilities as shown in Table 5.1. Using the Taxonomy of Leadership Theory (Table 3.1) as a reference, the capabilities and behavioural descriptors associated with the '*Achieving outcomes*' competency of the NSW Health Leadership Framework (Health Education and Training Institute, 2013) were analysed and found, on balance, to align most closely to the theoretical construct of Transactional theory (in that leadership derives mutual benefits from a form of 'contract' such as using outcomes for patients to drive performance).

It was recognised that there were limitations in the approach used to analyse the theoretical alignment of the healthcare leadership frameworks. The researcher interpreted the language used in the frameworks without engaging with the people who created the language and therefore there was a validity risk of misinterpretation (Maxwell, 1992). Healthcare leadership frameworks that are based on behavioural descriptors, such as the example above, are also predisposed by their nature to appear

to be founded only in behavioural and trait theoretical influences. Further interpretation was required to determine the theoretical influences that were underpinning the behavioural descriptors.

Through analysis of the capabilities and behavioural descriptors for each of the five domains of the NSW Health Leadership Framework (Health Education and Training Institute, 2013), a fuller picture of the theoretical alignment of that framework emerged.

The strongest theoretical alignment for the NSW Health Leadership Framework (Health Education and Training Institute, 2013) was with Influence and Transformational theories. There was some alignment with Trait, Behaviour, Transactional and Culture theories. There was little to no alignment with Great Man, Contingency and Organisational theories (please refer to Appendix C).

An interpretation of the findings presented above is that contemporary approaches to leadership have evolved from Great Man theories and the non-alignment of the NSW Health Leadership Framework (Health Education and Training Institute, 2013) with these theories is not surprising. Further, whilst there was little to no alignment with Contingency theories, it could be argued that the whole framework sits within the specific context of healthcare in New South Wales, and therefore the contingency factors do not need to be made explicit in the competencies of the framework.

Applying this method of analysis across all of the healthcare leadership frameworks sourced from the literature, it was found that the strongest theoretical alignment for the collective healthcare leadership frameworks reviewed as part of this study was with Trait, Influence, Contingency, and Transactional theories (please refer to Appendix C). There was some alignment with Behavioural and Transformational theories. There was little to no alignment with Great Man, Culture and Organisational theories. As with the earlier interpretive comments on non-alignment relating to the NSW Health Leadership Framework (Health Education and Training Institute, 2013), the non-alignment with Great Man theories is not surprising as contemporary thinking apropos leadership has moved on significantly from those theories. The non-alignment with Culture theories can be explained by the

observation that healthcare systems are characterised by efforts to promote productivity and efficiency and consequently there was little alignment with Culture theories, which focus primarily on expectations and values (Van Seters & Field, 1990). Non-alignment with Organisational theories may be due to these theories being emerging fields of leadership theory that may not have found their way into organisational application.

A summary table of the 10 healthcare leadership frameworks sourced from the literature and their alignment with leadership theory clusters is presented in Table 5.2. A summary of the word analysis of the frameworks and their associated elements is shown in Appendix C.

Table 5.2: Healthcare leadership frameworks and their alignment to leadership theory clusters

Healthcare Leadership Framework	Leadership Theory Cluster								
	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
The NSW Health Leadership Framework (Australia). The New South Wales (NSW) Health Leadership Framework (Health Education and Training Institute, 2013) has been shaped by the latest international evidence and a broad consultation process within the NSW Health system. The leadership approach in the NSW Health Leadership Framework emphasises that leadership can be exercised anywhere in a hospital or health service organisation; leadership is not solely the responsibility of positional leaders. The framework frames leadership in terms of five domains: Achieving outcomes; Developing and leading self; Engaging people and building relationships; Partnering and collaborating across boundaries; and Transforming the system. For each domain a set of four capabilities is defined and for each capability there is a set of three behavioural descriptors.	**L**	**S**	**S**	**A**	**L**	**S**	**A**	**S**	**L**
Competencies for Nursing and Midwife Managers (Ireland) Competencies developed by the Office for Health Management (Ireland) (2000) describe the management competencies required for nursing and midwifery management positions. The competencies were developed through field research with a representative sample of nurse managers at 'front, middle and top level roles' and then validated and refined through consultation with groups of nurse managers and other service stakeholders (Office for Health Management, 2000). The competencies are grouped under the headings of: Generic Competencies for Nurse Managers; Competencies for Top Level Nurse Managers; Competencies for Mid-Level Nurse Managers; and Competencies for Front Line Nurse Managers. Each competency has associated behavioural indicators. The competencies are designed to inform the recruitment and selection of nurse managers and facilitate the process of training and development.	**L**	**S**	**S**	**A**	**L**	**A**	**S**	**L**	**L**
Qualities of a Clinical Director (United Kingdom) Buchanan, Jordan, Preston and Smith (1997) developed their own set of qualities for a Clinical Director with clusters of: context factors; personal stance; core understanding; behavioural capabilities; and specific skills. They drew their data from interviews with six clinical directors and 19 other members of the hospital management team including the chief executive, nonclinical directors, business managers and senior nurse managers (from one hospital location).	**L**	**S**	**S**	**A**	**A**	**S**	**L**	**L**	**L**
Canterbury and West Coast DHB Leadership Capabilities (New Zealand) The Canterbury and West Coast District Health Boards have a Leadership Capability Framework (Marinelli-Poole, McGilvray, & Lynes, 2011) that consists of nine leadership capabilities, each of which has a competency requirement for leaders at seven levels of career progression (a total of 63 competencies). The framework details the skills, knowledge and behaviours required for each of the 63 competencies. The framework is designed to support transformational change and underpins all people-based activities for the Canterbury and West Coast District Health Boards, including recruitment, performance management and learning and development.	**L**	**S**	**L**	**A**	**L**	**L**	**A**	**S**	**L**

Table 5.2: Healthcare leadership frameworks and their alignment to leadership theory clusters

Healthcare Leadership Framework	Leadership Theory Cluster								
	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
Key: L = Little to no alignment; M = Moderate alignment; S = Strongest alignment									
Healthcare Leadership Alliance Model (United States) The Healthcare Leadership Alliance (HLA) is a consortium of six major healthcare professional membership organisations in the United States (Stefl, 2008). The consortium identified five competency domains common among all practising healthcare managers and then engaged in a formal process to delineate the knowledge, skills, and abilities within each domain. This process produced 300 competency statements, which were then organized into a Competency Directory. The HLA model is designed to be used for individual and organisational assessment, employee selection and team development. In addition, the model can be adapted for use in academic programs.	**L**	**S**	**S**	**S**	**S**	**S**	**L**	**L**	**L**
Health Leadership Capabilities Framework (Canada) The LEADS Leadership Capabilities Framework has been developed by the Health Care Leaders Association of British Columbia under their LEADS initiative. It represents the key skills, abilities and knowledge required to lead at all levels of the health system. It aligns and consolidates the competency frameworks of individual health employers, professional associations and other progressive organisations into a common strategy (Health Care Leaders Association of British Columbia, 2010). The framework consists of five major dimensions, with each major dimension having four minor dimensions.	**L**	**M**	**S**	**S**	**L**	**L**	**S**	**L**	**L**
Medical Leadership Competency Framework (United Kingdom) The Medical Leadership Competency Framework (MLCF) was jointly developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement (2009). Although the NHS Leadership Qualities Framework (National Health Service, 2006) was an influence, the MLCF specifically describes the leadership competences that doctors need for them to become more actively involved in the planning, delivery and transformation of services for patients. The MLCF consists of five domains: Demonstrating Personal Qualities; Working with Others; Managing Services; Improving Services; and Setting Direction. Within each domain are four elements and each of the elements is further divided into four competency outcomes (a total of 80 competencies). The Medical Leadership Competency Framework has been in development since August 2006 and was first published in 2008.	**L**	**S**	**L**	**S**	**M**	**S**	**M**	**L**	**L**
The NCHL Health Leadership Competency Model (United States) The National Centre for Healthcare Leadership (NCHL) Health Leadership Competency Model was created through research by the Hay Group with practising health leaders and managers across the administrative, nursing and medical professions, and early, mid and advanced career stages. In addition, the Competency Model incorporates benchmark data from other health sectors and insurance companies, and composite leadership competencies from a group of global corporations (National Center for Healthcare Leadership, 2013). The model contains three domains with 26 competencies.	**L**	**S**	**M**	**S**	**M**	**S**	**M**	**L**	**L**
Key: L = Little to no alignment; M = Moderate Alignment; S = Strongest Alignment									

Table 5.2: Healthcare leadership frameworks and their alignment to leadership theory clusters

Healthcare Leadership Framework	Leadership Theory Cluster								
	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
The Pan-Canadian Health Leadership Capability Framework (Canada) The Pan-Canadian Health Leadership Capability Framework (Canadian Health Services Research Foundation, 2007) was developed as the result of a qualitative research study by the Centre for Health Leadership and Research at Royal Roads University for the Canadian Health Services Research Foundation. The research team adopted a qualitative, action-research approach to gather data from three sources: 1) in-depth interviews with key informants and 10 focus groups with health leaders across Canada; 2) a review of peer-reviewed and grey literature on types and qualities of leadership; and 3) analysis of competency/capability frameworks from selected national and international sources. The framework has five domains of leadership capabilities: Champion caring; Cultivate self and others; Connect with others; Create results; and Change systems, each with four sub-domains.	**L**	**S**	**L**	**S**	**S**	**M**	**M**	**L**	**L**
Queensland Public Sector Nurse Executives: Professional Development Needs (Australia) Courtney, Yacopetti, James, Walsh and Montgomery (2002) developed a prioritised set of professional development needs for Queensland Public Sector Nurse Executives based on identified 'difficult problems' faced by these executives. The difficult problems identified by the executives were: Financial; Personnel; Workload; HRM skills; Information technology; Management; Change; Lack of time; Lack of appropriate staff to employ; Isolation in decision making; Inequity; and Devaluation of nursing input.	**L**	**L**	**M**	**M**	**S**	**S**	**L**	**L**	**L**

Key: **L = Little to no alignment;** **M = Moderate Alignment;** **S = Strongest Alignment**

Interpretation of the theoretical influences of the healthcare leadership frameworks sourced from the literature reveals that the frameworks were dominated by qualities, behaviours, competencies or characteristics that reflected a view of leadership as a leader with certain qualities (Trait theory) who influences colleagues and health networks (Influence theory) within the context of the health system (Contingency theory), whilst managing the day-to-day realities of delivering a service (Transactional theory).

There were encouraging reflections of contemporary organisational leadership theory within some healthcare leadership frameworks. The Pan-Canadian Health Leadership Capability Framework (Canadian Health Services Research Foundation, 2007), for example, recognises complexity as an environment within which healthcare leaders need to operate:

> A second major 'emerging' feature of this framework is capabilities that recognize the complexity of the health system. For example, the 'connect others' capability was identified and raised to a level of prominence not found in competency/capability frameworks in other sectors. This capability emphasizes the leadership challenge of aligning individuals and groups from a complex number of professional bodies, interest and stakeholder groups, and members of the public to create a quality health system. (p. 15)

Whilst complexity is acknowledged in the Pan-Canadian Health Leadership Capability Framework (Canadian Health Services Research Foundation, 2007), it is more as a context or a contingency factor. Complexity leadership theory, as described by Uhl-Bien and Marion (2008), is leadership within an interactive system of dynamic, unpredictable factors that interact with one another in complex networks, which then produce adaptive outcomes such as knowledge dissemination, learning, innovation and further adaptation to change. This depth of meaning is not conveyed in the Pan-Canadian Health Leadership Capability Framework (Canadian Health Services Research Foundation, 2007) as complexity in this framework is related to the complexity of the health system.

The review of healthcare leadership frameworks described above can be compared to Bolden, Gosling, Marturano and Dennison's (2003) review of organisational leadership frameworks which were sourced from a variety of sectors. Bolden, Gosling, Marturano and Dennison (2003) found that the frameworks that they reviewed had theoretical alignment with Trait theories of leadership and that they had a somewhat limited alignment to Transformational theories. The review of healthcare leadership frameworks in this study has found that the healthcare leadership frameworks reviewed also align strongly with Trait theories of leadership and have some alignment with Transformational theories. The review of healthcare leadership frameworks in this study also found strong alignment with Influence, Contingency and Transactional theories. An interpretive explanation for these findings is that healthcare cultures are often collegial by nature, particularly within disciplines, which may explain the alignment with Influence theories. Clinicians also strongly align with their practice and the healthcare context, which may explain the alignment with Contingencies theories. Healthcare systems are also under pressure to deliver services and outcomes with limited resources, which would drive alignment to Transactional theories.

5.3 Review of the NHS Leadership Qualities Framework

The desired outcomes for Phase 1 of the research were to provide a description of the healthcare leadership context within which the study participants operated and to review the leadership framework chosen by Queensland Health, the NHS Leadership Qualities Framework (National Health Service, 2006). A description of the healthcare leadership context within which the study participants operated has been provided in the Contextual framework chapter, Chapter 2, and in the preceding discussion on healthcare leadership frameworks.

In this section the NHS Leadership Qualities Framework (National Health Service, 2006), hereafter referred to as the Framework, is presented and then compared with the literature on leadership, leadership frameworks in general and the healthcare leadership frameworks and models that were presented in the previous section.

This analysis of the Framework is critical to the study as it is the Framework that forms the common frame of reference for Research Phase 2. That is, when leadership was discussed with the identified healthcare executive leaders, it was the Framework that was the reference point for a definition of leadership within this study. Whilst clearly the participants, and the researcher, came to this study with their own views on leadership, the common reference and language of the Framework enabled a conversation to occur in a constructive way and went some way towards mitigating the threats to interpretive validity (Maxwell, 1992).

5.3.1 A description of the NHS Leadership Qualities Framework

The National Health Service (NHS) Leadership Qualities Framework (National Health Service, 2006), the Framework, was a leadership framework initially developed by the NHS Leadership Centre in 2002. The NHS Leadership Centre contended that it was developed based on detailed research carried out with NHS Trust Chief Executives to determine the relevant qualities that are required for effective leadership in the NHS. The NHS Leadership Centre stated that it was tailored to the specific needs and environment of the NHS and that it was designed to be applicable to leadership roles at any level of the service. Contextualised leadership was considered through the concept that the range of situations that leaders faced in the NHS demanded the use of a wide range of qualities in particular combinations, with the best leaders using an effective combination of qualities in particular settings (Crowder & Woods, 2006; National Health Service, 2006).

This section presents the Framework and its associated constructs to provide the reader with sufficient background so that the analysis has context. Queensland Health, where this study was situated, had adopted the NHS Leadership Qualities Framework (2006). The Framework (Figure 5.1) describes 15 leadership qualities, clustered into three areas: Personal Qualities; Setting Direction; and Delivering the Service.

Figure 5.1: The NHS Leadership Qualities Framework (National Health Service, 2006, p. 1)

A summary table of the clusters and their associated qualities is presented in Table 5.3.

Table 5.3: NHS leadership qualities

NHS Leadership Quality	Definition
Personal Qualities	
Self Belief	The inner confidence that you will succeed and you can overcome obstacles to achieve the best outcomes for service improvement.
Self Awareness	Knowing your own strengths and limitations and understanding your own emotions and the impact of your behaviour on others in diverse situations.
Self Management	Being able to manage your own emotions and be resilient in a range of complex and demanding situations.
Drive for Improvement	A deep motivation to improve performance in the health service and thereby to make a real difference to others' health and quality of life.
Personal Integrity	A strongly held sense of commitment to openness, honesty, inclusiveness and high standards in undertaking the leadership role.
Setting Direction	
Seizing the Future	Being prepared to take action now to shape and implement a vision for the future development of services.
Intellectual Flexibility	The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services.
Broad Scanning	Taking the time to gather information from a wide range of sources.
Political Astuteness	Showing commitment and ability to understand diverse interest groups and power bases within organisations and the wider community, and the dynamic between them, so as to lead health services more effectively.
Drive for Results	A strong commitment to making service performance improvements and a determination to achieve positive service outcomes for users.
Delivering the Service	
Leading Change through People	Communicating the vision and rationale for change and modernisation, and engaging and facilitating others to work collaboratively to achieve real change.
Holding to Account	The strength of resolve to hold others to account for agreed targets and to be held accountable for delivering a high level of service.
Empowering Others	Striving to facilitate others' contributions and to share leadership, nurturing capability and long-term development of others.
Effective and Strategic Influencing	Being able and prepared to adopt a number of ways to gain support and influence diverse parties, with the aim of securing health improvements.
Collaborative Working	Being committed to working and engaging constructively with internal and external stakeholders.

5.3.2 A review of the NHS Leadership Qualities Framework

There is limited literature that reviews or critiques the NHS Leadership Qualities Framework (National Health Service, 2006). Some authors have described how they have used the Framework in their respective organisations (Bithell & Child, 2005; Crethar et al., 2011); however, these publications do not critique the Framework. Crowder and Woods (2006) evaluated the Framework in use in their organisation, West of Berkshire Primary Care Trusts, and found it to be a valuable tool that can be used to enhance and support leadership development. They found that staff members liked the basic structure of the Framework, although there were some issues with the terminology, and they found that some of the qualities were more applicable to some staff members than to others. They also found that the Framework's effectiveness was increased when it was used as an integral part of a leadership development program. Crethar, Phillips and Brown (2011) have also described how the Framework was being utilised across Queensland Health to achieve improvements in workplace culture and ultimately improvements in clinical care and patient outcomes.

Wood and Gosling's (2003) review of the NHS Leadership Qualities Framework (National Health Service, 2006) was more focused on the construct of the Framework rather than its use and they identified two main areas of concern: Methodological – the extent to which data collected from Chief Executives and Directors can be generalised to leaders at all levels in the NHS; and Epistemological – the Framework's exclusive focus on the definite article – that of individual identity and personal qualities.

The methodological concerns raised by Wood and Gosling (2003) related to the claim that the Framework's aim was to provide a foundation for developing leaders at all levels in the NHS. The method used for the framework development was based on in-depth structured interviews with a sample of only 50 Chief Executives and Directors. Wood and Gosling (2003) asked how, from a methodological viewpoint, this data generated from such a sample can then be generalized to apply to leaders at all levels. Wood and Gosling's (2003) concerns are echoed in Crowder and Woods' (2006) evaluation of the implementation of the Framework in their Trusts, which

included the comment that, “Although all qualities are important for effective leadership it is recognised that, depending on the role carried out, some are more applicable to some staff than others” (p. 18).

Wood and Gosling’s (2003) epistemological concerns with the Framework related to the nature of knowledge regarding leadership and how that was evident (or not) in the Framework’s constructs, particularly with regard to the Personal Qualities of *Self Belief, Self Awareness, Self Management, Self Improvement,* and *Personal Integrity*. They contended that a focus on the ‘leader’ and the leader’s personal characteristics, attitudes and behaviours neglected a broader, more contemporary view of leadership:

> Leaders and followers are parts of ongoing social networks and institutional structures within which individual identities, qualities and behaviours form part of an ongoing process. Leadership in this situation is the paradoxical in and between of driver and driven (being neither one or the other); it is both constitutive of and constituted by often contradictory clusters of attitudes, behaviours, values, abilities and beliefs that are perpetually in-tension and hence in a state of emergence. (Wood & Gosling, 2003, pp. 11-12)

Wood and Gosling’s (2003) methodological and epistemological concerns in and of themselves do not demonstrate that the NHS Leadership Qualities Framework (National Health Service, 2006) adopted by Queensland Health was a framework that did not adequately describe the leadership characteristics required of its healthcare executives.

This is particularly so as Crowder and Woods’ (2006) evaluation of the Framework in use in their healthcare organisation found it to be a valuable tool that can be used to enhance and support leadership development.

The analysis of the Framework is continued by considering its theoretical alignment. This was achieved by considering each of the Qualities and reviewing them against the Leadership Taxonomy developed in Chapter 3. Table 5.4 provides, for each Quality of the Framework, the definition of that Quality and an assessment of its theoretical alignment against the theories identified in the Leadership Taxonomy.

Table 5.4: NHS leadership qualities and their theoretical alignment with the taxonomy of leadership theory

NHS Leadership Quality	Definition	Theoretical Alignment
Personal Qualities Cluster		
Self Belief	The inner confidence that you will succeed and you can overcome obstacles to achieve the best outcomes for service improvement.	Trait Theories Behavioural Theories Contingency Theories
Self Awareness	Knowing your own strengths and limitations and understanding your own emotions and the impact of your behaviour on others in diverse situations.	Trait Theories Behavioural Theories Contingency Theories
Self Management	Being able to manage your own emotions and be resilient in a range of complex and demanding situations.	Trait Theories Behavioural Theories Contingency Theories
Drive for Improvement	A deep motivation to improve performance in the health service and thereby to make a real difference to others' health and quality of life.	Trait Theories Behavioural Theories Contingency Theories
Personal Integrity	A strongly held sense of commitment to openness, honesty, inclusiveness and high standards in undertaking the leadership role.	Trait Theories
Setting Direction Cluster		
Seizing the Future	Being prepared to take action now to shape and implement a vision for the future development of services.	Transformational Theories
Intellectual Flexibility	The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services.	Behavioural Theories Contingency Theories
Broad Scanning	Taking the time to gather information from a wide range of sources.	Behavioural Theories
Political Astuteness	Showing commitment and ability to understand diverse interest groups and power bases within organisations and the wider community, and the dynamic between them, so as to lead health services more effectively.	Trait Theories Behavioural Theories Influence Theories Contingency Theories
Drive for Results	A strong commitment to making service performance improvements and a determination to achieve positive service outcomes for users.	Transactional Theories

Table 5.4: NHS leadership qualities and their theoretical alignment with the taxonomy of leadership theory

NHS Leadership Quality	Definition	Theoretical Alignment
Delivering the Service Cluster		
Leading Change through People	Communicating the vision and rationale for change and modernisation, and engaging and facilitating others to work collaboratively to achieve real change.	Transformational Theories Organisational Leadership Theories
Holding to Account	The strength of resolve to hold others to account for agreed targets and to be held accountable for delivering a high level of service.	Transactional Theories
Empowering Others	Striving to facilitate others' contributions and to share leadership, nurturing capability and long-term development of others.	Organisational Leadership Theories
Effective and Strategic Influencing	Being able and prepared to adopt a number of ways to gain support and influence diverse parties, with the aim of securing health improvements.	Influence Theories
Collaborative Working	Being committed to working and engaging constructively with internal and external stakeholders.	Trait Theories Behavioural Theories Influence Theories

The Qualities of the Personal Qualities Cluster were strongly aligned to Trait, Behavioural and Contingency Theories. A breakdown of the *Self Belief* Quality, for example, shows how the Quality was aligned to these multiple theoretical viewpoints:

> The inner confidence that you will succeed [Trait theory] and you can overcome obstacles to achieve the best outcomes [Behavioural theory] for service improvement [Contingency theory].

A further example is shown by the analysis of the *Self Awareness* Quality:

> Knowing your own strengths and limitations and understanding your own emotions [Trait theory] and the impact of your behaviour on others [Behavioural theory] in diverse situations [Contingency theory].

The Setting Direction Cluster has a widely ranging theoretical alignment, an example being the *Political Astuteness* quality:

> Showing commitment [Trait theory] and ability to understand [Behavioural theory] diverse interest groups and power bases within organisations and the wider community, and the dynamic between them [Influence theory], so as to lead health services more effectively [Contingency theory].

The Delivering the Service cluster has theoretical alignment to Trait, Behavioural, Influence, Transactional, Transformational and Organisational leadership theories. The *Collaborative Working* quality from the Delivering the Service cluster has alignment with Trait, Behavioural and Influence theories:

> Being committed [Trait theory] to working and engaging constructively [Behavioural theory] with internal and external stakeholders [Influence theory].

This analysis of the Framework shows that, on the evidence of the analysis of the Qualities against the Leadership Taxonomy, the Framework was most strongly aligned to Trait, Behavioural and Contingency theories, with some alignment to Influence, Transactional and Transformational theories. The literature analysis earlier in this chapter and the consideration of a number of healthcare leadership frameworks found that they were most strongly influenced by Trait, Influence, Contingency and Transactional theories. There was some alignment with Behavioural and Transformational theories. There was little to no alignment with Great Man, Culture and Organisational theories.

5.4 Conclusion

The strong alignment to Trait, Behavioural and Contingency theories would see the Framework positioned further back into earlier theory than the collective healthcare theoretical analysis and confirms Wood and Gosling's (2003) epistemological concerns. The Framework is also further from Yukl's (2013) definition of leadership that, "Leadership is the process of influencing others to understand and agree about

what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives" (p. 7).

Despite the shortcomings outlined, it remains difficult to determine that the NHS Leadership Qualities Framework (National Health Service, 2006) adopted by Queensland Health does not adequately describe the leadership characteristics required of healthcare executives. From the interpretivist research perspective, objective knowledge of the world is not necessarily fully accessible and there is not yet an establishment of 'probable' truth. That is, the understanding of leadership continues to grow and evolve and, whilst there may be individual perspectives of what truth is in relation to leadership, it is not possible to state confidently and definitively that Trait, Behavioural and Contingency theories of leadership, to which the Framework most strongly aligns, are 'not true'. This is particularly the case when the evidence from Crowder and Woods (2006) was that the Framework, when used in their organisation, was found to be a valuable tool that could be used to enhance and support leadership development. Additionally, Crethar, Phillips and Brown (2011) reported that the Framework was being utilised across Queensland Health to achieve improvements in workplace culture and ultimately improvements in clinical care and patient outcomes.

6 Chapter 6: Presentation of the data from the interviews with the identified healthcare executive leaders

6.1 Introduction

This chapter presents the data obtained from Research Phase 2 of the study. Research Phase 2 was primarily concerned with obtaining qualitative data that described, from the experiences of the participants, the influence that formal education has had on the leadership capability development of healthcare executive leaders in Queensland Health.

This chapter firstly identifies the executive healthcare leaders in Queensland Health who align more strongly with the characteristics of leadership, as defined by the NHS Leadership Qualities Framework (National Health Service, 2006), than others and who in fact may be considered to be exemplary leaders within the leadership context understood through the response to Research Question 1.

This chapter then presents the data obtained from the semi-structured interviews that were conducted with these exemplary executive healthcare leaders. The data obtained from the semi-structured interviews are presented as narrative re-constructions in this chapter.

6.2 Queensland Health leaders

The method used to identify the Queensland Health leaders was a survey administered through interview, as described in Chapter 4. The survey used single stage non-probability convenience sampling (3%) of a survey population of 500 executives from Queensland Health. The 14 respondents to the survey were invited to identify healthcare executives from within Queensland Health whom they considered as having leadership characteristics that aligned most strongly with the NHS Leadership Qualities Framework (National Health Service, 2006), hereafter referred to as the Framework. This approach drew upon Bennis' (1989) view that although leadership is hard to define, you know it when you see it. That is, that peers and colleagues would know who amongst them were exemplary leaders. As

confirmation, reference was made to 360^0 feedback surveys. Healthcare executives who were identified through the survey, and who agreed to participate in the research, were asked to provide their 360^0 feedback report data for cross-reference.

6.2.1 Survey process

There were 14 respondents from across Queensland Health who were surveyed through face to face interviews, as described in Chapter 4. The surveys were conducted with each survey respondent first being asked if they were familiar with the Framework, so as to ascertain if they were able to provide an informed opinion. All of the respondents reported that they were familiar with the Framework. Respondents were then asked to identify those whom they believed exhibited leadership qualities that most strongly aligned with the qualities of the Framework (these identified healthcare executive leaders being candidates for future participation in the study).

Figure 6.1 shows the results of the surveys. Respondents were identified and surveyed until it was determined that there were sufficient data to identify the healthcare executives who the respondents believed exhibited leadership qualities that most strongly aligned with the Framework. The total number of respondents surveyed was 14. Figure 6.1 shows that there were 19 healthcare executives nominated by the 14 survey respondents. Of the 19 healthcare executives nominated, one (shown by the graph as Candidate 1) was identified by 12 of the survey respondents, two (Candidates 2 and 3) were identified by 11 of the respondents, and two (Candidates 4 and 5) were identified by nine of the respondents as having leadership qualities that most strongly align with the Framework.

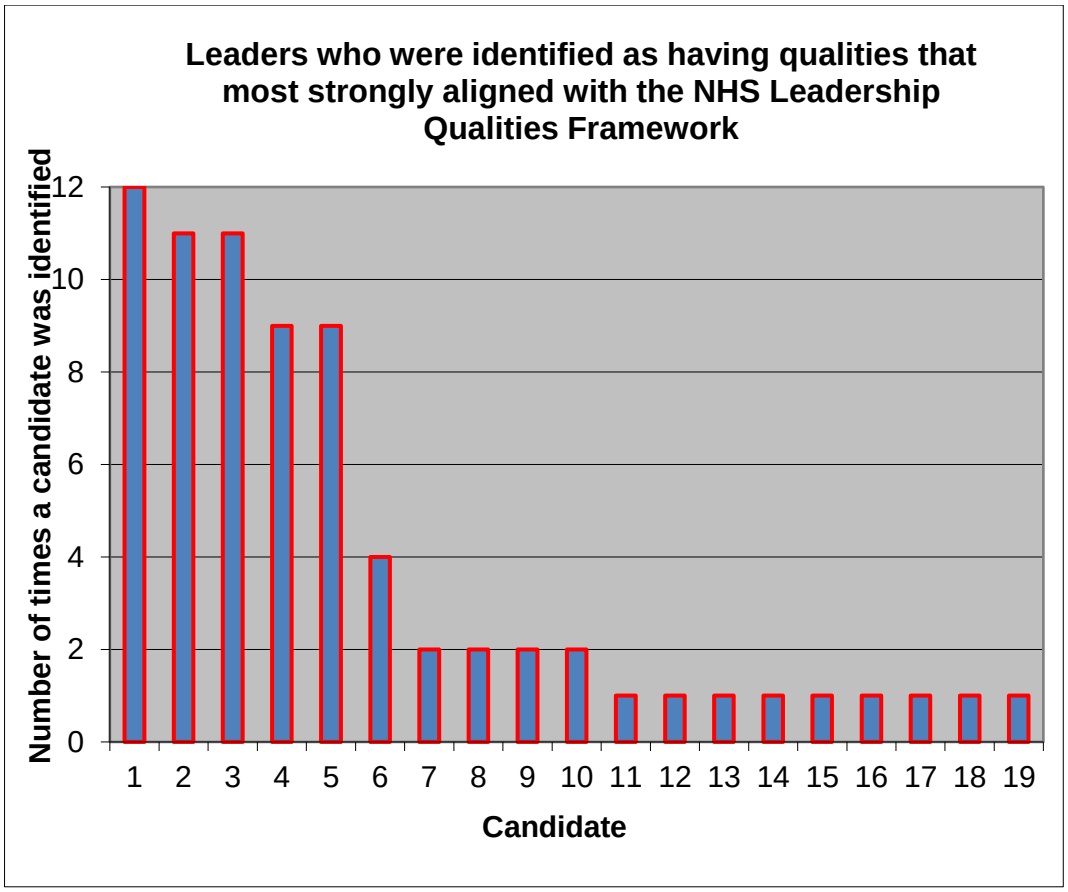

Figure 6.1: Queensland Health leaders who were identified as having qualities that align most strongly with the NHS Leadership Qualities Framework (National Health Service, 2006)

The interview survey results were charted at the completion of the 5th, 7th, 10th, 12th, and 14th interviews (not shown) to determine when the potential candidates could be clearly identified. After 14 surveys, five candidates had clearly emerged as being identified as leaders who exhibited leadership qualities that most strongly aligned with the qualities of the Framework. The cut-off at candidate five was determined as candidate six was identified as a leader by less than half of the survey respondents. Whilst five may be considered a small number of leaders to be the focus of the study, that is the number that were clearly identified through the selection methodology and a sample of this size is considered appropriate for an IPA approach (J. A. Smith et al., 2009). Whilst not a specific criteria, the five candidates also represented gender, discipline (medical and nursing) and geographical diversity.

The five identified candidates, who were given pseudonym names for the purposes of the study, were approached and provided with the Research Fact Sheet (please refer to Appendix E) and asked to participate in the study. All five agreed. The candidates who were identified as healthcare executive leaders and who exhibited leadership qualities that most strongly aligned with the Framework were:

1. Karen, the CEO of a Regional Health Service District and who has a nursing background
2. James, the CEO of a Metropolitan Health Service District and who has a medical/surgical background
3. Paul, the CEO of a Regional Health Service District and who has a medical/surgical background
4. Jane, the CEO of a Regional Health Service District and who has a nursing background
5. Mary, the Executive Director of Nursing and Midwifery for a Metropolitan Health Service District and who has a nursing background

The candidates were asked if they would be willing to provide their 360^0 leadership feedback report data and all five agreed.

6.2.2 Confirmation from the 360^0 feedback reports

When Queensland Health adopted the Framework, they also engaged the management consulting firm Hay Group to design and deliver a three stage leadership development program comprising of a residential workshop, 360^0 feedback process and executive coaching (Crethar et al., 2011). This leadership development program was known in Queensland Health as the Top 500 program as over 500 senior executives from across Queensland Health participated in the program. The five candidates, Karen, James, Paul, Jane and Mary, had all participated in the Top 500 program and therefore all had recent 360^0 feedback reports that directly related to the Framework.

The 360^0 feedback reports of the candidates were used as a form of confirmation of the survey respondents' opinions of the candidates' leadership capabilities.

Figure 6.2 is a summary of the 360^0 feedback reports for the five identified healthcare executive leaders. It can be seen from Figure 6.2 that all of the identified healthcare executive leaders scored highly on the 360^0 feedback dimensions, with all scoring 100% against almost all of the Framework Qualities.

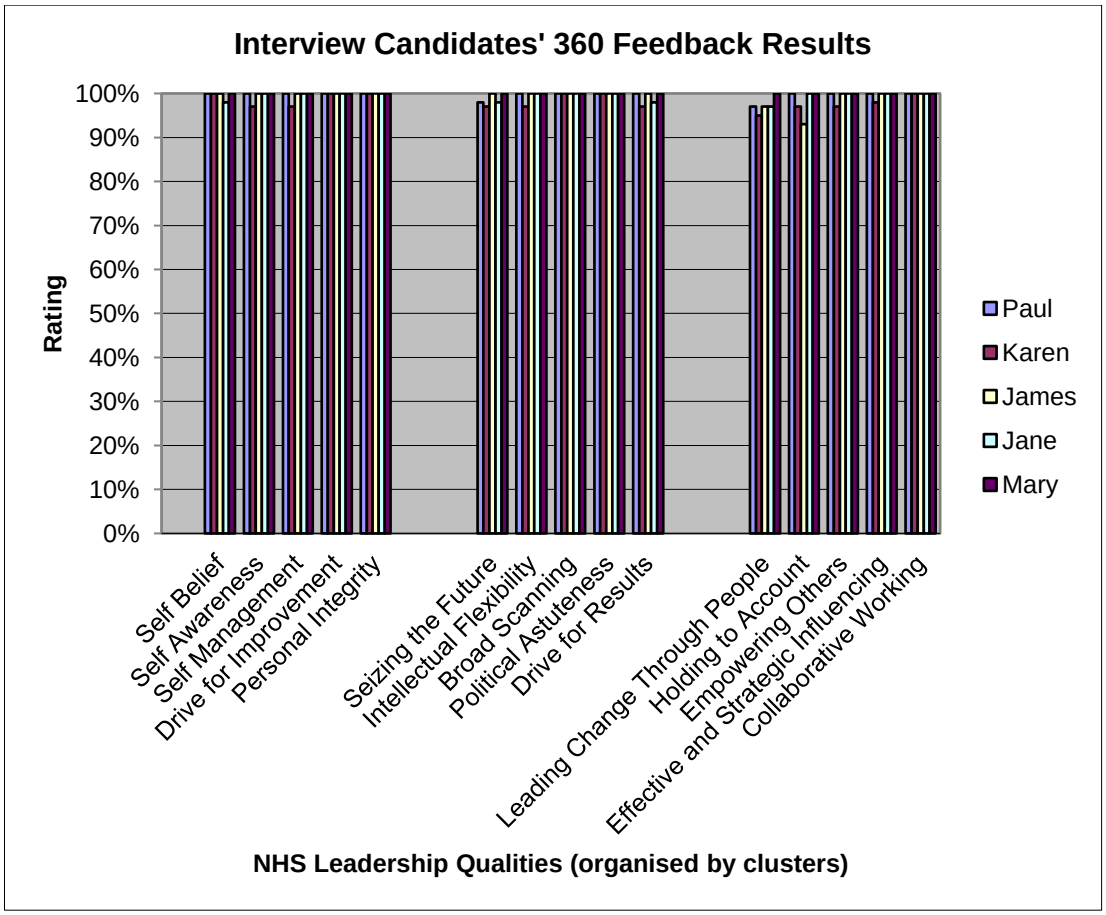

Figure 6.2: Interview candidates' 360^0 feedback results

Based on the results of the peer referral process and the 360^0 feedback reports, there was confidence that the five candidates identified to participate in the study were all healthcare executive leaders who had leadership characteristics that strongly aligned with the NHS Leadership Qualities Framework (National Health Service, 2006).

6.3 Data from the interviews

In this section of the chapter, the data from the interviews with the identified healthcare executive leaders, Karen, James, Paul, Jane and Mary, are presented. Using the notes and transcripts from the interviews, narrative reconstructions (Squire, 2008) are presented that capture the key and relevant information from each of the identified healthcare executive leaders. Each of the identified healthcare executive leaders interviewed was generous with personal information about themselves and their journey.

Two rounds of interviews were conducted and each interview is presented in this chapter as a narrative reconstruction. The first round of interviews focused on the identified healthcare executive leaders' leadership journey and their educational influences. The second round of interviews focused on their perceptions of the influence(s) that formal education have had on the development of their leadership qualities. For continuity purposes, the two narratives for each interviewed healthcare leader are presented consecutively. The NHS Leadership Qualities Framework (National Health Service, 2006) was used as the common construct of leadership within which the conversation of leadership was conducted. A limited number of examples of the researcher's reflective notes are included, where appropriate, to further illuminate aspects of the narratives.

Coding techniques were used to code the data obtained from the interviews with the identified healthcare executive leaders. At the conclusion of each narrative reconstruction is a presentation of the coded data. It should be noted that, as described in the methodology chapter, Chapter 4, the transcripts and notes from the interviews were coded using line coding, focused coding, axial coding and subsequently core categories and sub-categories developed. The core category and sub-category coding are shown in the data tables following each narrative reconstruction.

The data presentation for each identified healthcare leader follows the following format:

- a narrative reconstruction of the first interview which focused on their leadership journey and educational influences,
- some limited examples of the researcher's reflective notes,
- a data table of the first interview showing the core and sub category coding,
- a narrative reconstruction of the second interview which focused on the influence that formal education has had on the development of their leadership qualities, and
- a data table of the second interview showing the core and sub category coding.

To reintroduce the healthcare executive leaders who were identified through the survey and 360^0 feedback confirmation processes as having qualities that most strongly aligned with the Framework, the identified healthcare executive leaders were:

1. Karen, the CEO of a Regional Health Service District, has a nursing background
2. James, the CEO of a Metropolitan Health Service District, has a medical/surgical background
3. Paul, the CEO of a Regional Health Service District, has a medical/surgical background
4. Jane, the CEO of a Regional Health Service District, has a nursing background
5. Mary, the Executive Director of Nursing and Midwifery for a Metropolitan Health Service District, has a nursing background

6.4 Identified healthcare executive leader 1: Karen

Karen, the CEO of a Regional Health Service District, shared rich information about her background and experiences from her school days and early career through to the present.

6.4.1 Narrative re-construction: Interview 1 - leadership journey and educational influences

Karen's story of her leadership journey and educational influences started with her recollections of the influences of her schooling in England and she provided the comment "I think the influence of school is really important to the rest of your life". Karen enjoyed her Junior schooling and then, at the age of 11, she passed what in the English system is referred to as 11-plus, a form of admissions test. Passing 11-plus meant that Karen was able to go on to Grammar School.

Karen admits however that she was a "troublesome teenager" and she hated her Grammar schooling, wanting to leave as soon as possible. She took eight Ordinary Levels and got five through "a bit of swatting the night before" and decided to leave school at the age of 16.

Karen applied for a job at an engineering firm where, after she topped their entry assessment tests, they offered her a job as a trainee computer programmer. This was in 1976 and Information Technology was new then with "computers the size of rooms". Karen remembered quite well that the head of the department was a woman which as she said was "unusual" for 1976.

Karen found that in her job as a trainee computer programmer she "spent a lot of time on computers and not very much time interacting with people". She decided to go to evening school to complete her Ordinary National Certificate which she completed with a distinction.

> That sort of almost set the tone for the rest of my educational life, really, because the last time I studied full time was when I was 16 at school. The rest of my professional life, it's all been part time. I don't know how influential this is in your leadership, but I suppose what it does demonstrate is that you have to persevere really and be prepared to work at things outside of the normal hours. So I went to college in the evenings. I went to college three evenings a week between 16 and 18.

Karen's mother was a nurse and, despite saying to her mother as an angry five year old "if you think I'm going to be a nurse when I grow up you've got another thing coming", in her "heart of hearts" Karen knew nursing was what she wanted to do. So at 18, after completing her Ordinary National Certificate, Karen left her job and went to London to study nursing.

Karen enjoyed nursing and enjoyed interacting with and caring for people, a quality she has carried through to her current role as the Chief Executive Officer (CEO) for a large regional Healthcare District:

> If I think about my job now, the bit that I like best is to go out and talk to people. I think I'm relatively good at that. What I hate doing is sitting in an office doing paperwork. So when I've got a pile of signing to do, the executive support officer who works with me knows that if I head down the corridor I won't be back for an hour, because I'll find someone to talk to or go off and think - oh, I must go and just say hello to so and so.

Researcher's personal reflection: *Karen provided evidence of both a high academic achiever (IQ), through her references to obtaining her 11-plus and 'topping' the entrance tests to the engineering firm, and high Emotional Intelligence (EI)(Goleman, 1999), both from her 360^0 feedback results and her comments about her preference of interaction with people. The combination of high IQ and high EI is seen by Goleman (1999) as a contributing factor of leadership effectiveness. Goleman (2006) contends that "EI abilities rather than IQ or technical skills emerge as the discriminating competency that best predicts who among a group of very smart people will lead most ably."*

Karen was only part-way through her nursing program when she married a doctor and they left England for the USA where he took up a surgical residency. Karen now had an appetite for learning and she studied Biology part-time whilst working in the USA as a healthcare assistant. She enjoyed her study which she found academically challenging and which she did quite well at, "I was coming top of the class in a lot of things".

Unfortunately, after only a year in the USA, Karen had to give up her study once more as her husband wanted to return to the UK to pursue clinical research. Karen

resumed her career in England and also her nursing education which she completed successfully.

Karen was still looking for academic challenge and recommenced her studies in a Biology degree, part-time. Her professional interest as a nurse was in renal and urology and she found that Biology was a useful degree that complimented her work interest. This was the commencement of a phase of complimentary journeys of career and formal education for Karen.

As Karen was completing her nursing training, she recommenced her Biology degree. As she progressed through her degree, her career also progressed, being appointed as a Staff Nurse, Senior Staff Nurse and Sister. During this time she also completed a specialised Renal and Urology course. She then entered a period of her career where she did not undertake any formal education but she gained extensive practical experience in management roles and was President of a European association. Karen recommenced formal study by enrolling in a Masters of Business Administration (MBA). Halfway through her MBA, Karen was successful in obtaining a Director of Nursing position and then, after completing her MBA, she became Chief Nurse for the Department of Health in the UK.

Karen moved to Australia and took up a position as an Area Director of Nursing and was quickly promoted to Director of Clinical Operations before taking up her current role as Chief Executive Officer (CEO), completing an Institute of Company Directors Diploma in that time. Karen is currently considering commencing her Doctorate.

Table 6.1 presents the data coding of the first interview with Karen which was focused on her leadership journey and educational influences. The Table illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview. In Karen's example in Table 6.1, her narrative regarding her formal education experiences produced line coding of: Ordinary National Certificate in Business Studies; Nursing; Biology undergraduate degree; Specialist Renal and Urology course; MBA; and Company Directors course. These line codes were sub-

categorised as ‘Formal Education Courses’ and a number of related sub-categories, ‘Formal Education Processes’ and ‘Formal Education Insights and Influences’ were brought together under the category of ‘Formal Education’. This technique of coding enabled data from all the interviews with the identified healthcare executive leaders to be brought together under common sub-categories and categories for interpretation.

Table 6.1: Identified healthcare executive leader 1: Karen. Interview 1, leadership journey and educational influences

Core Categories

Core Category: Informal Learning

Informal Learning Experiences
As a nurse you are running wards and making decisions

Influences
School: School is really important to the rest of your life
School: Didn't do particularly well at school
Parents: Mother was a Nurse
Career: Enjoys interaction with people
Professional Networks: President of European association

Insights obtained informally
Need to be prepared to work at things after hours
Leadership is about people
Leadership is about being able to influence and being able to make decisions
Don't lose touch with reality

Core Category: Formal Education

Formal Education Courses
Ordinary National Certificate in Business Studies
Nursing
Biology undergraduate degree
Specialist Renal and Urology course
MBA
Company Directors course

Formal Education Processes
All study since leaving school has been part time
Was able to recommence study after a break
Part time degree in Biology

Formal Education Insights and Influences
Enjoyed academic challenge

Core Category: Career

Career Journey
Trainee computer programming at 16
Cost Management Accounting
Engineering Insurers
Considered Medicine but was easier for women to get into nursing at that time
Healthcare assistant
Senior staff nurse
Sister
Service Manager
Manager of Renal Unit
Director of Nursing
Department of Health
Director of Clinical Operations
Chief Executive Officer

6.4.2 Narrative re-construction: Interview 2 - formal education influences on leadership aligned to the Framework

The second interview with Karen focused on her perceptions of the influence that formal education has had on the development of her leadership qualities. The NHS Leadership Qualities Framework (National Health Service, 2006) was used as the common construct of leadership within which the conversation of leadership was conducted and the narrative reconstruction was organised around the Framework clusters.

Personal Qualities Cluster: *Self Belief, Self Awareness, Self Management, Drive for Improvement, Personal Integrity*

Karen identified her early formal educational experiences, and particularly junior school, as major contributors to the personal qualities of *Self Belief, Self Awareness* and *Self Management*:

> I think from a very early stage and the experience I had at junior school, which was my best educational experience in terms of building up my self belief, that I knew what I wanted and what I didn't want. That's why I found grammar school so difficult, because you were forced down paths which I didn't particularly want to pursue. So I think there's some of those personal qualities – *Self Belief, Self Awareness* and *Self Management* to a great extent – that all came out of those very early years of learning.

Karen also acknowledged her studies in Biology when she was in the USA as a contributor to *Self Management* "I found that I best understood myself and how I managed myself and my time when I was at the University of Colorado". She attributed this to the fact she was studying "hugely" working hard at a full time study load and working part-time as well.

When she returned to the UK she continued with her degree and, at the same time, post-graduate study:

> So I think there I learnt about *Self Management* because you could find the sort of boundaries of what you can expect of yourself and constantly pushing, pushing, pushing those boundaries. So I recognised where your priorities had to be in order to get success.

She recognised that some people never went through a degree in those days and that she could have got through her career without even doing a degree but she wanted to learn, "I wanted to constantly improve what I was doing through learning. So I think some of that *Drive for Improvement* certainly came through there".

She also acknowledged her MBA as some of the best education she had in contributing to the qualities of *Drive for Improvement* and *Personal Integrity*. She also found that the educational processes used in her MBA added to her educational experience, "I found with my MBA that I learnt as much from the other people in the course, who were from all walks of life".

Setting Direction Cluster: *Seizing the Future, Intellectual Flexibility, Broad Scanning, Political Astuteness, Drive for Results*

Karen was able to attribute much of the cluster of Setting Direction to her MBA:

> I found with my MBA that I learnt as much from the other people in the course, who were from all walks of life - from the post office, from all different walks of life – engineers who had their own companies - than I did from the course itself. The course itself gave me some rigors in terms of setting a strategic direction and giving me a better knowledge of finances, gave me the sort of foundations, but the most I learnt from the MBA was what I learnt from other people. That's around *Intellectual Flexibility*, really being able to take a concept and apply it in different ways. It was so obvious to me in that course how that happened. So I got the most *Intellectual Flexibility, Drive for Results*, scanning the horizon, from learning from others in particular. *Seizing the Future*, they're all areas that I got on the MBA. Would I have got where I have today without doing that, probably not.

Researcher's personal reflection: *Karen was making a connection here between content and process. That is, the MBA content was 'brought to life' through the educational process that facilitated discussion amongst course participants. As someone who enjoys interaction with people, this would have suited Karen as a process of learning.*

Karen also discussed how she felt her life had been guided by decisions made at a whole series of "crossroads" or "forks":

> I made decisions at particular forks that have led to other forks along the way. So some of the decisions I made right back when, to whether I stayed at school or not, have influenced my journey. If I'd have stayed at school, I may not have gone into nursing.

Karen also talked about her desire to be intellectually challenged and stimulated, which she found came from engaging with formal education:

> I like to be intellectually challenged. Although the job is challenging, it doesn't necessarily challenge me intellectually. I'm thinking to myself that I really do need that extra bit of challenge. I think if I look back - I haven't really thought about this - but if I reflect back, that's what I've constantly sought. I'm never satisfied with this bit; I always have to go and get that bit, as well.
>
> So I wasn't happy just doing nursing. I went off and tested the water in a degree. Yes, yes, I really like that, so carried on doing the degree in England. Then got the degree and carried on doing the degree while I was doing other things and carrying more qualifications. Then did some busy jobs, quite challenging jobs for a while and then when they settled down thought, alright, now I'm ready to do something else. Now I think okay, well now I'm ready to do a doctorate. I just feel like I need that intellectual stimulation.

Delivering the Service Cluster: *Leading Change through People, Holding to Account, Empowering Others, Effective and Strategic Influencing, Collaborative Working*

Karen attributed her MBA to the development of these qualities, “all of these very much fit into the MBA that I did” and her Institute of Company Directors course to the further development of *Holding to Account, Effective and Strategic Influencing* and *Empowering Others*.

She also acknowledged her nursing experience, and particularly her Ward Sister experience as contributing to the Delivering the Service cluster of qualities:

> When you nursed in the environment when I did it, that’s what you did. We didn't ever do management courses when you went to be a ward sister, because that’s what you did every day is that you managed. You managed patients or you managed staff and you grew and you grew and you grew without any formal education to support it. So I thought that I’d done quite a lot of management. I mean, if you manage a ward, you’re managing a half a million dollar business.
>
> So in terms of Delivering the Service, I mean, I think that I’ve been working in a service industry for the whole time, really. There’s no doubt, apart from when I was 16 to 18, but there’s no doubt that this is what drives you, about making sure that we deliver what we set out to deliver. So I think it’s interesting talking to you about it. It makes you realise just how much influence education’s had.

Table 6.2 presents the data coding of the second interview with Karen which was focused on the formal education influences on the development of her Leadership Qualities. Table 6.2 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.2: Identified healthcare executive leader 1: Karen. Interview 2, formal education influences on leadership qualities

Core Category: Formal Education

Formal Education Courses
Ordinary National Certificate in Business Studies in the evening
Nursing
Biology undergrad
Specialist Renal and urology course
MBA
Company Directors

Formal Education Processes
All study since leaving school has been part time
Able to recommence study after a break
Part time degree in Biology

Formal Education Influences
Enjoyed academic challenge

Formal Education influences on Leadership Qualities

Personal Qualities Cluster
Self belief: Influences from early experiences at school
Self Awareness: Influences from early experiences at school
Self Management: Influences from early experiences at school and when studying at University
Drive for Improvement: Wanting to improve through formal study
Personal Integrity: MBA a big influence by learning from other people

Setting Direction Cluster
Seizing the Future: From MBA
Intellectual Flexibility: Learning from others on the MBA
Broad Scanning: From MBA
Political Astuteness: From MBA
Drive for Results: From MBA

Delivering the Service Cluster
Leading Change through People: From MBA
Holding to Account: MBA and Institute of Directors Course
Empowering Others: MBA and Institute of Directors Course
Effective and Strategic Influencing: MBA and Institute of Directors Course
Collaborative Working: MBA

6.5 Identified healthcare executive leader 2: James

James, the CEO of a Metropolitan Health Service District, has a medical/surgical background. James was focused in his responses. He had read through the informed consent material prior to the interview and was pre-prepared with his responses and the information that he wanted to share. The interview highlighted that whilst the interviewer has some control over the questions and probing, the interviewee (quite rightly) has full control over their level of disclosure.

Researcher's personal reflection: *From interactions with James and Karen and the way that they had prepared for and participated in the interview process, it was evident that they had quite different personalities and leadership styles and yet both were identified by their peers and colleagues as being effective leaders. This highlights and reinforces the deficiencies of Great Man theories of leadership (refer to the Taxonomy of Leadership Theory, Table 3.1) in that attributes such as personality are not predictors of leadership effectiveness as leaders with quite different personalities can be highly effective.*

6.5.1 Narrative re-construction: Interview 1 - leadership journey and educational influences

At the commencement of the interview, James immediately nominated "ELDP 26, 2003 run by the OPSME" as the formal education experience that most influenced his leadership journey. The ELDP programs were a series of Executive Leadership Development Programs (ELDP) run by the Queensland Government's Office of Public Sector Merit and Equity (OPSME).

James described how the program consisted of two parts, the first part was a didactic approach whereby the participants were introduced to a suite of ideas and concepts of leadership based on the leading thinkers and authors of the time. The first week also focused on raising the participants' self-awareness and introduced concepts of learning theory and group dynamics. James also reported that during this first week he obtained insights on how to better work with people.

James described the second week (which was some time after the first) as having a much more psychological approach, where psychological pressure was applied to the participants by skilled facilitators who revealed to the participants aspects of

themselves that they had not explored before. James described the experience as positive “I really got a lot out of it – leadership is as much about knowing yourself”. It was the first time that James had been exposed to these models and “different paradigms of thinking”.

James’ education up to this point had been through a medical/surgical pathway. After completing his medical education and training, James undertook post graduate training in respiratory medicine. He then moved to the UK where he underwent sub-specialty training before becoming a transplant physician in his area of speciality.

James returned to Australia where he took up the posts as the Head of a transplant unit and as an Associate Professor of Medicine.

When he was at a metropolitan hospital, James participated in a corporate mentoring program and was mentored by a more senior and highly respected surgeon who had previously been a participant of the ELDP. As James started to take on clinical leadership roles, he was approached to be part of a Clinical Leadership Pathway and to undertake the ELDP for himself.

At about this same time, the Queensland Health Systems Review (Forster, 2005) was underway in Queensland Health with findings that included a greater emphasis on leadership capability for the Department. James had experience with some of the issues arising from the Queensland Health Systems Review (Forster, 2005) as he had been in the UK during the Bristol Infirmary Inquiry (2001) where he “saw examples of poor leadership”. James described the Queensland Health Systems Review (Forster, 2005) as “a carbon copy” of the Bristol Infirmary Inquiry (2001).

The combination of his experience in dealing with the issues raised through such an inquiry, his emergence as a clinical leader and his participation in the Clinical Leadership Pathway led to him coming to the attention of the Director General of the Queensland Health Department who asked him to take up the position of CEO at a major Queensland Hospital. He then became the CEO of a Queensland Health Service District despite what James described as “no health management training” but then went on to say that he had always been “collaborative by nature” and that

his formal leadership training had in many ways "affirmed things that he had already picked up on intuitively". An example he gave was that he had always tried to lead through influence rather than positional power and had found that was the best way to engage with people. He went on however, to say that his formal leadership education had given extension to his perspective that "it's not just about influence, it's about influencing with integrity".

> ***Researcher's personal reflection:*** *James may have been considered by the Director General as being the right person at the right time. Mayo and Nohria (2005) found that leadership success was not derived from the possession of certain personal characteristics but by the application of them within unique contextual settings – James' experiences and observations of the Bristol Infirmary Inquiry would have provided an appropriate context within which to consider the leadership challenges of Queensland Health at that time.*

James attributed his ELDP program with giving him practical leadership tools and techniques such as how to read and understand people through tools such as the Myers Briggs Type Indicator (Myers, 1980) and also insight into why some approaches he had tried in the past had not worked effectively.

James considered his medical training and could see how that had also contributed to his leadership development by giving him "the confidence to make decisions and reassess" and to "trust his instincts and intuition".

James finished the interview by sharing some of his personal informal learning about leadership, "Empowering people is a critical part of leadership. Back them if they make a mistake. I learnt that from Registrars who empowered me in that way. Get good people and then get out of the way".

Table 6.3 presents the data coding of the first interview with James which was focused on his leadership journey and educational influences. Table 6.3 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.3: Identified healthcare executive leader 2: James. Interview 1, leadership journey and educational influences

Core Categories

Core Category: Informal Learning

Informal Learning Experiences:
Learnt from experience in UK regarding how to deal with major health system crises

Influences
Mentoring: Participated in Corporate Mentoring program
Mentoring: Mentored by leading respected surgeon
Supervisor: Leading surgeon was an influence

Core Category: Formal Education

Formal Education Courses:
Medicine
Surgery
Safety and quality
Executive Leadership Development Program

Formal Education Processes:
Psychological approach
Skilfully facilitated
Practical approach

Formal Education Insights and Influences:
Opened thinking to different models of leadership
Raised self awareness
How to better work with people
Learning theory
Group dynamics
Leadership is as much about knowing yourself
Affirmed things that had been intuitive
Why approaches hadn't worked in the past
Fundamental to leadership journey
Positive experience
Improved confidence in decision making

Core Category: Career

Career Journey
Medicine
Surgery
Transplant physician
Advisor to the UK Dept of Health
Head of Transplant Services
Associate Professor of Medicine
Hospital Chief Executive Officer
Health District CEO

6.5.2 Narrative re-construction: Interview 2 - formal education influences on leadership aligned to the Framework

The second interview with James focused on the influence that formal education has had on the development of his leadership qualities. The NHS Leadership Qualities Framework (National Health Service, 2006) was used as the common construct of leadership within which the conversation of leadership was conducted and the narrative reconstruction is organised around the Framework clusters.

Personal Qualities Cluster: *Self Belief, Self Awareness, Self Management, Drive for Improvement, Personal Integrity*

James was once again quite clear and concise with his responses. When considering the quality of *Self Belief* he commented "Formal education provides positive reinforcement and with regards to *Self Belief*, building intellectual capability gives reinforcement to the sense of self and the belief you have in yourself to succeed". He also saw "definite benefits" of formal education in the development of *Self Awareness*, which he linked back to his experiences and learning from the ELDP. James saw that *Self Management* was "something concrete" that could be learnt and formal education contributes and influences that through the methods used in the formal education process. James reflected that he thought that the quality of *Drive for Improvement* was something that was "more inbuilt" as was *Personal Integrity* but he added that, with *Personal Integrity*, "formal education provides perspective" by opening up conscious thinking about issues such as integrity.

Setting Direction Cluster: *Seizing the Future, Intellectual Flexibility, Broad Scanning, Political Astuteness, Drive for Results*

When considering the Setting Direction Cluster, James thought that *Seizing the Future* was something that could be learnt through formal education "by analysing your internal frames of reference you can learn how to create your own future – you can learn optimism". With regards to *Intellectual Flexibility*, James put forward the argument that "formal education can reinforce issues associated with not being

intellectually flexible", that is, that formal education provides perspectives that expose the limitations of not being flexible in your thinking and the downsides of considering issues as purely black and white. James referenced a book he was currently reading to help make his point "I'm an avid reader of leadership books and articles, I'm currently reading Dee Hock's *Birth of the Chaordic Age* (Hock, 2000), you need to be flexible in your thinking to consider adopting new approaches to leadership".

James considered that the final three qualities in this cluster, *Broad Scanning, Political Astuteness* and *Drive for Results,* were not overly influenced by formal education. He thought that *Broad Scanning* was not something that was learnt and that *Political Astuteness* came more from experience and was somewhat intuitive. He viewed *Drive for Results* as something more of a personal, inbuilt characteristic.

> ***Researcher's personal reflection:*** *James expressed the view a number of times that, for him, some qualities were more inherent, in-built or intuitive (eg. Drive for Improvement, Personal Integrity, Drive for Results), perhaps reflecting a perspective that Traits contribute to leadership.*

Delivering the Service Cluster: *Leading Change through People, Holding to Account, Empowering Others, Effective and Strategic Influencing, Collaborative Working*

James was of the opinion that all of the qualities within the Delivering the Service Cluster were influenced through formal education.

> Knowing how to use and engage different change models can be learnt and that influences how you lead change, *Holding to Account* also comes through as does *Empowering Others* – the value of formal education comes through loud and clear, it also raises awareness of your own beliefs. You can learn how to influence more effectively though learning and using techniques such as neuro-linguistic programming and even *Collaborative Working*, which is more from experience, can benefit from learning structures and models.

Researcher's personal reflection: *Whilst Karen's leadership insights were formed through processes of interactions with others, James' leadership insights came more from processes of personal reflection and intellectual engagement with models and theories of leadership – reflective of different learning processes.*

Table 6.4 presents the data coding of the second interview with James which was focused on the formal education influences on the development of his Leadership Qualities. Table 6.4 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.4: Identified healthcare executive leader 2: James. Interview 2, formal education influences on leadership qualities

Core Category: Formal Education

Formal Education Courses:
Medicine
Surgery
Safety and quality
Executive Leadership Development Program

Formal Education Processes:
Psychological approach
Skilfully facilitated
Practical approach

Formal Education Insights and Influences:
Opened thinking to different models of leadership
Raised self awareness
How to better work with people
Learning theory
Group dynamics
Leadership is as much about knowing yourself
Affirmed things that had been intuitive
Why approaches hadn't worked in the past
Fundamental to leadership journey
Positive experience
Improved confidence in decision making

Formal Education influences on Leadership Qualities

Personal Qualities Cluster
Self Belief: Formal education provides positive reinforcement
Self Awareness: Definite benefits
Self Management: Concrete, can learn
Personal Integrity: Inbuilt but formal education gives perspective

Setting Direction Cluster
Seizing the Future: Can be learnt – learnt optimism
Intellectual Flexibility: Contributes, formal education can reinforce issues associated with not being intellectually flexible

Delivering the Service Cluster
Leading Change through People: Knowing how to engage different models, can be learnt
Holding to Account: Comes through
Empowering Others: Comes through clearly
Effective and Strategic Influencing: Can be learnt
Collaborative Working: More experiential but can learn structure and models

6.6 Identified healthcare executive leader 3: Paul

Paul, the CEO of a Regional Health Service District, was generous in his responses and shared personal reflections about his leadership experiences and influences from school age through to the present.

6.6.1 Narrative re-construction: Interview 1 - leadership journey and educational influences

Paul commenced his recollections by telling a story about an experience he had in Grade 8 at a regional State High School, "In Grade 8 I contracted Bell's Palsy [a form of facial paralysis that causes an inability to control the facial muscles on the affected side], I remember the teacher in charge of Grade 8 protected me and helped me deal with that situation and how others reacted to my condition". He went on to explain that he learnt that "people who are in leadership roles have the ability to help others and protect the vulnerable". He recollected that he attended a prefect camp at high school where he learnt the distinction between "policemen and leader". Another leadership influence in his early life was his father who was a minister in a church and who led a congregation and administered pastoral care to his parishioners.

After completing high school, Paul went on to University to study medicine. Whilst at university he dabbled in student politics, he reflected "I can look back at that time now and see the deficiencies I had in leadership".

After completing his medical training, Paul went on to specialise and became a leading surgeon in his field and a member of a Society of the Australasia and The Royal Australasian College of Surgeons. Paul was on the State Committee of the Society. He became treasurer of that society and wanted to take on the leadership role: "I've always had a sense of myself as a leader and wanting to take on leadership positions". However, he reflects now that others saw his leadership aspirations as him wanting control and power and he commented "people actually stopped me from getting the top position".

Paul became a Specialist Fellow and then became the Director of a surgical unit, "The Unit was going through a crisis. I could see the problem and wanted to try and solve it so I put my hand up to lead".

Paul undertook an organisational leadership program which was based on the NHS Leadership Qualities Framework (National Health Service, 2006) and this is when he first considered "leadership as something to learn". As part of this program he participated in a 360^0 feedback process which he described as of "great benefit in providing insight into leadership style" and team building activities which he described as being "great processes for getting to know people". He had no formal leadership training up to this point saying "surgery is all technical, there are some small group tutorials in medicine but surgery is mostly unconscious learning". He commenced an MBA and started to explore leadership in more depth.

Researcher's personal reflection: *Both James and Paul, who had medical/surgical backgrounds, had no formal leadership development through their medical/surgical careers and it was only as they approached senior organisational leadership roles that they engaged with some form of formal leadership development.*

He was appointed to the role of CEO of a major Queensland Health Service District and commenced that role whilst continuing his MBA. He also undertook business coaching at the time that he commenced in the CEO role and says he found himself in his new role as "being surrounded by people who are interested in personal development, who encourage reflection and learning". He describes this time as being his "leadership epiphany". He is continuing his leadership development journey as a journey of "continual leaning" and coming to terms with his identity as a leader (rather than solely as a surgeon).

> My surgical colleagues don't understand and think that I've gone to the dark side of becoming a bureaucrat. They see that management is something you only do when you're finished with surgery. The last couple of months I have been starting to deal with the enormity of my decision, I'm getting close to the point where I have to say I am not a neurosurgeon. I recently went to a meeting of the Neurosurgical Society and I remember standing there looking at my colleagues and thinking – I am different from you. Everybody was a

practising doctor in some way, shape or form. A lot of people said to me, Oh are you still in admin? That was very common. Are you still in admin? There's a notion in the medical world that leadership just is something you get by osmosis. So it was an interesting experience I did have - and I've not had it before - that I'm different. I thought it actually was that stark reality that I think differently for at least that cohort. I remember standing there and I looked around and I thought I feel very lonely here. I feel different. I think differently. I act differently from my colleagues. I think part of it is around learning and leadership, wanting to learn to be better et cetera versus hey I'm a powerful doctor and that's enough. So that was my reflection.

Researcher's personal reflection: *Paul's reflection echoes Eastman & Fulop's (1997) findings that many clinicians view engaging in hospital management as a waste of their highly developed skills and training and better left to others. They also found that clinicians feared that their collegial relationships with their peers will be compromised if they are seen to be aligning with management and taking on management responsibilities. Paul's experience* at the *Neurosurgical Society meeting and his questioning of his identity provides some insight into the dilemma faced by clinicians if they choose to move towards formal organisational leadership roles.*

Table 6.5 presents the data coding of the first interview with Paul which was focused on his leadership journey and educational influences. Table 6.5 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.5: Identified healthcare executive leader 3: Paul. Interview 1, leadership journey and educational influences

Core Categories

Core Category: Informal Learning

Informal Learning Experiences
Leadership aspirations seen by others as wanting control and power
Offered to lead Surgical Unit through a crisis
surgical training can involve unconscious learning

Influences
Parents: Father a minister
Teacher: Grade 8
Colleagues: Encourage reflection and learning
Colleagues: Management is not valued
Partner: Challenges thoughts
Coaching: Had coach when started CEO role
Networking: Surrounded by people who are interested in personal development and who encourage reflection and learning

Insights obtained informally
Sense of self as a leader and wanting to take on leadership positions
People who are in leadership roles have the ability to help others and protect the vulnerable
Leadership is enhanced through personal growth and development

Core Category: Formal Education

Formal Education Courses:
Medicine
Surgery
MBA
Top 500 program

Formal Education Processes
Team building as a process to get to know people
360 degree feedback process provides insight into leadership style

Formal Education Insights and Influences
Leadership development is a continuous leaning process
Risk of Leadership training is that it can be esoteric
Surgical training is technical
Organisational development is formal education
Programs can give opportunities to explore different approaches to learning
Exposure to leadership concepts through formal organisational program – led to desire to learn more

Core Category: Career

Career Journey
Medicine
Surgery
Head of Surgical Unit
Health District CEO

6.6.2 Narrative re-construction: Interview 2 - formal education influences on leadership aligned to the Framework

Paul's second interview was focused on the influence that formal education has had on the development of his leadership qualities. The NHS Leadership Qualities Framework (National Health Service, 2006) was used as the common construct of leadership within which the conversation of leadership was conducted and the narrative reconstruction is organised around the Framework clusters.

Personal Qualities Cluster: *Self Belief, Self Awareness, Self Management, Drive for Improvement, Personal Integrity*

When considering the Personal Qualities cluster and the quality of *Self Belief, Drive for Improvement* and *Personal Integrity* Paul stated "I've never had any issues with *Self Belief,* none at all. *Drive for Improvement, Personal Integrity*, always ticked off high for me". Paul then used his reflection on *Self Awareness* to consider the balance of the qualities:

> When you consider the cluster of qualities, it's not okay to be great in some and average in others, you actually have to have them all in balance, I didn't have a notion that it was a balance, so that for me is the benefit of formal education. Because formal education is, by definition, it's written, it's considered and it's impartial. Otherwise in our lives there is a risk that we just become a self-fulfilling prophecy.

Paul then chose to move away from the structure of considering the individual qualities and talked more broadly about the influence formal education, particularly his MBA, has had on the development of all of the qualities.

Setting Direction Cluster: *Seizing the Future, Intellectual Flexibility, Broad Scanning, Political Astuteness, Drive for Results*
Delivering the Service Cluster: *Leading Change through People, Holding to Account, Empowering Others, Effective and Strategic Influencing, Collaborative Working*

Paul reflected on the influence that formal education has had on his development as a leader:

> I think that for me leadership is both cerebral and heart and it's a lot of this stuff [referring to all the qualities]. To me that's your values. Your values are here [once more referring to the qualities] and your head should reinforce them, yes I do believe in this, and what it means. The risk I think without formal education is you don't know what you don't know. That for me has been my leadership epiphany, that whole focus on people and relationships and the importance of producing results through people. Because I used to take a very technical approach to producing results, the results weren't necessarily about taking people with you on a journey. The MBA was one of the best things that I ever did. It was great because it changed my thinking because I did go into my MBA with the idea that they'll give me a recipe book. They will tell me how to do the operation, the operation is running the district and they will give me the rules and the law and will keep me out of trouble, they'll tell me what to do. Nothing could be further from the truth of course. They just challenge you and give you notions. So no, I don't think I would have been anywhere near where I am now without the formal education of the MBA. That's assuming that where I am now is a good place to be.

Researcher's personal reflection: *Eastman & Fulop (1997) contend that those clinicians that take on management responsibilities and try to apply their medical paradigm and a scientific approach, when confronted with the political nuances and ambiguity of organisational management, find their skills are ineffective which leads to their frustration. Paul was able to recognise, through his MBA experience, that he required a new approach and a new set of skills.*

Paul summarised his thoughts on formal education and its influence on the development of his leadership qualities by referring to the concept of looking at the world through different lenses or perspectives (a concept he was introduced to through his MBA):

> So for me formal education - to get back to the point of your thesis - is really important because to me formal education puts up to you an impartial lens. That you can dip into the well and drink if you wish. You can challenge your

> own notions if you wish or you can surround yourself with people who will tell you what you think and you will be forever in your own mental model reinforcing type of world. That's what I think the value of formal education is about.

Table 6.6 presents the data coding of the second interview with Paul which was focused on the formal education influences on the development of his Leadership Qualities. Table 6.6 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.6: Identified healthcare executive leader 3: Paul. Interview 2, formal education influences on leadership qualities

Core Category: Formal Education

Formal Education Courses:
Medicine
Surgery
MBA
Top 500 program

Formal Education Processes
Team building as a process to get to know people
360 degree feedback process provides insight into leadership style

Formal Education Insights and Influences
Leadership development is a continuous leaning process
Risk of Leadership training is that it can be esoteric
Surgical training is technical
Organisational development is formal education
Programs can give opportunities to explore different approaches to learning
Exposure to leadership concepts through formal organisational program – led to desire to learn more

Formal Education influences on Leadership Qualities

Personal Qualities Cluster
Self Awareness: Benefit in realising this is important
Self Management: MBA

Setting Direction Cluster
Seizing the Future: MBA
Intellectual Flexibility: MBA
Broad Scanning: MBA
Political Astuteness: MBA
Drive for Results: MBA

Delivering the Service Cluster
Leading Change through People: MBA
Holding to Account: MBA
Empowering Others: MBA
Effective and Strategic Influencing: MBA
Collaborative Working: MBA

6.7 Identified healthcare executive leader 4: Jane – data presentation

Jane, the CEO of a Regional Health Service District, shared her experiences at school through to the present time.

6.7.1 Narrative re-construction: Interview 1 - leadership journey and educational influences

Jane's story of her leadership journey and educational influences started with her recollections of growing up on a farm the eldest of seven children and the eldest of her entire cohort of cousins. She felt the expectation to behave, set an example and "do the right thing". "From an early age I remember I was good at organising things and people" she commented. She was strongly influenced by her family values "contribute to society, the importance of family, not making judgements, sharing and fun". In primary school she was the youngest in her class and had to repeat Grade 8 but she enjoyed learning and gaining knowledge. She considers herself to have an extroverted personality and she has a sense of 'self belief' from her upbringing. She completed Junior but not Senior, which she said was common for girls at that time and she went into nursing as a student nurse.

> ***Researcher's personal reflection:*** *Karen, Paul and Jane all chose to commence their leadership story by reflecting on childhood and adolescent experiences. This corresponds with Bass and Bass'(2008) contention that leadership development is influenced by a number of early environmental factors such as family influences and opportunity in childhood and adolescence.*

Even at that time she was "prepared to step up and take a leadership role" becoming the student nurse representative on the Nurses Union in a regional town in Queensland. In her early twenties she was seen as someone who was sensible, logical and who could be relied upon to "do the right thing" although that could sometimes be interpreted differently by others, "I perhaps could be seen by some people as being judgemental and I got feedback from someone who said I was not empathetic". She was prepared to step up and take on leadership roles "I enjoy working with

people and can see that the ends sometimes don't justify the means and I wanted to do right by people". She had a strong work ethic and wanted to lead by example. As a student nurse she worked hard to impress and emulate her nurse tutors/educators but had a negative experience with one nurse educator who she perceived as a "know it all". She talked with this person about her feelings even though she "does not find having difficult conversations easy".

She found herself "driven by a need for improvement" and would seek out opportunities to make improvements in her workplace so things would run more efficiently and was particularly interested in quality improvements that contributed to patient safety.

After completing her nursing training, she went back to school to complete her Adult Senior. She started to think about management roles and went on to study a Diploma of Applied Science in Ward Unit Management through the Queensland University of Technology (QUT).

> We had good interactive conversations, including conversations on the theory of nursing and I enjoyed the discipline of writing assignments. I found that education changes people's career direction because the Diploma led to me being in charge of a Birth Suite.

Jane then became, as she called it, "bitten by the education bug". She commenced a Bachelor of Nursing Administration which was distance education but where she still got together with the other students for block periods, explaining that "My degree opened up new ways of thinking for me but the process was important as well. We were exposed to different viewpoints through conversations and were able to consolidate our workplace experiences".

Jane is of the belief that "education gives people options" and she was successful in becoming a Director of Nursing whilst completing her degree. She went on to complete a Masters of Health Administration through the University of NSW. There was a lot of workplace change during this period and Jane felt that the "topics were particularly relevant". She commented "I was unconsciously competent in a lot of areas of leadership and management but formal education gives you conscious competence". She became a District Manager and completed a Graduate Certificate

in Leadership where she learnt the importance of relationships with regard to leadership and the value of learning through reflective practice. She is currently the CEO of a regional Health Service District in Queensland.

Researcher's personal reflection: *Jane's discussion on how her career and formal learning experiences were influencing one another was not dissimilar to reflections from the other interview participants. A theme of influence between formal education and career emerged from the data which, although not initially an area of inquiry, is explored in Section 6.9 and further in Chapter 6.*

Table 6.7 presents the data coding of the first interview with Jane which was focused on her leadership journey and educational influences. Table 6.7 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.7: Identified healthcare executive leader 4: Jane. Interview 1, leadership journey and educational influences

Core Categories

Core Category: Informal Learning

Informal Learning Experiences:
Prepared to stand up and take leadership role
Leadership positions, Student Nurse Union
Do right by people
The ends don't justify the means
Being the person to lead
Does not find difficult conversations easy
Seen as an informal leader through the willingness to volunteer and contribute

Influences
Family: Eldest of seven children. Expectations to set example, lead, organise.
Family: Values – Do the right thing, Contribute to society, Importance of family, Do unto others, Sharing, Not making judgements, Fun
School: Youngest in class, enjoy gaining knowledge/information
Mentors: Encouraged further study
Colleagues: One executive who was exceptional, engaged in active reflection

Core Category: Formal Education

Formal Education Courses
Nursing
Adult education, Senior
Dip Applied Science Ward Unit Management
Bachelor of Administration - Nursing
Masters of Health Administration
Grad Cert in Leadership

Formal Education Processes
Discipline of writing assignments
Enjoyed conversations relating to theory of nursing
Education sponsored by Hospital
Experiential, learning while you do reflective practice

Formal Education Insights and Influences
The importance of relationships, data and information
Education gives you conscious competence
Education can change people's career direction
Formal education provides new ways of thinking
Education gives people options

Core Category: Career

Career Journey
Nursing
Nurse Unit Manager Birthing Suite
Director of Nursing
District Manager
Hospital Chief Executive Officer
Health District CEO

6.7.2 Narrative re-construction: Interview 2 - formal education influences on leadership aligned to the Framework

The second interview with Jane focused on the influence that formal education has had on the development of her leadership qualities. The NHS Leadership Qualities Framework (National Health Service, 2006) was used as the common construct of leadership within which the conversation of leadership was conducted and the narrative reconstruction is organised around the Framework clusters.

Personal Qualities Cluster: *Self Belief, Self Awareness, Self Management, Drive for Improvement, Personal Integrity*

Jane considered each of the qualities in the Personal Qualities Cluster and, with regards to the quality of *Self Belief,* commented that as a woman growing up in the late 40's she did not go on to University from school and in fact did not even complete Senior schooling until a little later in life, so when she did attend University she found "that I could compete in that environment was good for my self belief and that's not an uncommon thing for women of my age". She reflected that doing well at formal education can challenge societal thinking about women and their contribution in a positive way. When considering the influence of formal education on *Self Awareness*, Jane said that "formal education made you a bit more consciously competent or 'consciously aware' of some things that you didn't think too much about" and that "university teaches you to think about thinking". She went on to comment on the benefit of reflective practice and how reflective practice, combined with greater conscious awareness of better ways of doing things, can contribute to improved outcomes. For the quality of *Self Management*, Jane commented "I don't know that it [formal education] did a lot for me. I think there's an area that I have to constantly work on – it's a shame I couldn't blame education for that".

> ***Researcher's personal reflection:*** *Janes' reflection of the influence of formal education in developing self-belief for women is worthy of note as she is one of many female CEOs in the healthcare sector, most of whom have nursing backgrounds and who may have had a similar educational journey as Jane. The self-belief obtained through formal education and the practical management experiences of running wards would have positioned these women well and given them the self belief, confidence and skills to assume higher executive roles.*

Jane did see an influence on *Drive for Improvement* from her formal education experiences through the competitive component of studying and striving for grades. For the influence of formal education on the quality of *Personal Integrity*, Jane felt that "it might do for some people, but I would have thought my personal integrity was there very early in the piece. That's something my parents probably have most to do with and people that were there in my life".

Setting Direction Cluster: *Seizing the Future, Intellectual Flexibility, Broad Scanning, Political Astuteness, Drive for Results*

When considering the quality of *Seizing the Future*, Jane reflected "I think education makes a big difference to people" and that we need to "skill people up" for change, commenting that education "gives opportunities and opens doors". For *Intellectual Flexibility*, Jane said:

> If I look at my own experience, I think it certainly did challenge me with other ideas and I think that's good. I think the more you're able to listen to other people's ideas it certainly influences you as a leader and you're going to do it better if you can actually listen to other people's ideas. You don't always do that, because you can get caught up in the moment sometimes, but no, I think university does do that to say, what?, maybe that's not the only way to think about this.

Jane's thoughts on *Broad Scanning* were that it was something that universities do quite well, "They teach you to go and look for information, that's one of the major things universities do to teach you to seek out information and how to go and find information for yourself, rather than just this topic. It's about looking around".
On the quality of *Political Astuteness*, Jane commented that, for her, with university life came the opportunity to talk to people with various other experiences and to be exposed to other people's ideas and their political thoughts. Jane also noted "certainly during my masters we had a whole subject which was about political awareness, which was a communication topic about small politics and big politics and how you can apply them to a leadership role". Jane linked the final quality in this cluster,

Drive for Results, back to the competitive nature of formal education in some ways as being similar to *Drive for Improvement*.

Delivering the Service Cluster: *Leading Change through People, Holding to Account, Empowering Others, Effective and Strategic Influencing, Collaborative Working*

Jane considered the quality of *Leading Change through People* and commented:

> I think it did initially probably make some difference when I was doing my diploma, because that was fairly new. What was it, the freezing and unfreezing of people, that was all quite new. I had intuitively done things where change went well and some went appallingly badly, so some theory there I think was helpful. Being introduced to the theory, you can have some approach to it and a framework that was useful.

Jane thought that the qualities of *Holding to Account, Empowering Others* and *Effective and Strategic Influencing* were much less influenced by her formal education, being influenced by other factors such as work experiences.
For the quality of *Collaborative Working* Jane responded:

> To some extent, I've done some joint topics. They're not my favourite things, because I don't mind the group work at all, it's the deadline with the team that I feel under some pressure about, that you don't want to let a team down, but I think that's a very good teaching.

Table 6.8 presents the data coding of the second interview with Jane which was focused on the formal education influences on the development of her Leadership Qualities. Table 6.8 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.8: Identified healthcare executive leader 4: Jane. Interview 2, formal education influences on leadership qualities

Core Category: Formal Education

Formal Education Courses
Nursing
Adult education, Senior
Dip Applied Science Ward Unit Management
Bachelor of Administration - Nursing
Masters of Health Administration
Grad Cert in Leadership

Formal Education Processes
Discipline of writing assignments
Enjoyed conversations relating to theory of nursing
Education sponsored by Hospital
Experiential, learning while you do reflective practice

Formal Education Insights and Influences
The importance of relationships, data and information
Education gives you conscious competence
Education can change people's career direction
Formal education provides new ways of thinking
Education gives people options

Formal Education influences on Leadership Qualities

Personal Qualities Cluster
Self Belief: Doing well at Formal education can challenge societal thinking about women and their contribution in a positive way
Self Awareness: Education helps you to become consciously competent of your abilities
Drive for Improvement: The competitive component of studying and striving for grades contributes

Setting Direction Cluster
Seizing the Future: A catalyst, education gives opportunities and opens doors
Intellectual Flexibility: Challenge us with other ideas
Broad Scanning: Done quite well by Universities
Political Astuteness: Exposure to other peoples political thoughts and ideas and knowledge and insight from subjects. There is more than right and wrong – there is politics
Drive for Results: Comes from the competitive nature of formal education

Delivering the Service Cluster
Leading Change through People: Theory and models are useful
Collaborative Working: Working on a group project with a team with deadline pressure

6.8 Identified healthcare executive leader 5: Mary – data presentation

Mary, the Executive Director of Nursing and Midwifery for a Metropolitan Health Service District did not share information about her early life and was focused on the learnings and reflections of her formal education experiences during her career.

6.8.1 Narrative re-construction: Interview 1 - leadership journey and educational influences

Mary commenced her conversation about her journey at the point of when she started her nursing education "nursing required an educational program and I loved learning, loved the educational side of things". Eighteen months after completing her general nursing training, Mary was selected to do further training in Mental Health. After being a Mental Health nurse for a short time, Mary did a Diploma of Nursing Education and became a Nurse Educator. She left her education role to take up a leadership position as Assistant Nursing Director of Mental Health. At this same time Mary undertook a Bachelor of Arts with a Major in Political Science. Mary's interest in mental health also led her to undertake training in psychotherapy where she learnt to "know yourself, know your strengths". She held a number of leadership roles in major hospitals in Queensland and at one time also moved briefly to private practice in psychotherapy. Whilst in one of her leadership roles with Queensland Health, Mary developed one of the first Post Graduate programs in Mental Health run through the School of Nursing. Mary was also on the Board of Nursing Studies which accredited nursing programs. Mary expressed her passion for education and recounted a story where she needed to influence her peers to adopt a new program:

> I knew the program I wanted to implement was important, it would give credibility to Mental Health nurses. I had to be confident and courageous and I felt I was competent to do so. There was a major awards ceremony at the Hilton and all the establishment was there and I knew that was my opportunity to influence the debate and put the case forward for the program.

She went on to add, “success is important, wins are important”. Mary went back to Nurse Education in Queensland Health in the early 1990s and also taught the Graduate Diploma in Mental Health through a Queensland University. Mary then commenced a Masters of Health Management before taking up a role of Executive Director of Mental Health at a regional hospital, then the Executive Director of Women’s and New Born at a metropolitan hospital and then her current role as Executive Director of Nursing at a large metropolitan hospital in Queensland. Mary is currently completing a doctorate where she is exploring the roles of Nurse Unit Managers as pivotal leaders in the healthcare system. Part of her philosophy as a leader herself is that she believes that “you need to give people the required skills when they transition into leadership roles”, that “leadership does better being taught by leaders within the culture” and that you need to “work with your strengths – become exceptional”.

Mary has always endeavoured to build a legacy for the nursing profession for the future:

> I believe that so many wonderful leaders in nursing created the paths that we now walk. I’m so grateful they did that. For us not to clear a path for our more junior leaders coming through would just be cruel, that they couldn’t experience this great joy of our profession.

Table 6.9 presents the data coding of the first interview with Mary which was focused on her leadership journey and educational influences. Table 6.9 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.9: Identified healthcare executive leader 5: Mary. Interview 1, leadership journey and educational influences

Core Categories

Core Category: Informal Learning

Influences
Networks: Private practice networks

Core Category: Formal Education

Formal Education Courses:
Nursing
Diploma of Nursing Education
Masters of Health Service Management
Bachelor of Arts
Psychotherapy

Formal Education Insights and Influences:
Nurse Unit Manager group pivotal leaders in healthcare system
Need to give people the required skills when they transition to leadership roles
Work with your strengths – become exceptional
Know yourself – know your strengths
Success is important. Wins are important

Core Category: Career

Career Journey
Nursing
Nurse Educator
Assistant Nursing Director
Executive Director Mental Health
Executive Director Womens and New Born
Executive Director Nursing

6.8.2 Narrative re-construction: Interview 2 - formal education influences on leadership aligned to the Framework

Mary's second interview was focused on the influence that formal education has had on the development of her leadership qualities. The NHS Leadership Qualities Framework (National Health Service, 2006) was used as the common construct of leadership within which the conversation of leadership was conducted and the narrative reconstruction is organised around the Framework clusters.

Personal Qualities Cluster: *Self Belief, Self Awareness, Self Management, Drive for Improvement, Personal Integrity*

Mary held the view that formal education had an influence on her *Self Belief,*

> They [people who participate in formal education] can in fact test not only their intelligence but their persistence to finish a course, whatever the course may be. So I think education can very much add to your self belief, that you've demonstrated that you can achieve in the academic area.

She also linked *Self Awareness* to her formal education in Psychotherapy, "for me a great deal of my self awareness came through my formal training in psycho-dynamics". As part of her formal training she would meet with a supervisor who would encourage her to reflect on her practice and ask her reflective questions such as "What were you hoping to achieve?", and "Where was this coming from within you to be asking that sort of question or making that sort of comment?".

Mary saw *Self Management* as a continuous journey, to which formal learning contributes, "There is no greater subject for a leader than self management. How you manage yourself and where you put your time, energy, your focus, is all about the priorities you set as a person, as a leader. So there is never an end to the self management learning". Mary's comments on the quality of *Drive for Improvement* reflected her passion for learning and how it has contributed to her leadership journey:

> I did nursing obviously and then I did mental health education. I certainly remember my first tutorial at University of Queensland, when I was doing my

> Bachelor of Arts. I think almost from that day and certainly during nursing also, but just that environment that was all about this wonderful knowledge, this new knowledge and how it affects your world view and therefore affects what you believe you can achieve. So I see education, it's always been a companion. If I'm not doing something formally, I would read a number of books every week or at least a book a week on leadership or on self improvement or management or whatever. I see a nexus that I can't tease out from what made me a leader because education if you like has always been my companion.

Mary had an interesting perspective on the contribution of formal education to *Personal Integrity,* "I think that it can feed into your integrity of identifying that this is what you should stand up for, I think I would have learnt a great deal about my integrity along the way in my education processes".

Setting Direction Cluster: *Seizing the Future, Intellectual Flexibility, Broad Scanning, Political Astuteness, Drive for Results*

Mary linked the development of all of the qualities in the Setting Direction Cluster to formal education. For the quality of *Seizing the Future,* she thought that formal education "creates a knowledge base of how the future should look". Mary considered that formal education contributes to the quality of *Intellectual Flexibility* by "opening windows" for us to consider different ways of thinking about issues. When thinking about the quality of *Broad Scanning,* Mary thought that formal education "gives you the tools of knowledge and also the way of thinking". Political Science was Mary's major when she did her Bachelor of Arts, so she was clear that formal education, for her, had a major influence on the quality of *Political Astuteness* "for me my education was so important for political astuteness, understanding the public administration side of government and where I fit in that. I think my education is an absolute hand in glove". For the final quality in this cluster, *Drive for Results,* Mary commented, "Education teaches you there's good time for talking, then you've got to focus your thinking and get results".

Delivering the Service Cluster: *Leading Change through People, Holding to Account, Empowering Others, Effective and Strategic Influencing, Collaborative Working*

Mary thought that formal education has supported her in the quality of *Leading Change through People* "Education has supported me being able to do that, education gives you credibility, content and processes for success". She was quite clear about formal education's influence on *Holding to Account* that "There's not much better than the educational process that teaches you to hold to account". For the quality of *Empowering Others*, Mary thought that formal education gives you the way to think, the way to behave and the knowledge base required to influence and empower others and went on to link to the quality of *Effective and Strategic Influencing*:

> I think your strategic influencing and sorry if it's a little repetitive, but it's related to that again you scan the horizon of knowledge and worked on your skills so that you've got that vision. Through your relationships with people where they feel empowered, able to walk with you, that you're able to influence them about your strategic direction which is heading towards your vision. So again I think it's about gathering all of the information, all of the pieces of information. I always talk about there's lots of white noise. So when you're scanning the horizon what am I really going to focus on. What's going to be the pathway I'm going to cut out? I think that comes again from our studies as scholarship teaches you, you could read books - you know how you read an assignment. You read a thousand books and then you think I've got too much information, too much white noise. I've now got to come down and write something.
>
> I think that's what the education process does for you, it gets you to think, so you focus on your strategic planning. Through that I think you encapsulate often other people's ideas and they're happy to walk with you. So I think that's how you can influence others.

When considering the quality of *Collaborative Working*, Mary reflected "I'm not sure the education process in of itself is all about collaboration. In fact it's probably based

on a fair amount of competition", however she went on to say that "education can teach you things that allow you to be more collaborative".

Table 6.10 presents the data coding of the second interview with Mary which was focused on the formal education influences on the development of her Leadership Qualities. Table 6.10 illustrates examples of the line coding, coding sub-categories and category coding obtained through the application of the coding techniques to the raw data obtained from the interview.

Table 6.10: Identified healthcare executive leader 5: Mary. Interview 2, formal education influences on leadership qualities

Core Category: Formal Education

Formal Education Courses:
Nursing
Diploma of Nursing Education
Masters of Health Service Management
Bachelor of Arts
Psychotherapy

Formal Education Insights and Influences:
Nurse Unit Manager group pivotal leaders in healthcare system
Need to give people the required skills when they transition to leadership roles
Work with your strengths – become exceptional
Know yourself – know your strengths
Success is important. Wins are important

Formal Education influences on Leadership Qualities

Personal Qualities Cluster
Self Belief: You can demonstrate that you can achieve in the academic area and test yourself
Self Awareness: Self awareness came through formal training
Self Management: Continuous journey to improve focus and priorities
Drive for Improvement: Education as a companion that supports a drive for improvement
Personal Integrity: Education feeds into integrity by identifying what it is you should stand up for

Setting Direction Cluster
Seizing the Future: Knowledge from education can give you a base of how the future should look
Intellectual Flexibility: Formal education opens windows for us to consider different ways of thinking about issues
Broad Scanning: Formal education gives you the tools of knowledge and also the way of thinking
Political Astuteness: Education was important for political astuteness
Drive for Results: Education teaches you there's good time for talking, then you've got to focus your thinking and get results

Delivering the Service Cluster
Leading Change through People: Education has supported me being able to do that, education gives you credibility, content and processes for success
Holding to Account: There's not much better than the educational process that teaches you to hold to account
Empowering Others: education gives you of the way to think, the way to behave and the knowledge base
Effective and Strategic Influencing: Gather other people's views and ideas and they are happy to follow you
Collaborative Working: The education process is not of itself collaborative but it can teach you things that allow you to be collaborative.

6.9 Summary

In this chapter five healthcare executive leaders who had leadership qualities that strongly aligned with the NHS Leadership Qualities Framework (National Health Service, 2006) were identified. These identified healthcare executive leaders were interviewed to provide data to inform the response to Research Question 2. Narrative reconstructions of the data obtained from interviews with the identified healthcare executive leaders of Queensland Health have been presented together with tables of the coded interview data.

In the following chapter, Chapter 7, the data obtained from the identified healthcare executive leaders is analysed and interpreted.

7 Chapter 7: Interpretation of the data from the identified healthcare executive leaders

7.1 Introduction

This chapter presents the findings from Research Phase 3 of the study. In Research Phase 2 the five identified healthcare executive leaders were interviewed to ascertain their experiences of formal education and how, or if, formal education had contributed to the development of their leadership qualities. In this chapter the data obtained from the interviews with the identified healthcare executive leaders is analysed and interpreted to provide a substantial response to Research Question 3 which is re-stated here for convenience:

RQ3. What conceptual model of pedagogical approach can inform the development of leadership capability for healthcare executives?

This chapter presents, through the analysis and interpretation of the data, evidence that the formal educational experiences of the identified healthcare executive leaders had contributed towards their capacity to gain a more accurate and deeper understanding of the qualities required of leadership. This understanding in turn has aided their ability to demonstrate required leadership qualities in the workplace. The chapter presents evidence that the development of this leadership capability was an outcome of the interrelationship of factors in a dynamic system of learning.

7.2 Evidence of the influence that formal education has had on the leadership development of the identified healthcare executive leaders in Queensland Health

In this section of the chapter the data from the interviews with the identified healthcare executive leaders in Queensland Health have been analysed and interpreted to provide evidence of the influence that formal education has had on the development of their leadership qualities.

A summary view as to whether there was evidence obtained from the identified healthcare executive leaders that formal education had an influence on the development of their leadership qualities is presented in Table 7.1. This summary precedes the fuller analysis of the data and presentation of the evidence. Where there is no data recorded against a particular quality for an identified healthcare executive leader in the summary, that cell has been left blank and indicates that the identified healthcare executive leader either chose not to comment on the influence of formal education on the development of that quality or that they reported that their formal education experiences did not significantly contribute to the development of the quality. An example being James' reflection on the influence of formal education on the quality of *Drive for Improvement* where he thought that, for him, the quality was something that was "more inbuilt". So, whilst that data has been captured and noted in the narrative reconstructions, it has not been included here as the focus of this chapter is the influence that formal education has had on the development of the identified healthcare executive leaders' leadership qualities.

Table 7.1: Evidence of the influence of formal education on the development of leadership qualities

			Interview Subjects				
			Karen	**James**	**Paul**	**Jane**	**Mary**
Qualities	**Personal Qualities**	**Self Belief** The inner confidence that you will succeed and you can overcome obstacles to achieve the best outcomes for service improvement.	Evidence	Evidence		Evidence	Evidence
		Self Awareness Knowing your own strengths and limitations and understanding your own emotions and the impact of your behaviour on others in diverse situations.	Evidence	Evidence	Evidence	Evidence	Evidence
		Self Management Being able to manage your own emotions and be resilient in a range of complex and demanding situations.	Evidence	Evidence	Evidence		Evidence
		Drive for Improvement A deep motivation to improve performance in the health service and thereby to make a real difference to others' health and quality of life.	Evidence			Evidence	Evidence
		Personal Integrity A strongly held sense of commitment to openness, honesty, inclusiveness and high standards in undertaking the leadership role.	Evidence	Evidence			Evidence
	Setting Direction	**Seizing the Future** Being prepared to take action now to shape and implement a vision for the future development of services.	Evidence	Evidence	Evidence	Evidence	Evidence
		Intellectual Flexibility The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services.	Evidence	Evidence	Evidence	Evidence	Evidence
		Broad Scanning Taking the time to gather information from a wide range of sources.	Evidence		Evidence	Evidence	Evidence
		Political Astuteness Showing commitment and ability to understand diverse interest groups and power bases within organisations and the wider community, and the dynamic between them, so as to lead health services more effectively.	Evidence	Evidence	Evidence	Evidence	Evidence
		Drive for Results A strong commitment to making service performance improvements and a determination to achieve positive service outcomes for users.	Evidence		Evidence	Evidence	Evidence
	Delivering the Service	**Leading Change through People** Communicating the vision and rationale for change and modernisation, and engaging and facilitating others to work collaboratively to achieve real change.	Evidence	Evidence	Evidence	Evidence	Evidence
		Holding to Account The strength of resolve to hold others to account for agreed targets and to be held accountable for delivering a high level of service.	Evidence	Evidence	Evidence		Evidence
		Empowering Others Striving to facilitate others' contributions and to share leadership, nurturing capability and long-term development of others.	Evidence	Evidence	Evidence		Evidence
		Effective and Strategic Influencing Being able and prepared to adopt a number of ways to gain support and influence diverse parties, with the aim of securing health improvements.	Evidence	Evidence	Evidence		Evidence
		Collaborative Working Being committed to working and engaging constructively with internal and external stakeholders.	Evidence	Evidence	Evidence	Evidence	Evidence

A full analysis of the data and elucidation of the evidence of the influence that formal education has had on the leadership development of the identified healthcare executive leaders in Queensland Health is now presented. Development of all of the leadership qualities was reported, to some degree, as having been influenced by the identified healthcare executive leaders' formal education experiences. Evidence from the data of this influence is presented below for each of the Qualities within the Clusters.

Personal Qualities Cluster:

Self Belief *- The inner confidence that you will succeed and you can overcome obstacles to achieve the best outcomes for service improvement.*

Karen attributed development of her *Self Belief* to her formal education experiences in her early years of schooling whilst James thought that formal education provides positive reinforcement that contributes to *Self Belief*. Jane had the view that not only did formal education contribute to her *Self Belief*, but it also challenged societal thinking about women at the time, that women could participate and do well at formal education and contribute in a positive way. She noted that she worked with many bright women her age who had not had the opportunity to participate in formal tertiary education and who were "stuck" in lower level administration jobs. Mary commented that your *Self Belief* grows when you participate in formal education and can demonstrate that you can achieve in the academic area, test yourself and succeed.

The influence that formal education has had on the development of the leadership quality of *Self Belief* for the identified healthcare executive leaders is that formal education processes can lead to an increase in *Self Belief* through achievement, recognition and accomplishment.

Self Awareness *- Knowing your own strengths and limitations and understanding your own emotions and the impact of your behaviour on others in diverse situations.*

Karen thought that her *Self Awareness* was influenced by her early years of learning, particularly with regard to her awareness of what learning she did and did not want to pursue. James commented that he saw "definite benefits" of formal education's contribution to the development of his *Self Awareness* through the use of processes

that enabled him to consider his personal leadership style and behaviour and to then compare that behaviour to models, theories and frameworks of leadership. Paul recognised the contribution formal education has had towards the development of his *Self Awareness* and commented that he knew better who he was now because of formal education, often referring to his MBA as an epiphany in his understanding of himself and his understanding of others. When considering *Self Awareness*, Jane commented that formal education helped her to become consciously competent or consciously aware of things that she otherwise did not think too much about. She felt that formal education does change something intrinsically in people. Mary thought that you become more aware of yourself through engagement with formal education. For her this was particularly where there were educational processes that encouraged reflective practice and where her views of the world were challenged and explored.

The influence that formal education has had on the development of the leadership quality of *Self Awareness* for the identified healthcare executive leaders is that formal education provided them with alternative theories, models, processes and frameworks that they could compare themselves against. This raised their conscious awareness of themselves through better understanding of their preferred ways of operating compared to alternatives.

Self Management - *Being able to manage your own emotions and be resilient in a range of complex and demanding situations.*

Karen considered that her early experiences at school and when studying at University contributed to the development of the quality of *Self Management*. James thought that *Self Management* was something concrete that could be learnt and Paul attributed his MBA as a formal education experience that contributed to his *Self Management*. Mary felt that "there is no greater subject for a leader than *Self Management*" and that it was a continuous leadership journey to improve focus and priorities - a leadership journey that is enhanced through formal education.

The influence that formal education has had on the development of the leadership quality of *Self Management* for the identified healthcare executive leaders is that formal education requires *Self Management* in order to do well and be successful when managing multiple priorities.

Drive for Improvement *- A deep motivation to improve performance in the health service and thereby to make a real difference to others' health and quality of life.*
Karen reflected that, although some people never studied for a degree or participated in formal education in her early work career, she wanted to constantly improve and she saw that she could do that through formal education. She attributed her MBA as being the best education she has had in helping her develop the capability of *Drive for Improvement*. Jane considered that the competitive nature of formal education contributed towards her development of *Drive for Improvement*. She thought that once you start being graded, you want to ensure that you not only maintain a good grade but you want to improve and are not prepared to settle for just a pass. Mary connected *Drive for Improvement* and formal education by reflecting on how the goals and priorities she set for herself could be achieved through formal education. She viewed her formal education experiences as "all about wonderful knowledge, new knowledge that affects your world view and therefore affects what you believe you can achieve".

The influence that formal education has had on the development of the leadership quality of *Drive for Improvement* for the identified healthcare executive leaders is that formal education demonstrated to them that they can constantly improve and achieve their goals and priorities through the new knowledge obtained from formal education and the educational processes used.

Personal Integrity *- A strongly held sense of commitment to openness, honesty, inclusiveness and high standards in undertaking the leadership role.*
Karen thought that her formal education experiences in her MBA contributed to her development of *Personal Integrity*, particularly what she learnt from interacting with others from different "walks of life" and their different perspectives on issues. James considered that although *Personal Integrity* was "inbuilt", formal education contributes in that it gives perspective to issues of integrity. Mary thought that she had learnt a great deal about her integrity through her formal educational processes. She felt that formal education provided facts and information that gave her the understanding of what is important for her to "stand up for" to be authentic as a leader.

The influence that formal education has had on the development of the leadership quality of *Personal Integrity* for the identified healthcare executive leaders is that formal education contributed to issues of leadership integrity. Formal education does this by opening up different perspectives on issues of integrity and providing insight into authenticity in leadership.

Setting Direction Cluster:

Seizing the Future *- Being prepared to take action now to shape and implement a vision for the future development of services.*

Karen and Paul attributed their MBA's as the formal education experiences that most contributed to the development of the leadership quality of *Seizing the Future*. Mary noted that formal education's contribution to *Seizing the Future* was that it gives leaders the analytical thinking they need to build a view of how the future should look. James' view was that the ability to seize the future was something that could be learnt, that you can learn optimism and learn how to see a future that you can then create through leadership. Jane saw that education itself was a way of *Seizing the Future*. She has seen how for her and others, formal education has "opened doors" and given people the confidence to seize opportunities enabling them to create a better future for themselves, commenting that "if you're prepared to face the future, education will help you".

The influence that formal education has had on the development of the leadership quality of *Seizing the Future* for the identified healthcare executive leaders is that formal education provided them with the tools and analytical thinking to see what the future may be and the confidence to create that future through their leadership.

Intellectual Flexibility *- The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services.*

Karen stated that she developed capability in the area of *Intellectual Flexibility* from her MBA, particularly from being able to take a concept and consider how to apply it in different ways. Paul also saw that his MBA contributed to the development of his *Intellectual Flexibility*. James' view was that formal education can reinforce issues associated with not being intellectually flexible, by highlighting the negative

consequences of limited thinking. Jane considered that formal education develops *Intellectual Flexibility* through exposure to ideas and, through those ideas, challenging your beliefs and helping you to think differently about issues. Mary's view was that formal education "absolutely" contributes to *Intellectual Flexibility*. She thought that formal education "opens windows" for people to see alternate perspectives and that it encourages and challenges people to think differently about the world in which they operate.

The influence that formal education has had on the development of the leadership quality of *Intellectual Flexibility* for the identified healthcare executive leaders is that formal education provides exposure to new ideas and concepts that challenge people's beliefs and encourages leaders to think differently about the world in which they operate and apply new thinking to issues of leadership.

Broad Scanning *- Taking the time to gather information from a wide range of sources.*

Paul and Karen both attributed their MBAs as having contributed to the development of the quality of *Broad Scanning*. Jane thought that development of *Broad Scanning* was something that universities do quite well, "they teach you to go and look for information, teach you to seek out information and how to go and find information for yourself". Mary held a similar view in that Universities not only provide knowledge, but open up new ways of thinking, "I think education is so much related to teaching you how to think and what you need to think about. So *Broad Scanning* for me is very much linked to education".

The influence that formal education has had on the development of the leadership quality of *Broad Scanning* for the identified healthcare executive leaders is that formal education taught them how to find information and opened up new ways of thinking that encourages them to seek out new information and be broader in their perspective and outlook on issues.

Political Astuteness *- Showing commitment and ability to understand diverse interest groups and power bases within organisations and the wider community, and the dynamic between them, so as to lead health services more effectively.*

Karen and Paul attributed their development of *Political Astuteness* to their formal education experiences through their MBAs. Karen noted that by interacting with others she could see different approaches that her fellow participants were using in their organisations that were politically astute. Paul commented that what formal education does is to provide insight into the need to balance all the qualities to achieve an outcome. The example he gave was that just being good at, say, *Drive for Results*, is not as effective as being politically astute at how you go about driving for those results. James saw that the development of *Political Astuteness* for him was more intuitive but that formal education processes can develop further insight. Jane's university experience exposed her to people with different political views and, through the subjects she studied, she became more aware of the influence of organisational politics and how to be more politically astute in her role as a leader, particularly in a senior leadership role in a "big P" politically sensitive area such as healthcare. Mary's formal undergraduate education was a double major in political science and, for her, she viewed her formal education as very important for *Political Astuteness*. She also learnt through her formal education how to manoeuvre through the political system to get the best outcomes. She stated that "I think if you don't have political astuteness you will not be successful, you won't achieve your goals because you won't understand what's blocking you".

The influence that formal education has had on the development of the leadership quality of *Political Astuteness* for the identified healthcare executive leaders is that formal education provided them with awareness of the importance of being politically astute in order to achieve your objectives. Their formal education experiences did this by opening up their understanding of the issue and providing them with different perspectives and approaches on how to navigate a political environment.

Drive for Results *- A strong commitment to making service performance improvements and a determination to achieve positive service outcomes for users.* Paul and Karen both attributed their MBAs as having contributed to the development of the quality of *Drive for Results*. Whilst Paul always saw himself as "driven" his formal education experience showed him how to focus that energy towards the achievement of results. Jane's view was that *Drive for Results* comes through the

competitive nature of education, the drive to achieve good grades and good results. Mary's view was similar to Jane's in that she thought that "At the end of the semester I still had to get a result. I think education teaches you that there's good time for talking and then you've got to focus your thinking and get your results".

The influence that formal education has had on the development of the leadership quality of *Drive for Results* for the identified healthcare executive leaders is that formal education focused their energy towards achieving results. The educational processes used meant that, at a point in time, focus was required for achievement of outcomes.

Delivering the Service Cluster:

Leading Change through People - *Communicating the vision and rationale for change and modernisation, and engaging and facilitating others to work collaboratively to achieve real change.*

Both Karen and Paul attributed their MBAs as having contributed towards the development of the quality of *Leading Change through People*. James thought that he benefitted in the development of his ability to lead change through people through what he learnt in his formal education. His view was that he learnt how to use and engage different models of change that helped him to lead change more effectively. Jane felt that formal education provided her with the tools and theories that enabled her to lead change more effectively. Prior to her formal education experiences she had led "change well, and appallingly badly" and the theories and models of change obtained through her formal education helped her to be more consistent and effective. Mary's view was that to bring about real change you needed to win both the hearts and minds of people and she found that formal education gives you the credibility, the content and the processes that you need to lead change.

The influence that formal education has had on the development of the leadership quality of *Leading Change through People* for the identified healthcare executive leaders is that formal education provided the tools, theories, models, frameworks and processes required to lead change. Additionally, it provides leaders with the confidence and credibility to lead change through people.

Holding to Account *- The strength of resolve to hold others to account for agreed targets and to be held accountable for delivering a high level of service.*
Karen attributed the formal educational experiences of her MBA and a recently completed Australian Institute of Company Directors course as having influenced the development of the *Holding to Account* quality for her. Paul also attributed his MBA to the development of the *Holding to Account* quality. He gave an example of his approach to *Holding to Account*, "I talk to people and I say to them we've got this really difficult thing to deliver such as elective surgery targets, How are we going to do it together? Let's define what your role is, let's define what my role is and we'll both hold each other to account". James saw that the development of *Holding to Account* "comes through" as a learning from his formal education experiences and has contributed to the development of that quality. Mary thought that "I'm not sure there's anything much better than the educational process that teaches you to hold to account". This comes through for her from the educational processes whereby at "the end of the semester" you are "held to account" for your progress and learning.

The influence that formal education has had on the development of the leadership quality of *Holding to Account* for the identified healthcare executive leaders is that formal education provided an increased understanding of effective approaches that can be used to hold others to account and it also, through the educational processes used, developed within them the characteristics required to hold themselves to account.

Empowering Others *- Striving to facilitate others' contributions and to share leadership, nurturing capability and long-term development of others.*
Karen attributed the formal educational experiences of her MBA and a recently completed Australian Institute of Company Directors course as having influenced the development of the *Empowering Others* quality for her. Paul also attributed his MBA to the development of the *Empowering Others* quality and also the 360 degree feedback process which was used as part of the Queensland Health leadership programs. He noted that the 360 degree feedback process enabled him to see that, although he had strengths in many areas, that *Empowering Others* was a quality that he needed to work harder on developing. James thought that *Empowering Others* came through clearly for him as a learning from his formal educational experiences.

Mary considered that her formal education experiences have given her "a way of thinking, a way of behaving and provides the knowledge base" required to help her to be better at *Empowering Others*.

The influence that formal education has had on the development of the leadership quality of *Empowering Others* is best summed up by Mary's statement that formal education is "a way of thinking, a way of behaving and provides the knowledge base" required to develop the quality of *Empowering Others*.

Effective and Strategic Influencing *- Being able and prepared to adopt a number of ways to gain support and influence diverse parties, with the aim of securing health improvements.*

Karen and Paul both attributed the formal educational experience of their MBAs as having influenced the development of the *Effective and Strategic Influencing* quality. Karen reflected that "my MBA gave me in particular a real sense of understanding concepts around business and personal influence and being clear about what your sphere of influence is and what it isn't". Karen also mentioned that a recently completed Australian Institute of Company Directors course had contributed to her understanding of *Effective and Strategic Influencing*. James thought that *Effective and Strategic Influencing* could be learnt through formal education and mentioned his experience of learning about concepts of Neuro Linguistic Programming (NLP) as helping him to influence more effectively to achieve an outcome. Mary felt that formal education processes helped her to develop the *Effective and Strategic Influencing* quality and that her formal education experiences helped her to focus her strategic thinking and how to influence others to come with her on a strategic journey.

The influence that formal education has had on the development of the leadership quality of *Effective and Strategic Influencing* for the identified healthcare executive leaders is that formal education provided knowledge on how to influence others and highlighted effective processes that can be used with people to achieve strategic outcomes.

Collaborative Working *- Being committed to working and engaging constructively with internal and external stakeholders.*

Paul and Karen both attributed their MBAs as having contributed to the development of the *Collaborative Working* quality. Paul also reflected that, although he endeavours to adopt a collaborative approach with his team, he operates in a system where those above him are more directive. His MBA gave him alternative models of operating which are diametrically opposite to the approach he would use if he was just role modelling the behaviours learned from above. James' view was that you could learn structures and models for *Collaborative Working* from formal education experiences. Jane saw that formal education processes such as group assignments contribute towards the development of *Collaborative Working*, where your grade was dependent upon the contribution of others. Mary considered that, although in her view the education process was not collaborative of itself, she learnt theories and techniques that enabled her to be more collaborative.

The influence that formal education has had on the development of the leadership quality of *Collaborative Working* for the identified healthcare executive leaders is that formal education enabled the learning of theories, structures and models of *Collaborative Working* and, in some cases, processes that encouraged *Collaborative Working*. Formal education also provides alternative ways of operating collaboratively that may not otherwise have been learnt in the workplace.

The evidence presented above shows that the development of all of the leadership qualities were reported, to some degree, as having been influenced by the identified healthcare executive leaders' formal education experiences.

Thus far in this chapter, analysis and interpretation of the data has provided evidence that the identified healthcare executive leaders' formal education experiences have influenced the development of their leadership qualities. This chapter now focuses on the nature of that influence, the characteristics of that influence and on building a conceptual model of understanding of the influence based on the evidence of data from the identified healthcare executive leaders' interviews. The creation of a

conceptual model is achieved through the identification of the factors of influence and an exploration of the relationships between these factors.

Creswell's (2009) suggestion that data should be organised to build patterns, categories and themes was enacted in the study through the use of coding techniques in the data collection phase. As described in Chapter 4, the coding technique of line coding of the data led to the development of categories and subcategories. Subsequent Axial coding (Charmaz, 2006) of the categories enabled the data that had been fractured during the earlier coding process to be reassembled to give coherence to the emerging analysis of relationships between the data. As described in Chapter 4, it was the analysis of the substantive coding and the inductive interpretation of that coding that enabled, from the data collected in the field, the illumination of the relationships between the formal educational experiences of the identified healthcare executive leaders and the contribution these experiences have had on their development as leaders. This section of the chapter evidences this analysis and presents a conceptual model (Shoemaker, Tankard, & Lasorsa, 2004) that explores these relationships grounded in the data from the interviews with the healthcare executives.

Each of the identified factors of the model is discussed and supported by reference to the evidence from the identified healthcare executive leaders' interviews. The interrelationships between the factors are also identified and a complete conceptual model developed which is shown by Figure 7.5 in Section 7.4.

7.3 Evidence of the influence of leadership knowledge and educational process from the data

Through interpretive analysis of the data, it has been found that the identified healthcare executive leaders reported influence from the leadership knowledge obtained through their formal education experiences and the educational processes used in their formal education experiences contributed to the development of their leadership qualities. The identified healthcare executive leaders reported that this influence came from the leadership knowledge obtained through their formal education in the form of theories, models, frameworks and tools. They also reported

that the educational processes used in formal education, processes such as assessment, group discussion and interaction with other students influenced the development of their leadership qualities. These factors of Leadership Knowledge and Educational Process have been revealed from the data as having influenced the development of the leadership qualities of the identified healthcare executive leaders through their formal education experiences. Exemplars of Leadership Knowledge and Educational Processes that contributed to the influence of the development of each leadership quality for the identified healthcare executive leaders are presented in Table 7.2. Following the presentation of the exemplars, the identified influencing factors of Leadership Knowledge and Educational Process are explored in-depth through evidence from the data in Sections 7.3.1 and 7.3.2 respectively.

Table 7.2: Evidence of the influence of leadership knowledge and educational process from the data

	Quality	Evidence from the Data	
		Leadership Knowledge	**Educational Process**
Personal Qualities Cluster	***Self Belief***		Formal education processes can lead to an increase in *Self Belief* through achievement, recognition and accomplishment
	Self Awareness	Theories, models, processes and frameworks	Formal education processes raise conscious awareness of self through better understanding of preferred ways of operating compared to alternatives
	Self Management		Formal education requires *Self Management* in order to do well and be successful when managing multiple priorities
	Drive for Improvement		Formal education demonstrates that goals and priorities can be achieved through constant improvement
	Personal Integrity	Perspectives on issues of integrity and authenticity in leadership	Formal education processes open up different perspectives on issues of integrity and provides insight into authenticity in leadership
Setting Direction Cluster	***Seizing the Future***	Tools	Formal education processes enable analytical thinking to see what the future may be and the confidence to create that future through leadership
	Intellectual Flexibility	New ideas and concepts	Formal education challenges people's beliefs and encourages leaders to think differently about the world they operate within and to apply new thinking to issues of leadership
	Broad Scanning		Formal education processes open up new ways of thinking that encourages the seeking out of new information and for people to be broader in their perspective and outlook on issues
	Political Astuteness	Different perspectives and approaches	Formal education provides awareness of the importance of being politically astute in order to achieve objectives by opening up the understanding of issues of how to navigate a political environment
	Drive for Results		Formal education focusses energy towards achieving results. The educational processes used meant that, at a point in time, focus was required for achievement of outcomes
Delivering the Service Cluster	***Leading Change through People***	Tools, theories, models, frameworks and processes	Formal education provides leaders with the confidence and credibility to lead change through people
	Holding to Account	Effective approaches	Formal education, through the educational processes used, develops characteristics required to hold self to account
	Empowering Others	Knowledge base	Formal education processes provide a way of thinking, a way of behaving required to develop the quality of *Empowering Others*.
	Effective and Strategic Influencing	How to influence others	Formal education highlights effective processes that can be used with people to achieve strategic outcomes
	Collaborative Working	Theories, structures and models	Formal education processes can encourage *Collaborative Working* and provide alternative ways of operating collaboratively that may not otherwise be learnt in the workplace

7.3.1 Leadership knowledge

Knowledge can be defined as facts, information, and skills acquired through experience or education (Oxford University Press, 2014) and consequently leadership knowledge in this study is defined as the facts, information, and skills relating to leadership that were acquired by the identified healthcare executive leaders through their formal education experiences.

The identified healthcare executive leaders reported that they acquired leadership knowledge from their formal education experiences. This knowledge acquisition ranged from the leadership models and frameworks from the organisationally sponsored Executive Leadership Development Program undertaken by James through to the more formal advanced leadership concepts and theories covered by the MBA programs undertaken by Karen and Paul. Leadership content, models and frameworks for Jane and Mary came from their Masters of Health Administration and Graduate Certificate in Leadership (Jane) and a Masters of Health Service Management and Psychotherapy (Mary).

Specific examples of content, models and frameworks mentioned by the participants, which they described as providing a suite of new ideas and concepts and different paradigms of thinking, included (in their words): “leading through influence rather than positional power”; “how to read people”; “personality types”; “leadership styles and techniques”; “leading and influencing with integrity”; “leadership concepts”; “organisational concepts”; “process improvement”; “quality”; “psychotherapy”; “political science and women’s studies”; “concepts of business and personal influence”; and “corporate law”.

The content, models and frameworks that came to mind for the identified healthcare executive leaders during the interviews were not an exhaustive list of all that was covered during their formal education experiences. These examples are what each person chose as front of mind when responding to the questions. Each recalled from their experiences some aspects of leadership theory that resonated most with them and, at the time of the interviews, these were the examples of the content areas,

models and frameworks they mentioned and which they thought contributed to the development of their leadership knowledge.

The cluster of leadership qualities that the identified healthcare executive leaders most readily recalled as being influenced by leadership knowledge obtained through their formal education experiences was the *Delivering the Service* cluster. This cluster is characterised as consisting of more practical, tangible leadership skills in contrast to the relatively more intrinsic qualities of the *Personal Qualities* cluster or the more conceptual qualities of the *Setting Direction* cluster. This does not necessarily mean that leadership knowledge did not contribute strongly to the development of the *Personal Qualities* or the *Setting Direction* clusters, simply that examples of the more tangible leadership skills related to the *Delivering the Service* cluster were more readily recalled, the identified healthcare executive leaders being more readily able to provide specific tangible anecdotes relevant to their career journey and role.

Of note is that none of the formal education experiences mentioned by the identified healthcare executive leaders were specifically designed to develop the NHS Leadership Qualities (National Health Service, 2006). For example, the MBAs completed by Karen and Paul would have had no reference to the NHS Leadership Qualities (National Health Service, 2006) in their design. Neither would have the Masters of Health Administration completed by Jane and Mary or the Executive Leadership Development Program undertaken by James. Karen, James, Paul, Jane and Mary have been able to make meaning of the knowledge obtained through these disparate courses and apply that meaning to the context of their leadership roles in Queensland Health. This would appear to demonstrate the importance of choosing sound, well-researched theories and models when designing leadership courses and programs, preferably theories and models that are transferrable into different contexts (Gray, 2012), as leaders will draw upon that knowledge when undertaking different leadership roles long after completion of the course or program.

7.3.2 Educational process

A process can be defined as a series of actions or steps taken in order to achieve a particular end (Oxford University Press, 2014). Educational Process is defined in this study as the series of actions or steps taken in formal education environments in order to achieve educational outcomes.

The identified healthcare executive leaders provided evidence from their formal education experiences of the influence of formal education process on all of the leadership qualities across all clusters (please refer to Table 7.2). Analysis of these data revealed that they can be sub-categorised into processes that were related to the pedagogy experienced and processes related to formal education as a construct more generally (please refer to Table 7.3). For example, when considering the quality of *Self Awareness*, the identified healthcare executive leaders provided evidence that formal education processes raised conscious awareness of self through better understanding of preferred ways of operating compared to alternatives. The development of this quality is more related to the pedagogical processes used in the formal education teaching environment, whereas for the quality of *Self Belief* the identified healthcare executive leaders provided evidence that formal education processes can lead to an increase in *Self Belief* through achievement, recognition and accomplishment. Achievement, recognition and accomplishment came from the formal education construct of passing subjects and achieving qualifications.

Table 7.3: Pedagogical and formal education construct influences on the development of leadership qualities

	Quality	Evidence from the Data Educational Process	Pedagogy	Construct
Personal Qualities Cluster	***Self Belief***	Formal education processes can lead to an increase in *Self Belief* through achievement, recognition and accomplishment		×
	Self Awareness	Formal education processes raise conscious awareness of self through better understanding of preferred ways of operating compared to alternatives	×	
	Self Management	Formal education requires *Self Management* in order to do well and be successful when managing multiple priorities		×
	Drive for Improvement	Formal education demonstrates that goals and priorities can be achieved through constant improvement		×
	Personal Integrity	Formal education processes open up different perspectives on issues of integrity and provides insight into authenticity in leadership	×	
Setting Direction Cluster	***Seizing the Future***	Formal education processes enables analytical thinking to see what the future may be and the confidence to create that future through leadership	×	
	Intellectual Flexibility	Formal education challenges people's beliefs and encourages leaders to think differently about the world they operate within and to apply new thinking to issues of leadership	×	
	Broad Scanning	Formal education processes open up new ways of thinking that encourages the seeking out of new information and for people to be broader in their perspective and outlook on issues	×	
	Political Astuteness	Formal education provides awareness of the importance of being politically astute in order to achieve objectives by opening up the understanding of issues of how to navigate a political environment	×	
	Drive for Results	Formal education focusses energy towards achieving results. The educational processes used meant that, at a point in time, focus was required for achievement of outcomes		×
Delivering the Service Cluster	***Leading Change through People***	Formal education provides leaders with the confidence and credibility to lead change through people		×
	Holding to Account	Formal education, through the educational processes used, develops characteristics required to hold self to account		×
	Empowering Others	Formal education processes provide a way of thinking, a way of behaving required to develop the quality of *Empowering Others*.	×	
	Effective and Strategic Influencing	Formal education highlights effective processes that can be used with people to achieve strategic outcomes	×	
	Collaborative Working	Formal education processes that can encourage *Collaborative Working* and provide alternative ways of operating collaboratively that may not otherwise be learnt in the workplace	×	

The identified healthcare executive leaders provided evidence that the pedagogical approaches they found as being beneficial to the development of their leadership qualities included approaches that encouraged the seeking out of new information that opened up different perspectives on issues and approaches that stimulated them to challenge their own thinking on these issues. The essence of these pedagogical approaches is captured by Jane and Mary in their comments that "they [Universities] teach you to go and look for information, teach you to seek out information and how to go and find information for yourself" (Jane) and "I think education is so much related to teaching you how to think and what you need to think about" (Mary). What the identified healthcare executive leaders were describing as their experience can be defined as critical thinking (Lai, 2011) which is often seen as a universal goal of higher education (Fahim & Masouleh, 2012). Critical thinking is a key capability of leadership (Chung-Herrera, Enz, & Lankau, 2003) and there is evidence from this study that the identified healthcare executive leaders can attribute the attainment of critical thinking capability from the educational process used in their formal education experiences.

Further examples of the formal education constructs that the identified healthcare executive leaders reported as having an influence on the development of their leadership qualities included passing courses and obtaining formal qualifications. These constructs generated a sense of achievement, recognition and accomplishment that led to the development of confidence and credibility and consequently movement towards their leadership potential.

In Chapter 3 of this thesis, Knowles, Holton, and Swanson's (2015) andragogical principles were discussed and Principle 5 can be considered here in light of the identified healthcare executive leaders' experiences of educational constructs that contributed to movement towards their leadership potential:

Principle 5: Adults' orientation to learning is life-centred; education is a process of developing increased competency levels to achieve their full potential.
The experiences of the identified healthcare executive leaders support the proposition of this principle. Karen's desire to "spend more time interacting with people rather than computers" which lead her to go to evening school to complete her Ordinary

National Certicicate and that in her “heart of hearts” she knew nursing was what she wanted to do - and therefore she left her job to study nursing, are examples of how she oriented her learning to achieve her potential. Even now she is considering commencing her Doctorate, a step that would have little tangible benefit in her curent vocational role but would contribute to the sense of herself reaching her potential.

Paul’s reflections of his recent experience at a meeting of his former surgical colleagues where he considered himself to now be “different”, that it was no longer enough for him to be a doctor and that he “wanted to learn to be a better leader” is a further example of engaging in education to reach a self-determined potential.

Jane reflected that societal expectations of women when she was growing up meant that others’ views of women’s potential were limited and that she was able to challenge those ideas and reach her own self perception of her potential through formal education.

The evidence illustrates, that for the identified healthcare executive leaders of this study, their orientation to learning is life-centred and that education for them is a process of enabling them to move towards their potential, with formal education constructs giving them confidence and credibility through achievement, recognition and accomplishment.

The formal education factors that influenced the identified healthcare executive leader’s development of their leadership qualities are represented diagrammatically as shown in Figure 7.1.

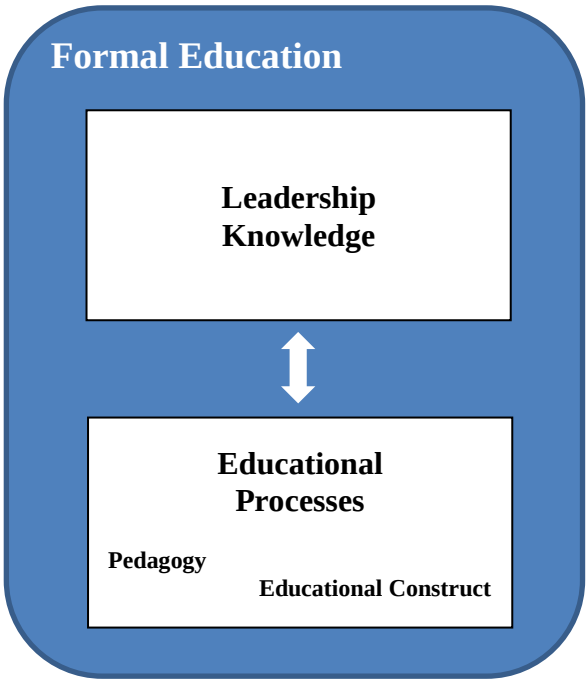

Figure 7.1: Formal education influences on the development of leadership qualities

7.3.3 Leadership insight

A further factor that was identified through analysis and interpretation of the data from the identified healthcare executive leaders was Leadership Insight. The definition of insight is "The capacity to gain an accurate and deep understanding of someone or something" (Oxford University Press, 2014). The definition of the Leadership Insight factor of the conceptual model (please refer to Figure 7.5) is the capacity to gain an accurate and deep understanding of the qualities required of leadership. The identified healthcare executive leaders provided rich evidence of the contribution of their formal education experiences to their more accurate and deeper understanding of leadership qualities.

The Leadership Qualities (National Health Service, 2006) collectively were a core category of data identified through the coding techniques applied to the raw interview data with each of the fifteen individual Leadership Qualities (National Health Service, 2006) coded as sub-categories of data. The inductive theoretical analysis of the data relationships commenced with analysis of the Leadership

Qualities (National Health Service, 2006) sub-categories, their associated line coding and raw data and the axial coding which connected this coding to other data to expose the relationships. An example is the analysis of the data associated with the Leadership Quality (National Health Service, 2006) of *Self Awareness*. There was evidence from the data that all of the identified healthcare executive leaders reported that formal education had contributed in some way to influencing the development of this quality. Although the formal educational experience was different for each person, ranging from the formal company sponsored program undertaken by James, through to University MBAs by Karen and Paul and post-graduate programs by Jane and Mary, each reported that their formal education experiences contributed to and influenced their *Self Awareness*.

Jane perhaps sums up best the perspective of the identified healthcare executive leaders with her statement: "(Formal education) made you a bit more consciously competent or consciously aware of some things that you didn't think too much about. University teaches you to think about thinking."

Jane was talking of the benefit of reflective practice and how her formal education experiences had encouraged her to engage in a level of self-reflective learning that was beyond her practical work-based nursing training. Mary related a similar insight saying that: "the educational arena, it's a different arena from your industry or service arena" in that the type of self-reflective practice encouraged in her formal education experiences were much more in-depth than what she was exposed to in the workplace.

> It was very good to have someone to challenge you, comments (such as) 'What were you hoping to achieve? Where was this coming from in you to be asking that sort of question or making that sort of comment?' That was a great educational experience. While sometimes your *Self Belief* grows when you're successful, equally I think your *Self Awareness* grows when someone comes back and says well, that's not how the real world is, you know. I think I see education very tied in that it's a wonderful vehicle to look at yourself as you try to implement theory. So yes, I think it's important. (Mary)

Carver and Scheier's (1981) proposition of how the comparison of the current self with an ideal standard motivates behaviour helps us to understand how formal education can assist with the development of *Self Awareness*. The identified healthcare executive leaders in the study were exposed to examples of ideal standards of leadership through their formal education experiences, either through processes of exposure to models and theories of leadership, conversations with fellow students and lecturers, or through intensive reflective practice. These experiences raised the consciousness of the identified healthcare executive leaders such that they now had awareness that there were alternative ways of operating, as Paul commented "I now see the deficiencies I had in early leadership roles". Paul was only able to see those deficiencies through the attainment of new models and frameworks of understanding about leadership and then experiencing processes through which he could compare those new approaches to his previous ways of operating. The formal educational experiences of the identified healthcare executive leaders had the effect of holding up a picture of an ideal standard of leadership and encouraging the identified healthcare executive leaders to compare this ideal standard to a mirror of themselves, enabling them to gain a more accurate and deeper understanding of the qualities required of leadership.

The Leadership Quality of *Self Belief* also had strong support from the identified healthcare executive leaders as having been influenced by their formal education experiences. Much of the research literature refers to self-efficacy rather than *Self Belief*. The definition of *Self Belief* in the Framework (National Health Service, 2006) is "*The inner confidence that you will succeed and you can overcome obstacles to achieve the best outcomes for service improvement*" which can be considered equivalent to self-efficacy which refers to one's belief in one's capability to perform a specific task (Gist, 1987).

Bandura and Cervone (1983) proposed that feedback is important in formulating efficacy perceptions and that was validated by the identified healthcare executive leaders' responses. James' view that "formal education provides positive reinforcement" and Mary's support for the concept through her statement "you can demonstrate that you can achieve in the academic area" are examples of how their formal education experiences, and particularly the positive reinforcement from

feedback through the achievement of passing subjects and gaining qualifications, have contributed to the development of their *Self Belief*. Jane goes further by considering how formal academic achievement helps to shape societies perception of women: “Doing well at formal education can challenge societal thinking about women and their contribution in a positive way”.

Through inductive analysis of the data, theoretical codes emerged that began to expose the relationship between the knowledge obtained through formal education, formal educational processes experienced by the identified healthcare executive leaders and how their leadership insights developed.

Whilst the identified healthcare executive leaders reported that the attainment of leadership knowledge through exposure to new models and frameworks was valuable, it was the educational processes that enabled insight to be obtained, insights that led to development of increased capability in *Self Awareness* and *Self Belief*. It would appear that Paul’s insight of “I now see the deficiencies I had in early leadership roles” was only made possible when he gained knowledge of alternative models of operating (leadership knowledge) and then considering, through educational process, how those models compared with his current and past operating style. Without the combination of leadership knowledge and educational process, his insight may not have occurred. Mary’s experience of an educational process that encouraged self-reflective practice provides further example of how process and knowledge combine to provide insight, “your *Self Awareness* grows when someone comes back and says well, that's not how the real world is, you know” (Mary).

The first two qualities of the Personal Qualities cluster, *Self Belief* and *Self Awareness* have been explored as examples to illustrate how Leadership Knowledge and Educational Process combine to produce an outcome of Leadership Insight. To illustrate further the relationship between Leadership Knowledge, Educational Process and Leadership Insight, examples from each of the clusters, the first quality of the Setting Direction cluster, *Seizing the Future*, and the first quality of the Delivering the Service cluster, *Leading Change through People*, are now presented as additional examples of how Leadership Knowledge and Educational Process combine to produce an outcome of Leadership Insight. It is not intended in this work

to present all sixteen qualities, however, these examples demonstrate that the nature of the relationship between Leadership Knowledge, Educational Process and Leadership Insight can be ascertained across all clusters.

The identified healthcare executive leaders' responses to the influence of formal education on the development of the leadership quality of *Seizing the Future* continues to reinforce the relationship between leadership knowledge, educational process and leadership insight. When discussing this quality, Mary thought that formal education "creates a knowledge base of how the future should look" (leadership knowledge), whilst Karen made the observation that whilst the MBA equipped her with foundational knowledge "the most I learnt from the MBA was what I learnt from other people" (educational process). And, discussing the same quality, James shared the observation that "by analysing your internal frames of reference you can learn how to create your own future" (leadership insight), further evidence of the interplay between formal education knowledge and educational process contributing to leadership insight.

Additional evidence of support for how Leadership Knowledge and Educational Process combine to produce an outcome of Leadership Insight comes from the analysis of the data from the identified healthcare executive leaders' views of the contribution of formal education towards the development of the leadership quality of *Leading Change through People*. Mary reported that "education has supported me being able to do that [lead change through people], education gives you credibility, content and processes for success". Mary was describing how her formal education experiences had given her the content (leadership knowledge) of the models and frameworks of change theory and that she had also gained credibility from the educational process as she had "passed" a post-graduate topic in leading change. The outcome of the leadership knowledge she gained and the educational processes used gave her insights and confidence for future success. Jane described how "[change] theory and models are useful" in the development of the leadership quality of *Leading Change through People* and that prior to her formal education experiences she had led change processes either "well or appallingly badly" relying heavily on "intuition". Her formal education experiences gave her the educational knowledge of theories and models of change and the educational processes used enabled her to

develop the insight required to lead change more effectively in the future. James stated that "knowing how to engage different models" was an important aspect of this quality which "can be learnt". For James it was not just "knowing" the models that was important (leadership knowledge), it was important to also learn how to engage them and apply them (through educational process). In the examples above from Mary, Jane and James, evidence from the data further supports the inductive theoretical interpretation that an accurate and deeper understanding of the qualities required of leadership, that is, Leadership Insight, is an outcome of Leadership Knowledge and Educational Process of Formal Education. This proposal is diagrammatically represented by Figure 7.2.

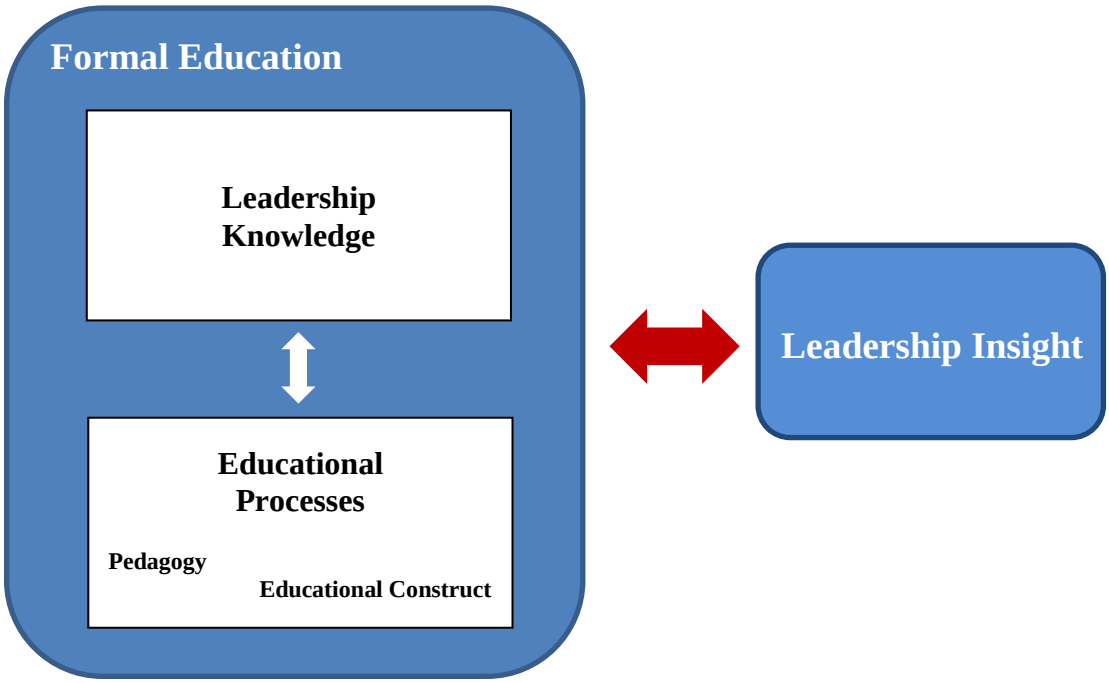

Figure 7.2: The diagrammatic representation of the interrelationship between formal education and the development of leadership insight

7.3.4 Leadership capability

A further factor that was identified through analysis and interpretation of the data from the identified healthcare executive leaders was Leadership Capability. The definition of capability is "The power or ability to do something" (Oxford University Press, 2014). The definition of Leadership Capability in this model is the ability to

demonstrate the qualities required of leadership. Whilst the Leadership Insight factor of the conceptual model may be considered as 'knowing'(Komives, Lucas, & McMahon, 2007), the question of whether the identified healthcare executive leaders are actually demonstrating leadership behaviours in the workplace also needs to be considered in light of the data that was obtained during the study. The identified healthcare executive leaders self-reported that they, for example, now know "why approaches hadn't worked in the past" (James) but that does not necessarily mean that they have now translated this leadership insight into demonstrated leadership behaviour.

Behaviour can be observed and a tool that captures people's perceptions of observed behaviour is a 360^0 feedback instrument. 360^0 feedback is an assessment of a person's behaviour and impact by those who work closely with them (Morgan et al., 2005).

The identified healthcare executive leaders provided their 360^0 feedback data which reports their behaviour and impact against the NHS Leadership Qualities (National Health Service, 2006). These data are shown in Figure 6.2. As background, Paul's 360^0 feedback was obtained from fifteen respondents, Karen's from eighteen respondents, James' from four respondents, Jane's from fifteen respondents and Mary's from six respondents. The reports were produced in proximity to the interviews in 2006 (James), 2007 (Paul), 2009 (Karen and Mary) and 2010 (Jane). The 360^0 feedback reports for the identified healthcare executive leaders use a scale of 0 to 100 percent for each quality to indicate the raters' opinions of how well the person receiving feedback demonstrates the leadership quality in the workplace.

The qualities of *Self Belief*, *Self Awareness*, *Seizing the Future* and *Leading Change through People* are continued as exemplars to illustrate that the identified healthcare executive leaders demonstrated the qualities required of leadership and therefore possessed a high level of Leadership Capability.

Table 7.4: Identified healthcare executive leaders' 360^0 feedback results for the qualities of *Self Belief, Self Awareness, Seizing the Future* and *Leading Change through People*

	Self Belief	Self Awareness	Seizing the Future	Leading Change through People
Paul	100%	100%	98%	97%
Karen	100%	97%	98%	95%
James	100%	100%	100%	97%
Jane	98%	100%	98%	97%
Mary	100%	100%	100%	100%

Table 7.4 shows that, for the quality of *Self Belief*, Paul's, Karen's, James' and Mary's raters gave the identified healthcare executive leaders the highest possible rating for that quality, 100%. Jane's rating was only marginally below the other identified healthcare executive leaders at 98%. This means that the raters, when responding based on their observations of the behaviour of the identified healthcare executive leaders in relation to *Self Belief*, considered that the identified healthcare executive leaders demonstrated that they have the inner confidence that they will succeed and that they can overcome obstacles to achieve the best outcomes for service improvements (National Health Service, 2006). For the quality of *Self Awareness*, the raters gave Paul, James, Jane and Mary a score of 100% and Karen 97%. The raters responses to the 360^0 survey show that they believed that the identified healthcare executive leaders demonstrated that they know their own strengths and limitations and understand their own emotions and the impact of their behaviour on others in diverse situations (National Health Service, 2006). For the quality of *Seizing the Future*, James and Mary received a rating of 100% and Paul, Karen and Jane a rating of 98%. The raters reported that they believed that the identified healthcare executive leaders demonstrated that they are prepared to take action now to shape and implement a vision for the future development of services (National Health Service, 2006). For the quality of *Leading Change through People*, Mary received a rating of 100%, Paul, James and Jane 97% and Karen 95%. The raters' responses showing that they believed that the identified healthcare executive

leaders demonstrated that they communicate the vision and rationale for change and modernisation, and engage and facilitate others to work collaboratively to achieve real change (National Health Service, 2006).

It is evident from the 360^0 feedback data provided by the identified healthcare executive leaders that they are perceived by others as exhibiting behaviours that align with the NHS Leadership Qualities (National Health Service, 2006), these behaviours being the observable indicators of Leadership Capability.

Thus far it has been established that, for the identified healthcare executive leaders, their formal education experiences have strongly influenced the development of their leadership qualities. This influence was reported as having come from the leadership knowledge obtained through their formal education experiences and the educational processes used in formal education. It has been further established that Leadership Insight is an outcome of the relationship between the Leadership Knowledge obtained through their formal education experiences and the Educational Processes used in Formal Education. It has also been established that people who know the identified healthcare executive leaders reported that they demonstrated these leadership qualities in the workplace, that is, that they possessed Leadership Capability. What remains unexplored is the relationship between Leadership Insight and Leadership Capability and the question of how Leadership Insight is translated to Leadership Capability.

7.3.5 Translation

The translation of Leadership Insight to Leadership Capability can be considered from the perspective of mental models and the work of Senge (2006) and Argyris (1982). Senge (2006) considered the question of how insight translates to practice and he came to the conclusion that, "new insights fail to get put into practice because they conflict with deeply held internal images of how the world works, images that limit us to familiar ways of thinking and acting" (p. 163).

Senge (2006) refers to these deeply held images of how the world works as mental models and he advocates that to change practice, people must learn how to reflect on

and challenge their current mental models, arguing that "If managers believe their worlds views are facts rather than sets of assumptions, they will not be open to challenging those world views" (p. 189). Argyris (1982) had earlier described this phenomena through his model of espoused theory versus theory in use. Argyris (1982) described theories in use as "the theories of action that people actually used" (p. 85) whereas espoused theories are "the theories of action that that they wrote or talked about" (p. 85). Argyris (1982) observed that people were often unaware that there was incongruence between their espoused theories and theories in use and advised the use of "double-loop learning" (p. 104) as a method of reflective practice to challenge assumptions and expose mental models.

When considering the influence of formal education on the development of the quality of *Self-Awareness*, Mary commented that through her formal training in psycho-dynamics she was encouraged to reflect on her practice. Her supervisor would ask her questions about her practice such as "What were you hoping to achieve?" and "Where was this coming from within you to be asking that sort of question or making that sort of comment?". In Mary's case, the supervisor was using double-loop learning techniques as a method of reflective practice to challenge Mary's assumptions and expose her mental models. This process of reflective practice assisted Mary to develop greater *Self-Awareness*. Jane also discussed the value of formal education's contribution to reflective practice as evidenced by her comment that "university teaches you to think about thinking" - thinking about thinking is a double-loop learning process.

Paul's powerful reflection of his experience at a gathering of his surgical colleagues provides further evidence of how formal education can influence shifts in mental models:

> So it was an interesting experience I did have - and I've not had it before - that I'm different. I thought it actually was that stark reality that I think differently for at least that cohort. I remember standing there and I looked around and I thought I feel very lonely here. I feel different. I think differently. I act differently from my colleagues. I think part of it is around learning and leadership, wanting to learn to be better et cetera versus hey I'm a powerful doctor and that's enough. So that was my reflection.

Paul's narrative brings to light the conflict between his previously held internal images of how the world works and the new mental model that was forming through the influence of his formal education journey and his reflection.

Literature that considers the effect of mental models on clinical practice include McComb and Simpson (2014) who presented a number of cases where the mental models of nurses and physicians affected clinical relationships and patient outcomes. They advocated greater awareness during the education of clinicians of the potential positive impact of shared mental models on healthcare provision. Krejci (1997) saw that a lack of awareness of one's mental models can be an obstacle to high-quality critical thinking. She considered that the unearthing and exploring of mental models to provide new insights was an important component of teaching critical thinking skills to nurses.

7.3.6 Readiness and opportunity

A shift in mental models can be an important precursor to translation of new insight to new practice. This translation effect can be further illuminated when viewed through the literature on learning transfer. Learning transfer is defined as the degree to which an individual effectively applies the knowledge, skills and attitudes gained through educational experience to the workplace context (Baldwin & Ford, 1988; Bouzguenda, 2014). Although the questions related to learning transfer are not yet fully resolved (Bouzguenda, 2014), there is some consensus in the literature that factors such as educational design, learner characteristics (e.g. motivation, readiness), and workplace environment (e.g. opportunity, career stage) all contribute to effective learning transfer (Baldwin & Ford, 1988; Bouzguenda, 2014; Kontoghiorghes, 2014).

An observation that became evident during the interview process with the identified healthcare executive leaders was that their career progression was often accompanied by proximity to a formal education experience. Jane, Mary and Karen, for example, as they talked about their formal education experiences, also provided connections to their career journey. As they moved from the equivalents of Nursing Team Leaders,

to Directors of Nursing, to, in some cases, CEOs of Health Service Districts, each career step was connected to a formal education experience. Jane made the comment that "I found that education changes people's career direction because the Diploma led to me being in charge of a Birth Suite." James' formal education experience coincided with him being appointed as Head of a Hospital and then being approached to head a Health Service District. Paul completed his MBA during his transition from the Head of a Surgical Unit to being the CEO of a Health Service District. Paul referred to his MBA experience as being his "leadership epiphany". It is important to note that all of the formal education experiences described by the identified healthcare executive leaders in the study were undertaken voluntarily. There may have been some encouragement from others, as in the case of James being encouraged by his mentor, but in all cases the timing of the formal education experiences were at the choosing of the identified healthcare executive leaders. It would appear that the identified healthcare executive leaders would have been motivated and ready to apply the Leadership Insight they had obtained from their formal education experiences to the opportunity their emerging leadership roles presented at different stages of their careers.

Knowles, Holton and Swanson (2015) considered issues of readiness and motivation in their work on adult learning and andragogy. Their andragogical principles, Principle 4 and Principle 6, are two elements of andragogy that are relevant to the data obtained from the identified healthcare executive leaders:

> Principle 4: Adults typically become ready to learn when they experience a need to cope with a life situation or perform a task
>
> Principle 6: The motivation for adult learners is internal rather than external

There is evidence from the data to support that the identified healthcare executive leaders became ready to learn when they experienced a need to cope with a life situation or perform a task. Clearly there was engagement with formal education as the identified healthcare executive leaders moved through their careers. It was also clear that formal education assisted them to deal with leadership situations as they arose in their roles, evidenced by a number of examples of the application of their learning. Knowles, Holton and Swanson (2015) identified that an especially rich source of readiness to learn is associated with moving from one developmental stage

to the next. They also emphasied the importance of timing learning experiences to coincide with those transitions. Readiness to learn and the connection to career need was not a specific focus of the study but rather emerged from the coding process with all of the identified healthcare executive leaders identifying formal educational experiences that coincided with their career journeys. It is an area of future exploration for research and this study has highlighted that there is value in persuing this area of interest.

There is also evidence from the data that the identified healthcare executive leaders' motivation for learning was internal rather than external. They could have remained in their highly successful clinical roles but all chose, for their own reasons, to learn about and move into more formal leadership roles. Knowles, Holton and Swanson (2015) contended that although adults are responsive to some external motivators such as better jobs, promotions and higher salaries, the most potent motivators are internal factors such as the desire for increased job satisfaction, self-esteem and quality of life. Tough (1979) found in his research that adults are motivated to keep growing and developing, but this motivation can be frequently blocked by such barriers as negative self-concept, inaccessibility of opportunities or resources or time constraints. Motivation was not a focus of the study and specific questioning about motivation was not asked of the identified healthcare executive leaders however this dynamic did emerge through the data coding. Motivation is identified as another area for further, more focused research attention.

The discussion above illustrates that, for the identified healthcare executive leaders of this study, their formal education experiences provided an opportunity for them to consider and challenge their mental models through reflective practice and double-loop learning techniques. The timing of their formal education experiences, their individual readiness and the opportunity provided by their career stages were additional factors that contributed to the Translation of the Leadership Insight obtained from their Formal Education learning experiences to their demonstration of Leadership Capability in practice. The diagrammatic representation of the interrelationships between the factors of Leadership Insight, Leadership Capability and Readiness and Opportunity is shown by Figure 7.3.

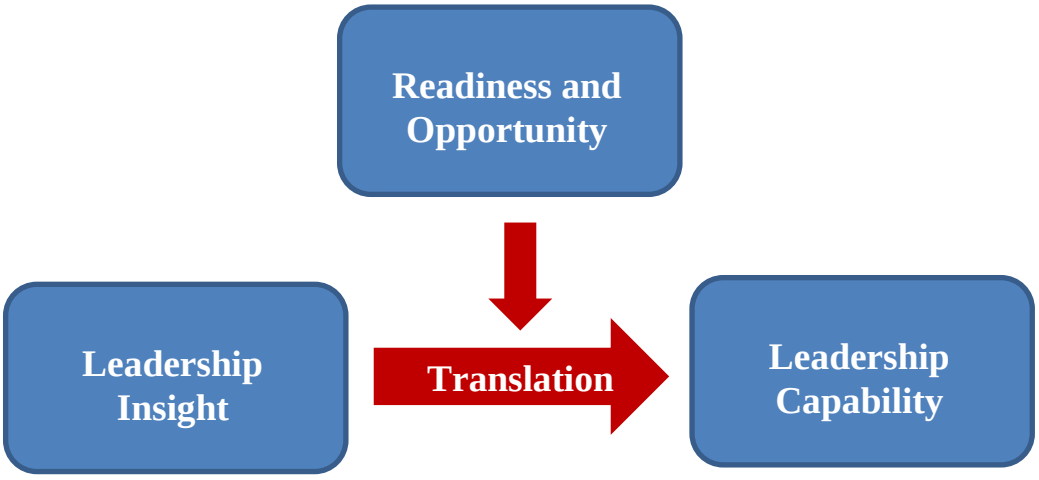

Figure 7.3: The diagrammatic representation of the interrelationships among the factors of leadership insight, leadership capability and readiness and opportunity

7.3.7 Informal learning

The focus of this study was on the influence that formal education has had on the development of leadership capability for Queensland Health healthcare executive leaders. Formal education was defined in this study as education that is engaged in through institutions such as universities and professional colleges and which would typically result in some form of recognised professional qualification, or workplace training that is organised, structured and has learning objectives (Section 1.5.1). It is recognised that formal education often comprises both formal and informal learning (Dabbagh & Kitsantas, 2012; Malcolm, Hodkinson, & Colley, 2003; Peeters et al., 2014). Malcolm, Hodkinson and Colley(2003) stated that although informal and formal learning are essentially different, attributes of informal and formal learning are present and interrelated in almost all learning environments, a view supported by Dabbagh and Kitsantas (2012) and Cross (Cross, 2007) who posited that most learning experiences are a blend of both formal and informal learning. Attributes of informal and formal learning can be presented on a continuum as shown by Figure 7.4.

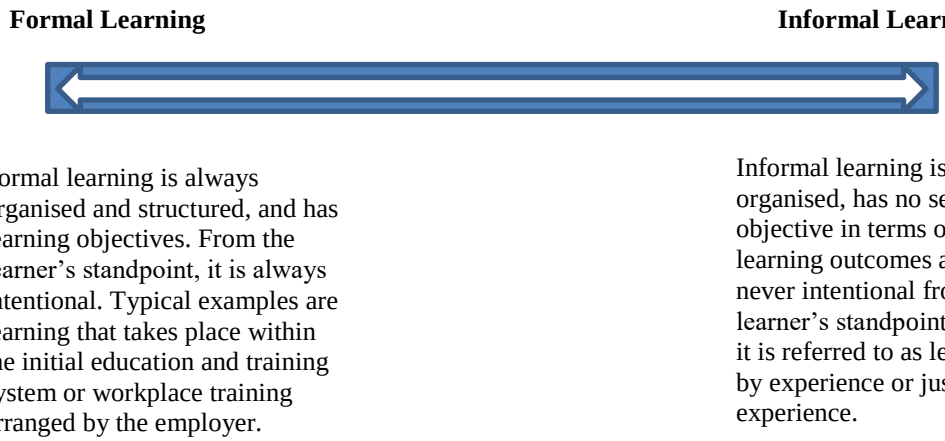

Figure 7.4: Formal – Informal Learning continuum (adapted from Cross, 2007; Organisation for Economic Co-operation and Development, 2009)

The identified healthcare executive leaders provided examples of informal learning that occurred both within and outside of their formal educational experiences. Evidence from the data of the identified healthcare executive leaders' informal learning that occurred within their formal educational experiences include Karen's observation that:

> I found with my MBA that I learnt as much from the other people in the course, who were from all walks of life - from the post office, from all different walks of life – engineers who had their own companies - than I did from the course itself. The course itself gave me some rigors in terms of setting a strategic direction and giving me a better knowledge of finances, gave me the sort of foundations, but the most I learnt from the MBA was what I learnt from other people.

A further example from the data is Jane's reflection when discussing the quality of *Political Astuteness* that, for her, with university life came the opportunity to talk to people with various other experiences and to be exposed to other people's ideas and their political thoughts. These informal interactions with others in the formal education environment of a university contributed to and influenced her development in the quality of *Political Astuteness*.

Data were also captured that showed the informal learning experiences of the identified healthcare executive leaders, outside of their formal education experiences, also had influence. This is captured in the coding shown in Chapter 6. These data have been categorised in the coding as 'Informal Learning Experiences' and 'Influences'. Informal Learning Experiences include "running wards and making decisions" (Karen), "How to deal with major health system crises" (James), "Leading a Surgical Unit through a crisis" (Paul), and "Being prepared to stand up and take a leadership role" (Jane). The category of informal learning Influences included sub-categories of Parents, Family, Partners, School, Teachers, Colleagues, Supervisors, Professional Networks, Mentors and Coaches.

These experiences and influences contributed to leadership insights such as "Leadership is about being able to influence and being able to make decisions" (Karen) and "People who are in leadership roles have the ability to help others and protect the vulnerable" (Paul).

Informal Learning is included in the conceptual model in Figure 7.5 and is intended to show the influence of Informal Learning that occurs outside of the Formal Education experience. Although the data related to informal learning in the formal education environment and data related to informal learning outside of the formal education environment have been isolated, categorised and presented separately, it is recognised that there are interrelationships between these factors.

Svensson, Ellstrom and Aberg (2004) contended that although informal learning in the course of daily life is important, it is not sufficient for the acquisition of knowledge and needs to be supported by formal education. Their view is that where there are arrangements for both informal and formal learning in an educational situation, conditions for reflective learning are created. They further contended that formal education needs to be "backed up" (p. 481) by informal learning in order to be effective. They proposed that rather than maintaining an opposition between informal and formal learning, that the emphasis should be on how they can complement each other. Evidence from the data that supports Svensson, Ellstrom and Aberg (2004) contention include Jane's reflection, when considering the quality of *Leading Change through People*, that prior to her formal education experiences she

had done things where change went well and where some went appallingly badly and that the theories and models she learnt through her formal education experiences had been helpful for future change efforts.

Whilst the influence of informal learning outside of formal education experiences is acknowledged and is evident in the data, it was not the focus of the study and was not explored fully. The interrelationships between Informal Learning, Formal Education and Leadership Insight presents as an area for future research.

7.4 A diagrammatic representation of the influence of formal education on the development of leadership capability

Thus far in this chapter, analysis and interpretation of the data has provided evidence that the identified healthcare executive leaders' formal education experiences have influenced the development of their leadership qualities. Analysis and interpretation of the data has also provided evidence of the nature of that influence and has identified the factors and interrelationships of the characteristics of that influence.

It has been shown that the leadership knowledge obtained through formal education and the formal educational processes used in formal education interrelate in a way that influences the development of leadership insight. It has further been shown that informal learning contributes towards the development of leadership insight. Interpretive analysis of the data has also shown that the translation of leadership insight to leadership capability may be influenced by the readiness of the learner to apply the learning and the opportunity for them to do so. The identification of these factors and their interrelationships has been illuminated in the preceding sections of this chapter. Diagrammatically, the relationships between the identified factors of Formal Education, Leadership Insight, Leadership Capability, Readiness and Opportunity, Translation and Informal Learning are shown by the conceptual model in Figure 7.5. Summary descriptions of each factor of the model are provided in Section 7.4.1 below.

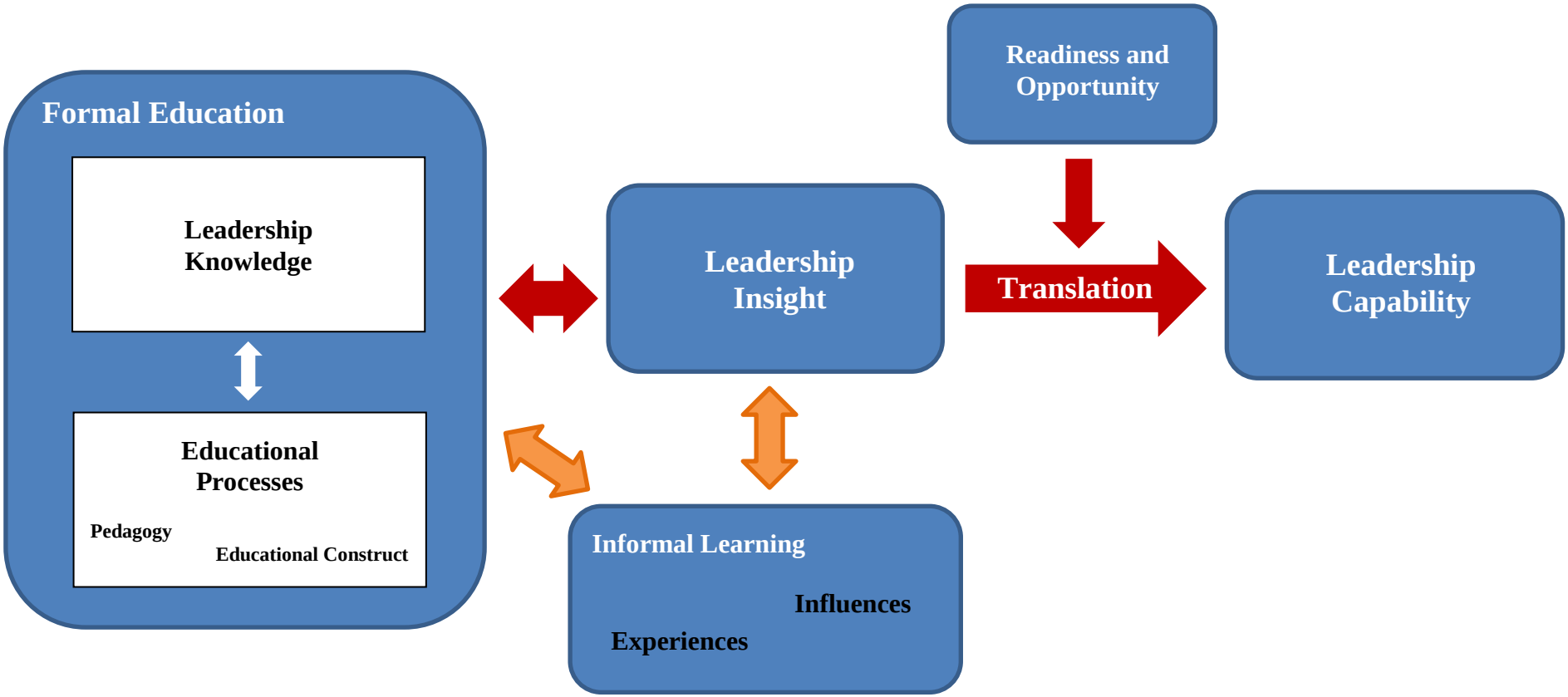

Figure 7.5: A diagrammatic representation of the influence of formal education on the development of leadership capability

7.4.1 Summary descriptions of factors

Formal Education - Education that is engaged in through institutions such as universities and professional colleges and which would typically result in some form of recognised professional qualification, or workplace training that is organised, structured and has learning objectives

Leadership Knowledge –The facts, information, and skills relating to leadership that are acquired through formal education.

Educational Process - The series of actions or steps taken in formal education environments in order to achieve educational outcomes.

Leadership Insight –The capacity to gain an accurate and deep understanding of the qualities required of leadership.

Informal Learning - Learning that is not organised, has no set objective in terms of learning outcomes and is not intentional from the learner's standpoint and, in this model, occurs outside of formal education environments.

Leadership Capability –The ability to demonstrate the qualities required of leadership.

Translation – The degree to which an individual effectively applies the knowledge, skills and attitudes gained through educational experience to the workplace context

Readiness and Opportunity – The readiness of an individual to apply new insight and learning to the workplace context and the opportunity to do so

7.5 The influence of formal education on the development of leadership capability described as a dynamic system

To illustrate how the factors of the model interrelate as a dynamic system, a conceivable scenario is presented:

Trish is an accomplished, well-respected surgeon who is beginning to recognise that she has a contribution that can be made to broader issues of healthcare improvement. She is interested in influencing models of care and delivery of health services beyond the services she provides to her own patients. She has identified deficiencies in the

healthcare system within which she works and has realised that, as a leader, she could make a positive impact that could benefit many more patients than she could as an individual contributor. Her organisation, State Health, is supportive of Trish's aspirations and proactively encourages healthcare practitioners to enhance their leadership capability through an evidence based pedagogical approach to their development. State Health has a program in place that encourages and supports clinicians to engage with formal education as a mechanism to develop their leadership capability.

Specialist learning and development practitioners within State Health work with Trish and together they identify an education provider who has the flexibility she requires that will enable her to balance her work, personal and educational needs. The education provider, State University, has developed a range of post-graduate courses that use well researched, sound theories of leadership with transferrable models and frameworks that can be applied in a variety of contexts. State University has also ensured that the pedagogical approaches used in these courses in the exploration of leadership issues encourage applied critical thinking and reflective practice.

State Health provides opportunities for Trish to apply the insights that she obtains from her formal educational experience to the real challenges facing her and the organisation. State Health view leadership effectiveness as being an outcome of the connections or relationships within the system rather than the function of leader-follower and so they provide Trish and other emerging leaders with opportunities to contribute to and influence healthcare policy, models of care, and healthcare practice whilst they are engaging with their formal education. As Trish has done exceptionally well in her studies, she has the confidence to contribute strongly to these organisational forums and she is successful in influencing improvements in healthcare outcomes for patients more broadly across the state system. The opportunity for Trish to apply the insights she has obtained through her formal education enables her to more effectively translate the learning into practice and this contributes significantly to the development of her leadership capability.

7.6 Conclusion

This chapter has analysed and interpreted the data provided by the identified healthcare executive leaders. This analysis and interpretation has led to the finding that formal education has had a strong influence on the development of the leadership qualities of the identified healthcare executive leaders. Further, it has been found that the characteristics of that influence can be identified as factors, namely: Formal Education, Leadership Insight, Leadership Capability, Readiness and Opportunity, Translation and Informal Learning. It has further been found that these identified factors interrelate in a dynamic system of leadership capability development.

The next chapter, Chapter 8, will explore the significance of these findings.

8 Chapter 8: The significance of the study and conclusions

8.1 Introduction

This chapter firstly provides a summary of the responses to the research problem and the research questions. The chapter then identifies the significance of the study and the contributions of the study to enhancing and extending understandings of leadership theory, to leadership research methodology and to leadership capability development practice. The chapter also identifies areas for future research. Finally, the chapter concludes with the researcher's reflections on the study and the findings.

8.2 Responses to the research problem and the research questions

This section of the chapter provides a summary of the responses to the research problem and the research questions.

8.2.1 Response to the research problem

The overarching research problem was stated as:

> What is the influence of formal education on the leadership development of healthcare executive leaders in Queensland Health?

The rationale for considering this problem was that healthcare systems are under increasing pressures to deliver improved services in a climate of ageing populations, increasing demands from and expectations of patients and communities, epidemics and pandemics and fiscal constraints (Armstrong et al., 2007; Deloitte, 2014; World Health Organisation, 2014b). More effective approaches to the development of healthcare leadership capability have been called for as one strategy that will help to respond to these pressures and to deliver better healthcare outcomes for patients and communities (L. Knowles et al., 2012; World Health Organisation, 2008, 2014a, 2014b).

This study found that formal education can be used as an effective method of developing increased leadership capability in healthcare organisations and, more specifically, that formal education has had a positive influence on the leadership

development of the healthcare executive leaders in Queensland Health who participated in the study. The formal education experiences of the identified healthcare executive leaders were reported by them as having contributed to the development of the leadership qualities defined by the NHS Leadership Qualities Framework (National Health Service, 2006).

It was also found that the positive influence of formal education can lead to enhanced leadership capability through effective translation facilitated by reflective practice, by challenging mental models and through the readiness and opportunity of the aspirant. Informal learning that occurs both within and outside formal education experiences was found to be an additional positive influencing factor that contributed to the development of leadership capability.

The findings from this study provide compelling evidence that healthcare organisations should focus increased attention on the development of their healthcare leadership capability through formal education as one important response to the systemic challenges facing healthcare systems. This educational response should be solidly founded on sound pedagogical approaches that lead to enhanced leadership practice, as was shown through these research findings and as was represented diagrammatically in Figure 7.5.

It is recommended that healthcare providers and associated entities (such as professional associations) identify clinicians who are motivated to make a contribution to broader issues of healthcare improvement through leadership. These clinicians should be proactively encouraged to participate in formal education experiences that enhance their leadership capability through an evidence-based pedagogical approach to their development. Healthcare providers and associated entities should work with education providers who have sufficient flexibility to enable clinicians to balance their work, personal and educational needs. The education providers should offer formal education experiences that use well researched, sound theories of leadership with transferrable models and frameworks that can be applied in a variety of contexts. The pedagogical approaches used by these education providers should encourage applied critical thinking and reflective practice.

Healthcare providers and associated entities should provide opportunities for clinicians who engage with formal education to apply the insights that they obtain from their formal educational experiences to the real challenges facing them and their organisations. Opportunities should be provided to these clinicians to contribute to and influence healthcare policy, models of care, and healthcare practice whilst they are engaging with their formal education to facilitate more readily translation of learning into practice and to enhance the development of the clinicians' leadership capability.

The research findings from this study are a significant contribution towards an enhanced approach to the leadership development of clinicians in healthcare systems as called for by, among others, Armstrong, Gillespie, Leeder, Rubin, and Russell (2007), Deloitte (2014, 2015), Forster (2005), Kennedy (2001) and the World Health Organisation (2006, 2008, 2014a, 2014b).

8.2.2 Findings related to Research Question 1

The first question considered in this study was "How does the NHS Leadership Qualities Framework (National Health Service, 2006) adopted by Queensland Health compare with the leadership characteristics required of its healthcare executives?".

The detailed response to Research Question 1 was presented in Chapter 5. The response to Research Question 1 was achieved through firstly undertaking a qualitative literature analysis of healthcare leadership frameworks more generally before then focusing more specifically on the NHS Leadership Qualities Framework (National Health Service, 2006).

Through the literature analysis undertaken in this study, it was found that the Framework's strongest influences came from Trait, Behavioural and Contingency theories of leadership. It was further found through the literature that Crowder and Woods (2006) had used the Framework in their organisation and had found it to be a valuable tool that could be used to enhance and support leadership development. Crethar, Phillips and Brown (2011) had also reported that the Framework had been

utilised across Queensland Health to achieve improvements in workplace culture and ultimately improvements in clinical care and patient outcomes. It was therefore found from the available literature that the NHS Leadership Qualities Framework (National Health Service, 2006) adopted by Queensland Health does adequately describe the leadership characteristics required of its healthcare executives.

It was also found, however, that there were shortcomings in the Framework and that these are acknowledged. Wood and Gosling (2003) have raised methodological and epistemological concerns, and a review of the Framework against the Taxonomy of Leadership Theory (please refer to Table 3.1) found that the Framework was positioned further back into earlier theory than the collective healthcare frameworks' theoretical analysis. More contemporary leadership theoretical constructs, such as those identified as Organisational Leadership theories in the Taxonomy, are not well represented by the Framework.

8.2.3 Findings related to Research Question 2

The second question considered in this study was "What is the influence that formal education has had on the leadership development of the identified healthcare executive leaders in Queensland Health?"

The detailed response to Research Question 2 was presented in Chapters 6 and 7. Through an interview survey process, validated by 360^0 feedback results, five healthcare executives within Queensland Health were identified as having leadership characteristics that most strongly aligned with the NHS Leadership Qualities Framework (National Health Service, 2006). These five healthcare executives all agreed to participate in the study and were identified as follows:

1. Karen, the CEO of a Regional Health Service District and who had a nursing background
2. James, the CEO of a Metropolitan Health Service District and who had a medical/surgical background
3. Paul, the CEO of a Regional Health Service District and who had a medical/surgical background

4. Jane, the CEO of a Regional Health Service District and who had a nursing background
5. Mary, the Executive Director of Nursing and Midwifery for a Metropolitan Health Service District and who had a nursing background.

It was found through semi-structured interviews with the identified healthcare executive leaders that there was clear evidence that formal education had a strong influence on the development of their leadership qualities. The identified healthcare executive leaders were readily able to give examples and to make connections between the NHS leadership qualities (National Health Service, 2006) and the educational experiences that had influenced the development of those qualities. Development of all of the leadership qualities was reported, to some degree, as having been influenced positively by the identified healthcare executive leaders' formal education experiences (please refer to Table 7.1).

8.2.4 Findings related to Research Question 3

The third question considered in this study was "What conceptual model of pedagogical approach can inform the development of leadership capability for healthcare executives?"

The detailed response to Research Question 3 was presented in Chapter 7. Through interpretation of the data from the interviews with the identified healthcare executive leaders, it was found that there was a relationship between Leadership Knowledge, obtained through formal education, and the Educational Processes used in formal education such that, when that interrelationship was effective, Leadership Insight was an outcome. It was also found that Leadership Insight was translated into Leadership Capability as a function of the leader's ability to challenge their existing mental models and the Readiness and Opportunity to apply such behaviour. The diagrammatic representation of this conceptual model was presented as Figure 7.5.

The model presented in Figure 7.5 informs an approach to the effective development of leadership capability for healthcare executives. A characteristic of this approach is

the systemic interrelationships among contributing factors. Within this developmental system is an approach to formal education that utilises well researched, sound theories of leadership with transferrable models and frameworks that can be applied in a variety of contexts and that utilise pedagogical approaches that encourage applied critical thinking and reflective practice. Torrez and Rocco (2015) have called for a greater emphasis on metacognition and critical self-reflection as desirable attributes of leadership development experiences and this study has shown how these attributes have positively contributed to the leadership development of the participants in this study, thus affirming Torrez and Rocco's (2015) proposition. Ford (2015) has also called for new approaches to leadership development, specifically in healthcare contexts, and has advocated a more critical approach to leadership development that encourages "studying, conceptualising and practising" (p. 262) leadership. The conceptual model of pedagogical approach to leadership described by this study and diagrammatically represented by Figure 7.5 is one response to Ford's (2015) call, as it describes a systemic approach to leadership development that encourages the attainment of leadership knowledge through formal education, the conceptualisation of this knowledge through reflective educational practice and then, as opportunity and readiness present, the practice of leadership in context.

The conceptual model of pedagogical approach developed through this study can inform new and improved approaches to the development of leadership capability for healthcare executives.

8.3 Contribution to leadership theory

This section of the chapter identifies the contribution of the study to leadership theory. The study's contribution is discussed around three areas of significance: the Taxonomy of Leadership Theory developed in Chapter 2; the contribution to the understanding of pedagogy as it applies to leadership capability development; and the conceptual model of the influence of formal education on the development of leadership capability developed in Chapter 7.

8.3.1 The Taxonomy of Leadership Theory

The Taxonomy of Leadership Theory (please refer to Table 3.1), which was developed in Chapter 3, was necessarily created to bring together some of the major leadership theories into theory clusters and to provide a synthesis of the themes of those clusters. The significance of the Taxonomy, in the context of its contribution to leadership theory, is that it brings together the works of Van Seters and Field (1990), Bolden, Gosling, Marturano and Dennison (2003), Bass and Bass (2008), Avolio, Walumbwa and Weber (2009), Yukl (2006, 2013) and Dinh, Lord, Gardner, Meuser, Liden and Hu (2014) in a new way. The Taxonomy enables theorists to consider the clustering of leadership theory as was shown in Table 3.1 and to categorise new and emerging theory against the existing clusters of the Taxonomy or to identify and add to the Taxonomy new cluster categories.

Another use of the Taxonomy, and how it was used in this study, is as a point of reference when considering the theoretical influences of organisational leadership frameworks. As was demonstrated in Chapters 3 and 5, organisational leadership frameworks can be considered against the Taxonomy to assist the identification of their theoretical influences.

A further use of the Taxonomy, in the context of theoretical contribution, is to assist positioning new research into the body of established and emerging theoretical constructs. This study, for example, when considered against the Taxonomy is positioned within the Organisational Leadership Theories cluster of the Taxonomy. The focus of this study has been to understand more comprehensively how leaders build leadership capability through education and learning, this focus aligning with Strategic Leadership theory - that is, a theory within the Organisational Leadership Theories cluster of the Taxonomy. Organisational Leadership Theories, and specifically Strategic Leadership theory, have been identified by Dinh, Lord, Gardner, Meuser, Liden and Hu (2014) as the most prolific of the emerging leadership theories currently being researched. Strategic Leadership theory has been described by Boal and Hooijberg (2014) as “the capacity to learn, the capacity to change, and managerial wisdom” (p. 515). This study has contributed to a better understanding of how leaders learn and thus is positioned within Strategic

Leadership theory and within the Organisational Leadership Theories cluster of the Taxonomy.

8.3.2 Pedagogy relating to leadership capability development

There was support from the findings of this study for three of Knowles, Holton and Swanson's (2015, pp. 93-96) pedagogical principles (principles 4 - 6) as they apply to adult learners:

4. Adults typically become ready to learn when they experience a need to cope with a life situation or perform a task.
5. Adults' orientation to learning is life-centred; education is a process of developing increased competency levels to achieve their full potential.
6. The motivation for adult learners is internal rather than external.

The evidence for Knowles, Holton and Swanson's (2015) pedagogical principles 4 and 6 was explored in Section 7.3.6 of the thesis. The study showed that there was engagement with formal education as the identified healthcare executive leaders moved through their careers and that their formal education experiences assisted them to deal with leadership situations as they arose in their roles. The identified healthcare executive leaders also gave examples of how their formal education experiences were proximate with changes in their career roles. All of the formal education experiences described by the identified healthcare executive leaders in the study were undertaken of their own accord. There was some encouragement from others, as in the case of James, but in all cases the motivations for undertaking the formal education experiences were internal to the identified healthcare executive leaders. They could have remained in their highly successful clinical roles and continued to pursue only clinically based education but all chose, for their own reasons, to learn about and to move into more formal leadership roles. In the case of Paul, this internal motivation was in contrast to the views of some of his clinical colleagues who expressed to him the view that leadership roles were "administration". This evidence from the study of the identified healthcare executive leaders' internal motivation for learning supports Knowles, Holton and Swanson's (2015) pedagogical principle 6.

Examples were also presented that showed how identified healthcare executive leaders oriented their learning to achieve their potential. One example was Paul's reflections on his recent experience at a meeting of his former surgical colleagues where he considered himself now to be "different", that it was no longer enough for him to be a doctor and that he "wanted to learn to be a better leader". Jane also reflected that societal expectations of women when she was growing up meant that others' views of the potential of women were limited. Jane was able to challenge those ideas and to reach her own self perception of her potential through formal education. The evidence from the study of the identified healthcare executive leaders' developing increased leadership capability towards the achievement of their leadership potential supported Knowles, Holton and Swanson's (2015) pedagogical principle 5.

8.3.3 Conceptual model of the influence of formal education on the development of leadership capability

The conceptual model that has been developed from the data analysis and interpretation in this study illustrates a systemic approach to the development of leadership, an illustration that had been called for by Allen and Hartman (2011) and Yukl (2013). This study has shown that it was not one approach or source (Allen & Hartman, 2011; Conger, 1992) of learning that contributed solely to the identified healthcare executive leaders' development of leadership qualities, but rather that it was an interaction of factors that enabled those qualities to develop.

Although Allen and Hartman (2011) advocated a systemic approach to leadership development, neither their work nor Conger's (1992) research showed the systemic linkages between learning approaches. Yukl (2013) considered a systems perspective on leadership development and posited a model that showed three ways to acquire leadership competencies: formal training; developmental activities; and self-help activities. Yukl (2013) stated that "learning acquired from one approach can facilitate or enhance learning from the other approaches" (p. 398). He expressed concern, however, at the lack of research about how these approaches combine:

> There has been little research on the relative advantage of training, development, and self-help activities for different types of leadership skills.

> Likewise, little is known about the best way to combine training, development and self-help activities to maximise their mutual effects. There is clearly need for a more systematic approach to the study of leadership development activities. (Yukl, 2013, p. 399)

This study provides an extension of the theories of Conger (1992), Allen and Hartman (2011) and Yukl (2013) by exploring the systemic interrelationships among factors of leadership capability development. The relationship between Leadership Knowledge and Educational Processes within Formal Education was illuminated extensively in Chapter 7 of this work. Further, the interrelationships among Formal Education, Leadership Insight, Informal Learning, Readiness and Opportunity, Translation and Leadership Capability are also illuminated in a way not shown in other work as they are not only evidenced as individual factors but also are shown through this work to combine as a systematic approach to leadership capability development, represented diagrammatically as a conceptual pedagogical model by Figure 7.5.

8.4 Contribution to leadership research methodology

This section of the chapter identifies the contribution of the study to leadership research methodology. This contribution is discussed in relation to two areas of significance: the participant selection method; and the coding techniques used to identify factors of leadership capability influence and their interrelationships.

8.4.1 Participant selection

The issue of what constitutes leadership, and the related issue of the identification of who are effective leaders within definitions of leadership, were explored extensively in this study. A careful approach was taken to ensure that people who were recognised as leaders, and not just people who were in leadership positions, were the focus of the study. The multi-staged approach to participant selection used in the study, which consisted of defining the leadership context, peer referral and identification of potential candidates for the study, and finally validation through the use of a 360^0 feedback instrument, is a significant contribution to leadership research methodology and, in particular, to interpretative phenomenological analysis (IPA).

IPA is still an emerging approach to research. Smith, Flowers and Larkin (2009) and Quinn and Clare (2008) have recommended the use of the purposeful participant selection of small sample sizes as appropriate for IPA approaches and this study provides, in some detail, a method of purposeful participant selection that other researchers may find useful to emulate, particularly researchers in the field of leadership.

8.4.2 The use of coding techniques

Coding techniques were used in the data collection phase of this study with the identified executive healthcare leaders to facilitate the organisation, analysis and interpretation of the data. Charmaz's (2006) coding techniques were used which enabled data categories to be related to data subcategories. Theoretical coding (Charmaz, 2006; Hernandez, 2009) was then used to identify the relationships among categories, thus enabling the development of an integrated and explanatory conceptual model.

It is acknowledged that Charmaz's (2006) method of coding is most often associated with grounded theory approaches; however, a method of data coding is not prescribed for IPA (Roberts, 2013; J. A. Smith et al., 2009; J. A. Smith & Osborn, 2007) and, as Charmaz's (2006) framework emphasised flexible guidelines within a scaffold of principles and practices, it was considered to be appropriate to be used for this study. The area of inquiry described by the research problem was predominantly directed at discovering the impact that formal education has had on the leadership capability development of the identified healthcare executive leaders. The use of Charmaz's (2006) coding techniques allowed understanding and reconstruction to develop through inquiry with the identified healthcare executive leaders whilst still allowing more informed and sophisticated new constructions to be explored.

Tashakkori and Teddlie's (2009) view that research questions should drive research methods and Charmaz's (2006) advice that coding techniques could be used flexibly empowered me to adopt the coding method as described in this study. It is my contention that the use of Charmaz's (2006) coding techniques in this way is a contribution to leadership research methodology when using an IPA approach.

8.5 Contribution to leadership capability development practice

This section of the chapter identifies the contribution of this study to leadership capability development practice. This contribution is discussed in relation to two areas of significance: the use of the Taxonomy of Leadership Theory developed in Chapter 3 to guide the development of Leadership Frameworks; and the use of the conceptual model of pedagogical approach to inform the development of leadership capability and, as shown in Chapter 7, to guide the design of leadership capability development initiatives.

8.5.1 The Taxonomy of Leadership Theory's contribution to leadership capability development practice

The Taxonomy was used in this study as a point of reference when considering leadership frameworks. Leadership frameworks were reviewed against the Taxonomy and a determination made as to the frameworks' theoretical alignment. Leadership frameworks continue to be used in many organisations but little is known from the literature regarding their effectiveness or their theoretical influences. It is envisioned that the Taxonomy of Leadership Theory developed for this study can be used by other researchers and practitioners to consider analysing their current or proposed leadership frameworks to identify their frameworks' theoretical underpinnings. Through such an understanding, frameworks that promote concepts of organisational leadership can be identified more readily and/or modifications made to existing frameworks to ensure that they align to more contemporary views of leadership and leadership theory.

It was found through this study that healthcare leadership frameworks, and consequently healthcare leadership capability development approaches, are not influenced by singular theory. The NHS Leadership Qualities Framework (2006), as one example, was found, when analysed through the lens of the Taxonomy, to align most strongly to Trait, Behavioural and Contingency theories, with some alignment to Influence, Transactional and Transformational theories. Crethar, Phillips and Brown's (2011) description of the leadership development approach used in Queensland Health does not explicitly explore the theoretical influences of the

leadership development approach; however, it is worth noting that the approach was based on the NHS Leadership Qualities Framework (2006). The use of the Taxonomy allows the purposeful alignment of the theoretical leadership construct envisioned by an organisation and the leadership development practice implemented.

8.5.2 The contribution of the conceptual model of the influence of formal education to the practice of leadership capability development

This study can inform the design of formal education approaches by encouraging the designers of such approaches to consider how their instructional design elements interact to build a more systemic approach to leadership development. The aim should be to design educational systemic approaches that lead to leadership capability being developed more effectively in healthcare organisations.

In Chapter 3, analysis was presented that described a number of leadership development programs in the healthcare context (Crofts, 2006; Currie, 1999; Eastman & Fulop, 1997; McAlearney et al., 2005; Owen & Phillips, 2000; Wolf et al., 2006). In the concepts reviewed in Chapter 3, there were various descriptions of the content covered, or the workshop design employed, but there was little to no description of the learning processes employed or of the learning experiences of the individual healthcare executive leaders of the programs.

The significance of the findings from this study is that the development of leadership qualities for healthcare executives can be facilitated by formal education experiences. Therefore it might be concluded that formal education experiences should have the following characteristics:

- The leadership theories, models and frameworks (leadership knowledge) taught in formal education programs should be sound, well-researched and transferrable into different leadership contexts as leaders will draw upon the knowledge that they have obtained from these programs long after their formal education experience has ended.
- The pedagogical approaches used in formal education programs should encourage the development of critical thinking. This can be achieved by using approaches that encourage the seeking out of new information that will

open up different perspectives on issues and stimulate participants to challenge their own thinking on these issues.

- The pedagogical approaches used in formal education programs should also encourage reflective practice and double-loop learning to highlight and challenge existing mental models.
- The educational construct of formal education programs should be robust enough to enable a sense of achievement to be obtained from the formal education experience. This might be achieved through the setting of challenging criteria for assessment, providing full or partial qualification and providing meaningful, constructive feedback on progress.
- Formal education programs should be able to be readily integrated into the career journeys of participants. Flexibility in commencement timing, entrance criteria, delivery mode and program duration should be considered to encourage maximum participation from leaders who are balancing work, personal and educational aspirations.

8.6 Future research

Yukl's (2013) call for a better understanding of a systemic approach to leadership development has been partially satisfied by this study. It is recognised that this qualitative study was focussed on the experiences of a small number of executive healthcare leaders in Queensland Health and no broader claims are made regarding the application of the findings without further research and peer review of the work. There continues to be a rich field of opportunity for researchers to consider exploring in this area. The interrelationships among Informal Learning, Formal Education and Leadership Insight in particular present as an area for more in-depth future research.

A relationship between readiness to learn and career need was identified from the coding process, with all of the healthcare executive leaders identifying formal educational experiences that coincided with their career journeys. Exploration of this relationship was not a specific focus of the study but rather an emergent product. The relationship between readiness to learn and career need is an area of future exploration for research and this study has highlighted that there is value in pursuing this area of interest.

Motivation towards learning was also not a specific focus of the study and in-depth questioning about motivation was not pursued with the identified healthcare executive leaders; however, this dynamic also emerged through the data coding. Motivation towards learning is identified as another area for further, more focused research attention.

The interrelationships among factors within the system require further exploration and deeper understanding. Whilst a conceptual model of pedagogical approach has been constructed through this research, it now needs to be deconstructed to be better understood and to test the rigour of the initial construct. Further exploration is required to determine if the construct presented by this study is a more widely interpreted phenomenon.

8.7 Final thoughts: Views of the researcher

As a practitioner who has delivered hundreds of organisationally-based leadership development programs, I have often felt a concern as to how the theories and concepts of leadership discussed and explored in the classroom (or in outdoor, experiential-based approaches) are translated into changed behaviour in the workplace and in more effective organisational leadership. To use leadership theory terminology, leadership development was transactional by nature, which was somewhat ironic as transactional methods were being used, in some cases, to try to develop transformational qualities with participants. Executives would attend, mostly voluntarily, but sometimes through some mandatory organisational requirement, and then the transaction of training would occur.

In recent years the aim of organisational development activity around leadership development has been for it to become more strategic, linking organisational objectives and strategy to leadership capability development. There remains, however, much more to be done, particularly with regard to the further understanding of a strategic systems approach to leadership development. The world is constantly evolving and changing, organisations are constantly evolving and changing and,

consequentially, our approach to the development of leadership needs to be constantly evolving and changing. This study and the associated conceptual model that explains the influence of formal education on the development of leadership capability are posited as one part of an evolving understanding of approaches to more effective leadership development.

References

Adair, J. (1973). *Action-centred leadership*. New York, NY: McGraw-Hill.

Allen, S. J., & Hartman, N. S. (2011). Leadership development: An exploration of sources of learning. In M. F. R. Kets de Vries & K. Korotov (Eds.), *Leadership development* (pp. 165-175). Cheltenham, UK: Edward Elgar.

Amazon.com. (2013). Best sellers in biographies. Retrieved from http://www.amazon.com/Best-Sellers-Books-Biographies/zgbs/books/2#5

Argyris, C. (1976). *Increasing leadership effectiveness*. New York, NY: John Wiley.

Argyris, C. (1982). *Reasoning, learning and action*. San Francisco, CA: Jossey-Bass.

Armstrong, B. K., Gillespie, J. A., Leeder, S. R., Rubin, G. L., & Russell, L. M. (2007). Challenges in health and health care for Australia. *Medical Journal of Australia, 187*(9), 485-489.

Australian Government. (2007). National statement on ethical conduct in human research. Retrieved from http://www.nhmrc.gov.au/publications/synopses/e72syn.htm

Avolio, B., Walumbwa, F., & Weber, T. J. (2009). Leadership: Current theories, research, and future directions. Retrieved from http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1036&context=managementfacpub

Baldwin, T. T., & Ford, J. K. (1988). Transfer of training: A review and directions for future research. *Personnel Psychology, 41*(1), 63-105.

Bandura, A., & Cervone, D. (1983). Self-evaluative and self-efficacy mechanisms governing the motivational effects of goal systems. *Journal of personality and social psychology, 45*(5), 1017-1028.

Bass, B. M. (1960). *Leadership, psychology and organizational behavior*. New York, NY: Harper.

Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York, NY: Free Press.

Bass, B. M. (1990). *Bass and Stogdill's handbook of leadership: Theory research and managerial applications* (3rd ed.). New York, NY: Free Press.

Bass, B. M., & Bass, R. (2008). *The Bass handbook of leadership : Theory, research, and managerial applications* (4th ed.). New York, NY: Free Press.

Belbin, R. M. (1993). *Team roles at work*. Oxford, UK: Butterworth-Heinemann.

Bennis, W. G. (1989). *On becoming a leader*. Reading, MA: Addison-Wesley Publishing Company.

Berger, P. L., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge*. London, UK: Penguin Books.

Bernard, L. L. (1926). *An introduction to social psychology*. New York, NY: Holt.

Bingham, W. V. (1927). Leadership. In H. C. Metcalf (Ed.), *The psychological foundations of management* (pp. 244-260). New York, NY: Shaw.

Bird, C. (1940). *Social psychology*. New York, NY: Appleton-Century.

Bithell, A., & Child, D. (2005). How to apply the NHS leadership qualities framework to pharmacists. *Pharmaceutical journal, 274*(7343), 394-396.

Blake, R. R., & Mouton, J. S. (1964). *The managerial grid*. Houston, TX: Gulf Publishing Company.

Blake, R. R., & Mouton, J. S. (1978). *The new managerial grid*. Houston, TX: Gulf Publishing Company.

Boal, K. B., & Hooijberg, R. (2014). Strategic leadership research: Moving on. *Leadership Quarterly, 11*(4), 515-549.

Bolden, R., Gosling, J., Marturano, A., & Dennison, P. (2003). *A review of leadership theory and competency frameworks*. Retrieved from http://centres.exeter.ac.uk/cls/documents/mgmt_standards.pdf

Borgatta, E. F., Bales, R. F., & Couch, A. S. (1954). Some findings relevant to the great man theory of leadership. *American Sociological Review, 19*(6), 755-759.

Bouzguenda, K. (2014). Enablers and inhibitors of learning transfer from theory to practice. In K. Schneider (Ed.), *Transfer of learning in organizations* (pp. 23-44). Cham, Switzerland: Springer International Publishing

Bowden, A. O. (1927). A study of the personality of student leaders in colleges in the United States. *Journal of Abnormal Social Psychology, 21*, 149-160.

Bryant, A., & Charmaz, K. (2007). The coding process and its challenges. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 265-290). Thousand Oaks, CA: Sage Publications.

Buchanan, D., Jordan, S., Preston, D., & Smith, A. (1997). Doctor in the process: The engagement of clinical directors in hospital management. *Journal of Management in Medicine, 11*(3), 132-156.

Bunniss, S., & Kelly, D. R. (2010). Research paradigms in medical education research. *Medical Education, 44*(4), 358-366.

Burgoyne, J., Hirsh, W., & Williams, S. (2004). *The development of management and leadership capability and its contribution to performance: The evidence, the prospects and the research need*. Retrieved from

http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/RR560.pdf

Burns, J. M. (1978). *Leadership*. New York, NY: Harper & Row.

Canadian Health Services Research Foundation. (2007). The Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada. Retrieved from http://www.cfhi-fcass.ca/Migrated/PDF/Health_Leadership_Framework_E.pdf

Carlyle, T. (1841). *Heroes and hero worship*. Boston, MA: Adams.

Carver, C. S., & Scheier, M. (1981). *Attention and self-regulation: A control-theory approach to human behavior*. New York, NY: Springer-Verlag.

Charmaz, K. (2006). *Constructing grounded theory*. Thousand Oaks, CA: Sage Publications.

Chung-Herrera, B. G., Enz, C. A., & Lankau, M. J. (2003). Grooming future hospitality leaders: A competencies model. *Cornell Hotel and Restaurant Administration Quarterly*, *44*(3), 17-25.

Colley, H., Hodkinson, P., & Malcom, J. (2003). *Informality and formality in learning: A report for the Learning and Skills Research Centre*. Retrieved from https://kar.kent.ac.uk/4647/3/Informality%20and%20Formality%20in%20Learning.pdf

Conger, J. (1992). *Learning to lead: The art of transforming managers into leaders*. San Francisco, CA: Jossey-Bass.

Courtney, M., Yacopetti, J., James, C., Walsh, A., & Montgomery, M. (2002). Queensland public sector nurse executives: Professional development needs. *Australian Journal of Advanced Nursing*, *19*(3), 8-14.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Crethar, M., Phillips, J., & Brown, P. (2011). Queensland Health - a leadership development journey. *Leadership in Health Services, 24*(4), 308-324.

Crofts, L. (2006). A leadership program for critical care. *Intensive and Critical Care Nursing*, *22*, 220-227.

Cross, J. (2007). *Informal learning: Rediscover the natural pathways that inspire innovation and performance*. San Francisco, CA: Pfeiffer.

Crowder, R., & Woods, M. (2006). Implementing the NHS Leadership Qualities Framework in the West of Berkshire Primary Care Trusts *The British Journal of Leadership in Public Services, 2*(3), 15-18.

Currie, G. (1999). Resistance around a management development programme: Negotiated order in a hospital trust. *Management Learning, 30*(1), 43-61.

Dabbagh, N., & Kitsantas, A. (2012). Personal learning environments, social media, and self-regulated learning: A natural formula for connecting formal and informal learning. *Internet and Higher Education, 15*, 3-8.

Dansereau, R., Graen, G., & Haga, W. J. (1975). A vertical dyad linkage approach to leadership in formal organizations. *Organizational Behavior and Human Performance, 13*, 46-78.

Day, D. V., Fleenor, J. W., Atwater, L. E., Sturm, R. E., & McKee, R. A. (2014). Advances in leader and leadership development: A review of 25 years of research and theory. *Leadership Quarterly, 25*, 63-82.

Day, D. V., Gronn, P., & Salas, E. (2004). Leadership capacity in teams. *Leadership Quarterly, 15*, 857-880.

Deloitte. (2014). *2014 Global health care outlook: Shared challenges, shared opportunities*. Retrieved from http://www2.deloitte.com/content/dam/Deloitte/global/Documents/Life-Sciences-Health-Care/dttl-lshc-2014-global-health-care-sector-report.pdf

Deloitte. (2015). *2015 Global health care outlook: Common goals, competing priorities*. Retrieved from http://www2.deloitte.com/content/dam/Deloitte/global/Documents/Life-Sciences-Health-Care/gx-lshc-2015-health-care-outlook-global.pdf

Denzin, N. K., & Lincoln, Y. S. (2005). The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 1-32). Thousand Oaks, CA: Sage Publications.

Dinh, J. E., Lord, R. G., Gardner, W. L., Meuser, J. D., Liden, R. C., & Hu, J. (2014). Leadership theory and research in the new millennium: Current theoretical trends and changing perspectives. *Leadership Quarterly, 25*, 36-62.

Eastman, C. J., & Fulop, L. (1997). Management for clinicians or the case of "bringing the mountain to Mohammed". *International Journal of Production Economics, 52*, 15-30. Retrieved from http://www.sciencedirect.com/science/article/pii/S0925527396000928

Eden, D. (1984). Self-fulfilling prophecy as a management tool: Harnessing Pygmalion. *Academy of Management Review, 9*, 64-73.

Evans, M. G. (1970). The effects of supervisory behavior on the path-goal relationship. *Organizational Behavior and Human Performance, 5*, 277-298.

Fahim, M., & Masouleh, N. S. (2012). Critical thinking in higher education: A pedagogical look. *Theory and Practice in Language Studies, 2*(7), 1370-1375.

Fiedler, R. E. (1964). A contingency model of leadership effectiveness. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 149-190). New York, NY: Academic Press.

Field, R. H. G. (1989). The self-fulfilling prophecy leader: Achieving the Metharme Effect. *Journal of Management Studies, 26*, 151-175.

Fleishman, E. A., & Harris, E. F. (1962). Patterns of leadership behavior related to employee grievances and turnover. *Personnel Psychology, 15*, 43-56.

Fleishman, E. A., Harris, E. F., & Burtt, H. E. (1955). *Leadership and supervision in industry*. Columbus, OH: Ohio State University Press.

Ford, J. (2015). Going beyond the hero in leadership development: The place of healthcare context, complexity and relationships. *International Journal of Health Policy and Management, 4*(4), 261-263.

Forster, P. (2005). *Queensland Health systems review: Final report*. Brisbane, Qld, Australia: Queensland Government.

Fowler, F. J. (2009). *Survey research methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

French, J. R. P. (1956). A formal theory of social power. *Psychological Review, 63*, 181-194.

French, J. R. P., & Raven, B. H. (1959). The bases of social power. In D. Cartwright (Ed.), *Studies of social power* (pp. 150-167). Ann Arbor, MI: Institute for Social Research.

Galton, F. (1869). *Hereditary genius*. London, UK: MacMillan and Co.

Gist, M. (1987). Self-efficacy: Implications for organizational behavior and human resource management *Academy of Management Review, 12*(3), 472-485.

Givant, S., & Halmos, P. (2009). *Introduction to boolean algebras*. New York, NY: Springer Science and Business Media.

Goleman, D. (1999). *Working with emotional intelligence*. London, UK: Bloomsbury.

Goleman, D. (2006). How emotional intelligence matters. Retrieved from http://www.danielgoleman.info/how-emotional-intelligence-matters/

Graen, G., & Cashman, J. (1975). A role-making model of leadership in formal organizations: A developmental approach. In J. G. Hunt & L. L. Larson (Eds.), *Leadership frontiers* (pp. 143-165). Kent, OH: Kent State University Press.

Gray, H. (2012). The myth of "transferable skills" for senior executives – key lessons to be learned. *Development and Learning in Organisations, 26*(3), 5-7.

Greene, C. N. (1975). The reciprocal nature of influence between leader and subordinate. *Journal of Applied Psychology, 60*, 187-193.

Greene, J. C. (2007). *Mixed methods in social inquiry*. San Francisco, CA: Jossey-Bass.

Greene, R. L. (2014). *Human memory: Paradigms and paradoxes*. New York, NY: Psychology Press.

Greenleaf, R. K. (1977). *Servant leadership: A journey into the nature of legitimate power and greatness*. New York, NY: Paulist Press.

Groves, R. M. (2004). *Survey methodology*. Hoboken, NJ: J. Wiley.

Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks, CA: Sage Publications.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). New York, NY: Taylor and Francis.

Harris, A., & Spillane, J. (2008). Distributed leadership through the looking glass. *Management in Education, 22*(1), 31-34.

Harris, K., Huber, D., Jones, R., Manojlovich, M., & Reineck, C. (2006). Future nursing administration graduate curricula, Part I call to action. *Journal of Nursing Administration, 36*(10), 435-440.

Hazy, J. K., Goldstein, J. A., & Lichtenstein, B. B. (2007). *Complex systems leadership theory: New perspectives from complexity science on social and organizational effectiveness*. Mansfield, MA: ISCE Publishing.

Health Care Leaders Association of British Columbia. (2010). Health Leadership Capabilities Framework. Retrieved from http://www.leadersforlife.ca/framework/LEADS%20Brochure.pdf

Health Education and Training Institute. (2013). *The NSW Health Leadership Framework*. Sydney, New South Wales, Australia: New South Wales Government Retrieved from http://www.heti.nsw.gov.au/Global/HETI-Resources/leadership/HETI-leadership-framework.pdf.

Heard, C. P. (2014). Choosing the path of leadership in occupational therapy. *The Open Journal of Occupational Therapy, 2*(1).

Heifetz, R. A. (1994). *Leadership without easy answers*. Cambridge, MA: Belknap Press.

Hernandez, C. A. (2009). Theoretical coding in grounded theory methodology. *The Grounded Theory Review, 8*(3), 51-60.

Hersey, P., & Blanchard, K. H. (1969). Life cycle theory of leadership. *Training Development Journal, 23*(26-34).

Hersey, P., & Blanchard, K. H. (1977). *Management of organizational behavior: Utilizing human resources*. Englewood Cliffs, NJ: Prentice-Hall.

Hewison, A., & Griffiths, M. (2004). Leadership development in health care: A word of caution. *Journal of Health Organisation and Management, 18*(6), 464-473.

Hock, D. W. (2000). *Birth of the chaordic age*. San Francisco, CA: Berrett-Koehler

Hollander, E. P. (1958). Conformity, status and idiosyncrasy credit. *Psychological Review, 65*, 117-127.

Hollander, E. P. (1979). *Leadership dynamics: A practical guide to effective relationships*. New York, NY: Free Press.

Hollander, E. P. (1980). Leadership and social exchange processes. In M. S. Gergen (Ed.), *Social exchange: Advances in theory and research* (pp. 343-354). New York, NY: Plenum Press.

Hook, S. (1943). *The hero in history*. New York, NY: John Day.

Hooper, A., & Potter, J. (1997). *The business of leadership*. Aldershot, UK: Ashgate Publishing Company.

House, R. J. (1971). A path-goal theory of leader effectiveness. *Administrative Science Quarterly, 16*, 321-338.

House, R. J. (1977). A 1976 charismatic theory of leadership. In J. G. Hunt & L. L. Larson (Eds.), *Leadership: The cutting edge* (pp. 189-207). Carbondale, IL: Southern Illinois University Press.

Hunt, J. G., & Larson, L. L. (1977). *Leadership: The cutting edge*. Carbondale, IL: Southern Illinois University Press.

Jacobs, T. O. (1970). *Leadership and exchange in formal organizations*. Alexandria, VA: Human Resources Research Organization.

James, W. (1880). Great men, great thoughts and the environment. *Atlantic Monthly, 46*, 441-459. Retrieved from http://www.brocku.ca/MeadProject/James/James_1880.html

Jenkins, W. O. (1947). A review of leadership studies with particular reference to military problems. *Psychological Bulletin, 44*(1), 54-79.

Katzenbach, J., & Smith, D. (1994). *The wisdom of teams*. New York, NY: Harper Business.

Kennedy, I. (2001). *Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995*. Retrieved from

http://webarchive.nationalarchives.gov.uk/20090811143745/http:/www.bristol-inquiry.org.uk/final_report/the_report.pdf

Knowles, L., O'Dowd, C., Hewett, D. G., Schafer, J., & Wilkinson, D. (2012). The University of Queensland Medical Leadership Program: A case study. *The Ochsner Journal, 12,* 344-347.

Knowles, M. (1977). Adult learning processes: Pedagogy and andragogy. *Religious Education: The official journal of the Religious Education Association, 72*(2), 202-211.

Knowles, M., Holton, E., & Swanson, R. (2015). *The adult learner: The definitive classic in adult education and human resource development*. Oxford, UK: Taylor and Francis.

Komives, S. R., Lucas, N., & McMahon, T. R. (2007). *Exploring leadership: For college students who want to make a difference* San Francisco, CA: John Wiley.

Kontoghiorghes, C. (2014). A systemic perspective of training transfer. In K. Schneider (Ed.), *Transfer of learning in organizations* (pp. 65-79). Cham, Switzerland: Springer International Publishing

Krejci, J. W. (1997). Imagery: Stimulating critical thinking by exploring mental models. *Journal of Nursing Education, 36*(10), 482-484.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago, IL: University of Chicago Press.

Lai, E. R. (2011). Critical thinking: A literature review. Retrieved from http://images.pearsonassessments.com/images/tmrs/CriticalThinkingReviewFINAL.pdf

Lee, J. D. (2013). *An interpretative phenomological analysis of five-fold apostolic leadership in conjunction with executive leadership theory and practice.* University of Charleston, Charleston.

Likert, R. (1961). *New patterns of management*. New York, NY: McGraw-Hill.

Loan-Clarke, J. (1996). Health-care professionals and management development. *Journal of Management in Medicine, 10*(6), 24-35.

Machi, L. A., & McEvoy, B. T. (2009). *The literature review: Six steps to success*. Thousand Oaks, CA: Corwin Press.

Malcolm, J., Hodkinson, P., & Colley, H. (2003). The interrelationships between informal and formal learning. *Journal of Workplace Learning, 15*(7/8), 313-318.

Manz, C. C., & Sims, H. P. (1987). Leading workers to lead themselves: The external leadership of self-managing work teams. *Administrative Science Quarterly, 32*, 106-128.

Marinelli-Poole, A., McGilvray, A., & Lynes, D. (2011). New Zealand health leadership. *Leadership in Health Services, 24*(4), 255-267.

Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review, 62*(3), 279-300.

Mayo, A. J., & Nohria, N. (2005). *In their time: The greatest business leaders of the twentieth century*. Boston, MA: Harvard Business School Press.

McAlearney, A. S., Fisher, D., Heiser, K., Robbins, D., & Kelleher, K. (2005). Developing effective physician leaders: Changing cultures and transforming organizations. *Hospital Topics: Research and Perspectives on Healthcare, 83*(2), 11-18.

McArthur, G., & Johnston, M. (2015). Bacchus Marsh Hospital investigated over deaths of seven babies. *Herald Sun*. Retrieved from http://www.heraldsun.com.au/news/bacchus-marsh-hospital-investigated-over-deaths-of-seven-babies/story-fni0fiyv-1227570917427?sv=6d775f832a47e00026a8c5b1a4ac4a9

McComb, S., & Simpson, V. (2014). The concept of shared mental models in healthcare collaboration. *Journal of Advanced Nursing, 70*(7), 1479-1488.

McGregor, D. (1960). *The human side of enterprise*. New York, NY: McGraw Hill.

McGregor, D. (1966). *Leadership and motivation*. Cambridge, MA: MIT Press.

Mendenhall, M. E. (2001). Introduction: New perspectives on expatriate adjustment and its relationship to global leadership development. In G. K. Stahl (Ed.), *Developing global business leaders: Policies, processes, and innovations* (pp. 1-16). Westport, CT: Quorum.

Metcalf, H. C. (1931). *Business leadership*. New York, NY: Pitman.

Morgan, A., Cannan, K., & Cullinane, J. (2005). 360 feedback: A critical enquiry. *Personnel Review, 34*(6), 663-680.

Myers, I. B. (1980). *Gifts differing: Understanding personality type*. Mountain View, CA: Davies-Black Publishing.

National Center for Healthcare Leadership. (2013). NCHL Health Leadership Competency Model. Retrieved from http://www.nchl.org/static.asp?path=2852,3238

National Health Service. (2006). *NHS Leadership Qualities Framework*. Leeds, UK: National Health Service.

National Health Service Institute for Innovation and Improvement and Academy of Medical Royal Colleges. (2009). Medical Leadership Competency Framework. Retrieved from http://www.leadershipacademy.nhs.uk/

Nicholas, M. C., & Hathcoat, J. D. (2014). Ontology. In D. Coghlan & M. Brydon-Miller (Eds.), The Sage encyclopedia of action research (Vol. 15, pp. 571-573). London, UK: Sage Publications.

Office for Health Management. (2000). Office for Health Management report on nursing competencies. Retrieved from http://www.lenus.ie/hse/handle/10147/82534

Ogawa, R. T., & Bossert, S. T. (1995). Leadership as an organizational quality. *Educational Administration Quarterly, 31*(2), 224-243.

Organisation for Economic Co-operation and Development. (2009). Recognition of non-formal and informal learning. Retrieved from http://www.oecd.org/document/25/0,3343,en_2649_39263238_37136921_1_1_1_37455,00.html

Ouchi, W. G., & Jaeger, A. M. (1978). Type Z organization: Stability in the midst of mobility. *Academy of Management Review, 3*, 305-314.

Owen, J., & Phillips, K. (2000). Improving practice: Ignorance is not bliss: Doctors, managers and development. *Journal of Management in Medicine, 14*(2), 119-129.

Oxford University Press. (2014). Oxford dictionary. Retrieved from http://www.oxforddictionaries.com/definition/english/insight

Page, D. P. (1935). Measurement and prediction of leadership. *American Journal of Sociology, 41*(1), 31-43.

Pascale, R. T., & Athos, A. G. (1981). *The art of Japanese management: Application for American executives*. New York, NY: Warner.

Paterson, J. (2005). Reflections on courageous leadership. *Middle Ground, National Middle School Association, 8*(3), 12-14.

Pearce, C. L., & Conger, J. A. (2003). *Shared leadership: Reframing the hows and whys of leadership*. Thousand Oaks, CA: Sage Publications.

Peeters, J., De Backer, F., Buffel, T., Kindekens, A., Struyven, K., Zhu, C., & Lombaerts, K. (2014). Adult learners' informal learning experiences in formal education settings. *Journal of Adult Development, 21*, 181-192.

Peters, T. J., & Waterman, R. H. (1982). *In search of excellence: Lessons from America's best-run companies*. New York, NY: Warner.

Pfeffer, J. (1981). *Power in organizations*. Marshfield, MA: Pitman.

Principals Australia. (2011). Lead lead succeed. Retrieved from http://www.principalsaustralia.edu.au/LLS_PROGRAMS

Queensland Government. (2007). *Queensland Health strategic plan 2007-12*. Brisbane, Qld, Australia: Queensland Government.

Queensland Government Statistician's Office. (2015). *Population growth, Queensland, March quarter 2015*. Brisbane, Qld, Australia: Queensland Treasury.

Queensland Health. (2010). Annual report 2009-2010. Retrieved from http://www.health.qld.gov.au/publications/corporate/annual_reports/annualreport2010/AR_2009-10.pdf

Queensland Health. (2011). *Queensland Health yearly staff profile*. Retrieved from http://www.health.qld.gov.au/performance/staffing/staff15yr_11.pdf.

Queensland Health. (2013). *Blueprint for better healthcare in Queensland*. Brisbane, Qld, Australia.

Quinn, C., & Clare, L. (2008). Interpretive phenomenological analysis. In R. Watson, H. McKenna, S. Cowman, & J. Keady (Eds.), Nursing research designs and methods (pp. 375-384). Edinburgh, UK: Churchill Livingstone Elsevier.

Raelin, J. (2003). *Creating leaderful organizations*. San Fransisco, CA: Berrett-Koehler Publishers.

Roberts, T. (2013). Understanding the research methodology of interpretative phenomenological analysis. *British journal of midwifery, 21*(3), 215-218.

Schenk, C. (1928). Leadership. *Infantry Journal, 33*, 111-122.

Senge, P. (2006). *The fifth discipline*. New York, NY: Doubleday.

Sherman, R. O. (2010). Lessons in innovation: Role transition experiences of clinical nurse leaders. *Journal of Nursing Administration, 40*(12), 547-554.

Shoemaker, P. J., Tankard, J. W., & Lasorsa, D. L. (2004). Theoretical models. In P. J. Shoemaker, J. W. Tankard, & D. L. Lasorsa (Eds.), *How to build social science theories* (pp. 107-145). Thousand Oaks, CA: Sage Publications.

Smith, H. L., & Krueger, L. M. (1933). A brief summary of literature on leadership. *Indiana University, School of Education Bulletin*.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Thousand Oaks, CA: Sage Publications.

Smith, J. A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. Thousand Oaks, CA: Sage Publications Ltd.

Sonnino, R. E. (2013). Professional development and leadership training opportunities for healthcare professionals. *The American Journal of Surgery, 206*(5), 727-731.

Squire, C. (2008). *Approaches to narrative research*. Retrieved from http://eprints.ncrm.ac.uk/419/1/MethodsReviewPaperNCRM-009.pdf

Stefl, M. (2008). Common competencies for all healthcare managers: The Healthcare Leadership Alliance Model. *Journal of Healthcare Management, 53*(6), 360-374.

Stogdill, R. M. (1948). Personal factors associated with leadership: A survey of the literature. *Journal of Applied Psychology, 25*, 35-71.

Stogdill, R. M. (1959). *Individual behavior and group achievement*. New York, NY: Oxford University Press.

Stogdill, R. M. (1974). *Handbook of leadership*. New York, NY: Free Press.

Sun Tzu. (c400$_{B.C.}$). *The art of war*.

Svensson, L., Ellstrom, E., & Aberg, C. (2004). Integrating formal and informal learning at work. *Journal of Workplace Learning, 16*(8), 479-491.

Tannenbaum, R., & Schmidt, W. (1958). How to choose a leadership pattern. *Harvard Business Review, 36*(2), 95-101.

Tashakkori, A., & Teddlie, C. (2009). Integrating qualitative and quantitative approaches to research. In L. Bickman & D. J. Rog (Eds.), *The Sage handbook of applied social research methods* (2nd ed., pp. 283-318). Thousand Oaks, CA: Sage Publications.

Tead, O. (1929). *Human nature and management*. New York, NY: McGraw-Hill.

Tichy, N., & Devanna, M. (1986). *Transformational leadership*. New York, NY: Wiley.

Torrez, M. A., & Rocco, M. L. (2015). *Building critical capacities for leadership learning*. Retrieved from http://wileyonlinelibrary.com

Tough, A. (1979). *The adult's learning projects: A fresh approach to theory and practice in adult learning*. Toronto, Ontario, Canada: The Ontario Institute for Studies in Education.

Trist, E. L., & Bamforth, K. W. (1951). Some social and psychological consequences of the longwall method of coal getting. *Human Relations, 4*, 3-38.

Uhl-Bien, M., & Marion, R. (2008). *Complexity leadership*. Charlotte, NC: Information Age Publishing.

University of Southern Queensland. (2008). Human research ethics. Retrieved from http://www.usq.edu.au/research/ethicsbio/human/default.htm

University of Southhampton. (2011). Approaches to your literature review. Retrieved from

http://www.erm.ecs.soton.ac.uk/theme3/approaches_to_your_literature_review.html

Van Dyne, L., & Ang, S. (2006). Getting more than you expect: Global leader initiative to span structural holes and reputational effectiveness. In W. H. Mobley & E. Weldon (Eds.), *Advances in global leadership* (pp. 101-122). New York, NY: Elsevier.

Van Seters, D. A., & Field, R. H. G. (1990). The evolution of leadership theory. *Journal of Organizational Change Management, 3*(3), 29-45.

VanScoy, A., & Evenstad, S. B. (2015). Interpretative phenomenological analysis for LIS research. *Journal of Documentation, 71*(2), 338-357.

von Clausewitz, C. (1833). *On war*.

Vroom, V. H., & Jago, A. G. (1988). *The new leadership: Managing participation in organizations*. Englewood Cliffs, NJ: Prentice-Hall.

Vroom, V. H., & Yetton, P. W. (1973). *Leadership and decision-making*. Pittsburgh, PA: University of Pittsburgh Press.

Wallace, E. (2015). *Report of an investigation into perinatal outcomes at Djerriwarrh Health Services*. Vic, Australia: State Government of Victoria.

Walshe, K., & Offen, N. (2001). A very public failure: Lessons for quality improvement in healthcare organisations from the Bristol Royal Infirmary. *Quality in Health Care, 10*, 250-256.

Whittred, J. (2008). *A qualitative exploration into the transformational leadership styles of senior police women.* (Master of Science), University of Leicester, Leicester, UK.

Windsor, J., Searle, J., Hanney, R., Chapman, A., Grigg, M., Choong, P., . . . Gladman, M. A. (2015). Building a sustainable clinical academic workforce to meet the future healthcare needs of Australia and New Zealand: Report from the first summit meeting. *Internal Medicine Journal, 45*, 965-971.

Wolf, G., Bradle, J., & Greenhouse, P. (2006). Investment in the future: A 3-level approach for developing the healthcare leaders of tomorrow. *Journal of Nursing Administration, 36*(6), 331-336.

Wood, M., & Gosling, J. (2003). Is the NHS Leadership Qualities Framework missing the wood for the trees? Retrieved from http://leadership-studies.com/documents/WP1.pdf

Woods, F. A. (1913) The influence of monarchs. New York, NY: Macmillan.

World Health Organisation. (2006). The world health report 2006 - working together for health. Retrieved from http://www.who.int/whr/2006/en/

World Health Organisation. (2008). *The world health report 2008 - primary health care (now more than ever).* Retrieved from http://www.who.int/whr/2008/en/

World Health Organisation. (2014a). *Twelfth general programme of work 2014–2019: Not merely the absence of disease*. Retrieved from http://www.who.int/about/resources_planning/twelfth-gpw/en/

World Health Organisation. (2014b). *The world health report 2013: Research for universal health coverage.* Retrieved from http://www.who.int/whr/2013/report/en/

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.

Yukl, G. A. (2006). *Leadership in organizations* (6th ed.). Upper Saddle River, NJ: Pearson/Prentice Hall.

Yukl, G. A. (2013). *Leadership in organizations* (8th ed.). Boston, MA: Pearson.

Appendices

Appendix A: Leadership frameworks reviewed by Bolden, Gosling, Marturano and Dennison (2003)

Private Sector Frameworks

- AstraZeneca Leadership Capabilities
- BAE Performance Centred Leadership
- Federal Express Leadership Qualities
- Lufthansa Leadership Compass
- Philips Leadership Competencies
- Shell Leadership Framework
- Vodafone Global Leadership Competencies.

Public Sector Frameworks

- Senior Civil Service Competency Framework (United Kingdom)
- Department for Education and Skills (DfES) - Management and Leadership Attributes (United Kingdom)
- Northern Ireland Senior Civil Service Core Criteria
- Scottish Executive Framework
- Ministry of Defence (United Kingdom)
- Employers' Organisation (EO) for Local Government – Compendium of Competencies (United Kingdom)
- National Health Service (NHS) Leadership Qualities Framework (United Kingdom)
- National College for School Leadership – Hay McBer Model (United Kingdom)
- Senior Executive Service (United States of America).

Generic Frameworks

- Council for Excellence in Management and Leadership (CEML) Framework of Management and Leadership Abilities (United Kingdom)
- Management Education Training Organisation (METO) Management Standards (United Kingdom)
- Investors in People Leadership and Management Model (United Kingdom)
- European Foundation for Quality Management (EFQM) Business Excellence Model
- Institute of Chartered Management – Chartered Management Skills (United Kingdom)
- International Monetary Fund (IMF) Management Competencies
- Hamlin's Generic Model of Managerial and Leadership Effectiveness (United Kingdom)
- The Zenger Miller Grass-Roots Leadership Model (United States of America).

Appendix B: Healthcare leadership frameworks

Healthcare Leadership Framework A: The New South Wales Health Leadership Framework (Australia).

The New South Wales (NSW) Health Leadership Framework (Health Education and Training Institute, 2013) has been shaped by the latest international evidence and a broad consultation process within the NSW Health system. The leadership approach in the NSW Health Leadership Framework emphasises that leadership can be exercised anywhere in a hospital or health service organisation; leadership is not solely the responsibility of positional leaders. The framework frames leadership in terms of five domains: Achieving outcomes; Developing and leading self; Engaging people and building relationships; Partnering and collaborating across boundaries; and Transforming the system. For each domain a set of four capabilities is defined and for each capability there is a set of three behavioural descriptors.

The domains and associated capabilities are:

Achieving outcomes

- Building a common vision for future health outcomes
- Using outcomes for patients and clients as well as service agreements to drive performance
- Focusing on what makes a difference to results
- Being accountable for performance and resources.

Developing and leading self

- Demonstrating self-awareness
- Actively seeking personal growth
- Modelling desired behaviours and values
- Taking responsibility for own performance and contribution to the service agreement.

Engaging people and building relationships

- Facilitating effective team processes
- Fostering the development of others

- Harnessing talent and diversity
- Creating workplace culture environments where people can contribute.

Partnering and collaborating across boundaries

- Employing a collaborative approach to transforming the organisation
- Mobilising people to undertake collaborative action for service transformation
- Creating cross-sectoral collaborations to deliver service agreements
- Encouraging fresh insights from diverse sources to foster innovation.

Transforming the system

- Shaping a preferred future for health service delivery
- Demonstrating critical and systems thinking
- Assessing and working through resistance and other impediments to change
- Being politically astute and building support for change.

Further information about the framework can be found here: http://www.heti.nsw.gov.au/Global/HETI-Resources/leadership/HETI-leadership-framework.pdf

Healthcare Leadership Framework B: Qualities of a Clinical Director (United Kingdom).

Buchanan, Jordan, Preston and Smith (1997) developed their own set of qualities for a Clinical Director with clusters of: context factors; personal stance; core understanding; behavioural capabilities; and specific skills:

Context factors

- have clinical credibility and the confidence of colleagues

- respected for their clinical practice by colleagues
- acceptable to the Chief Executive
- perceived by colleagues to be experienced.

Personal stance

- willing to be part of corporate management, to take a corporate view, accept collective responsibility for management decisions
- willing to take on the role and to devote time to it
- willing and reliable adviser to the Chief Executive
- willing to be accountable to the Chief Executive
- willing to take collective responsibility for management decisions
- hold a patient-centred orientation.

Core understanding

- understanding of current management issues, and the broader management role
- understanding of the role
- understanding of the NHS political climate
- understanding of the specialty.

Behavioural capabilities

- general leadership qualities – having ideas and taking the department forward
- influential with colleagues, able to bring them on board
- able to represent their specialty and its staff
- team player within their own directorate "triumvirate"
- charisma: character and presence
- able to balance corporate responsibility with representation of the specialist area
- able to take hard decisions, and criticism from colleagues
- able to understand how different groups will be affected by their actions
- able to demonstrate clinical qualities.

Specific skills

- good political skills – political animals – deal with the in-fighting
- communication and interpersonal skills
- able to argue a case
- teaching skills
- time management
- motivational skills
- influencing skills
- diplomacy and negotiating skills
- even tempered, calm and patient.

Buchanan, Jordan, Preston and Smith (1997) drew their data from interviews with six clinical directors and 19 other members of the hospital management team, including the chief executive, nonclinical directors, business managers and senior nurse managers (from one hospital location).

Healthcare Leadership Framework C: Canterbury and West Coast DHB Leadership Capabilities (New Zealand).

The Canterbury and West Coast District Health Boards have a Leadership Capability Framework (Marinelli-Poole et al., 2011) that consists of nine leadership capabilities, each of which has a competency requirement for leaders at seven levels of career progression (a total of 63 competencies). The framework details the skills, knowledge and behaviours required for each of the 63 competencies. The nine leadership capabilities, and an example of the competencies at Level 5, are:

Leadership Capability	Level 5 Competency
1. Display self knowledge	Drives for superior personal and professional performance
2. Establish the change imperative	Design and implement cross-functional change initiatives
3. Build relationships and mobilise support	Forge cross-organisational relationships and commitment

Leadership Capability	Level 5 Competency
4. Think and act strategically	Shape organisational, professional and/or industry strategy
5. Communicate a vision and sense of purpose	Promote and communicate organisational purpose and vision
6. Empower others to act	Mentor and empower other leaders to act
7. Stimulate innovation and create immediate wins	Build and sustain organisational innovation
8. Consolidate and continuously improve on strategic change	Mobilise others and champion change initiatives
9. Foster a positive culture	Foster a culture of responsibility and commitment

The framework is designed to support transformational change and underpins all people-based activities for the Canterbury and West Coast District Health Boards, including recruitment, performance management, and learning and development.

Healthcare Leadership Framework D: Healthcare Leadership Alliance Model (United States of America).

The Healthcare Leadership Alliance (HLA) is a consortium of six major healthcare professional membership organisations in the United States (Stefl, 2008). The consortium identified five competency domains common among all practising healthcare managers and then engaged in a formal process to delineate the knowledge, skills and abilities within each domain. This process produced 300 competency statements, which were then organised into a Competency Directory. The five competency domains are:

1. Communication and relationship management
2. Professionalism
3. Leadership
4. Knowledge of the healthcare system
5. Business skills and knowledge.

The HLA model is designed to be used for individual and organisational assessment, employee selection and team development. In addition, the model can be adapted for use in academic programs. The competency directory can be accessed here: http://www.healthcareleadershipalliance.org/directory.htm

Healthcare Leadership Framework E: Health Leadership Capabilities Framework (Canada).

The LEADS Leadership Capabilities Framework has been developed by the Health Care Leaders Association of British Columbia under their LEADS initiative. It represents the key skills, abilities and knowledge required to lead at all levels of the health system. It aligns and consolidates the competency frameworks of individual health employers, professional associations and other progressive organisations into a common strategy (Health Care Leaders Association of British Columbia, 2010). The framework consists of five major dimensions, with each major dimension having four minor dimensions:

Lead Self

- Are Self Aware
- Manage Themselves
- Develop Themselves
- Demonstrate Character.

Engage Others

- Foster Development of Others
- Contribute to the Creation of Healthy Organisations
- Communicate Effectively
- Build Teams.

Achieve Results

- Set Direction
- Strategically Align Decisions with Vision, Values and Evidence
- Take Action to Implement Decisions
- Assess and Evaluate.

Develop Coalitions

- Purposefully Build Partnerships and Networks to Create Results
- Demonstrate a Commitment to Customers and Service
- Mobilise Knowledge
- Navigate Socio-Political Environments.

Systems Transformation

- Demonstrate Systems/Critical Thinking
- Encourage and Support Innovation
- Orient Themselves Strategically to the Future
- Champion and Orchestrate Change.

Further information about the framework can be found at http://www.leadersforlife.ca/leads-resources

Healthcare Leadership Framework F: Medical Leadership Competency Framework (United Kingdom).

The Medical Leadership Competency Framework (MLCF) (please refer to Figure 1 of this Appendix) was jointly developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement (2009). Although the NHS Leadership Qualities Framework (National Health Service, 2006) was an influence, the MLCF specifically describes the leadership competencies that doctors need for them to become more actively involved in planning, delivering and transforming services for patients.

Figure 1: Medical Leadership Competency Framework (National Health Service Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2009)

The MLCF consists of five domains: Demonstrating Personal Qualities; Working with Others; Managing Services; Improving Services; and Setting Direction. Within each domain are four elements and each of these elements is further divided into four competency outcomes (a total of 80 competencies). The domains and their associated elements are:

Demonstrating Personal Qualities

- Developing self awareness
- Managing yourself
- Continuing personal development
- Acting with integrity.

Working with Others

- Developing networks
- Building and maintaining relationships
- Encouraging contribution
- Working within teams.

Managing Services

- Planning
- Managing resources
- Managing people
- Managing performance.

Improving Services

- Ensuring patient safety
- Critically evaluating
- Encouraging improvement and innovation
- Facilitating transformation.

Setting Direction

- Identifying the contexts for change
- Applying knowledge and evidence
- Making decisions
- Evaluating impact.

The Medical Leadership Competency Framework has been in development since August 2006 and was first published in 2008. Further information about the framework can be found here: http://www.leadershipacademy.nhs.uk/

Healthcare Leadership Framework G: The NCHL Health Leadership Competency Model (United States of America).

The National Center for Healthcare Leadership (NCHL) Health Leadership Competency Model (please refer to Figure 2 of this Appendix) was created through research by the Hay Group with practising health leaders and managers across the administrative, nursing and medical professions, and early, mid and advanced career stages. In addition, the Competency Model incorporates benchmark data from other health sectors and insurance companies, and composite leadership competencies from a group of global corporations (National Center for Healthcare Leadership, 2013). The model contains three domains with 26 competencies.

Figure 2: NCHL Health Leadership Competency Model (National Center for Healthcare Leadership, 2013)

The three domains are Transformation; Execution; and People. The domains and their associated competencies are shown here:

Transformation

- Achievement Orientation
- Analytical Thinking
- Community Orientation
- Financial Skills
- Information Seeking
- Innovative Thinking
- Strategic Orientation.

Execution

- Accountability
- Change Leadership
- Collaboration

- Communication Skills
- Impact and Influence
- Initiative
- Information Technology Management
- Organisational Awareness
- Performance Measurement
- Process Management/Organisational Design
- Project Management.

People

- Human Resources Management
- Interpersonal Understanding
- Professionalism
- Relationship Building
- Self Confidence
- Self Development
- Talent Development
- Team Leadership.

Further information about the model can be found at http://www.nchl.org/static.asp?path=2852,3238

Healthcare Leadership Framework H: The Pan-Canadian Health Leadership Capability Framework (Canada).

The Pan-Canadian Health Leadership Capability Framework (Canadian Health Services Research Foundation, 2007) was developed as the result of a qualitative research study by the Centre for Health Leadership and Research at Royal Roads University for the Canadian Health Services Research Foundation. The research team adopted a qualitative, action-research approach to gather data from three sources: 1) in-depth interviews with key informants and 10 focus groups with health leaders across Canada; 2) a review of peer-reviewed and grey literature on types and qualities of leadership; and 3) analysis of competency/capability frameworks from selected national and international sources. The framework has five domains of

leadership capabilities: Champion caring; Cultivate self and others; Connect with others; Create results; and Change systems, each with four sub-domains.

CHAMPION caring

- Inspire and encourage a commitment to health
- Show respect for the dignity of all persons
- Act with compassion
- Exhibit fairness and a sense of justice.

CULTIVATE self and others

- Demonstrate self-awareness and self-management
- Exhibit character: honesty, integrity, optimism, confidence and resiliency
- Enable others to grow
- Create engaging environments where people have meaningful opportunities to contribute.

CONNECT with others

- Communicate effectively with a wide variety of stakeholders
- Build effective multi-disciplinary teams
- Develop networks, coalitions and partnerships
- Navigate socio-political environments successfully.

CREATE results

- Develop a shared vision and translate it into action
- Hold themselves and others accountable for results
- Integrate quality improvement and evidence into decision-making
- Manage resources responsibly and creatively.

CHANGE systems

- Build personal and organisational understanding of the complexity of health systems
- Mobilise knowledge to challenge processes and guide change

- Lead changes consistent with vision, values and a commitment to health
- Orchestrate changes to improve health service delivery.

Further information about the model can be found here: http://www.cfhi-fcass.ca/Migrated/PDF/Health_Leadership_Framework_E.pdf

Healthcare Leadership Framework I: Queensland Public Sector Nurse Executives: Professional Development Needs (Australia).

Courtney, Yacopetti, James, Walsh and Montgomery (2002) developed a prioritised set of professional development needs for Queensland Public Sector Nurse Executives based on identified difficult problems faced by these executives. The difficult problems identified by the executives were: Financial; Personnel; Workload; HRM skills; Information technology; Management; Change; Lack of time; Lack of appropriate staff to employ; Isolation in decision making; Inequity; and Devaluation of nursing input. The professional development requirements were identified as:

- Financial management: budget development, support
- Education updates: in-service, small group updates, nursing forums
- Information technology training and support
- Networking: more formal opportunities, state-wide networking, information networks
- HRM skills: managing difficult people, conflict management, counselling, mediation training, industrial relations
- Communication skills
- Acknowledgment of remote nursing
- Organisational training: guidance, support
- Supportive structures: mentoring
- Professional development for Level 3s
- Management: skill development, change management, new management practices.

Whilst it can be argued that the above set of professional development needs identified by Courtney, Yacopetti, James, Walsh and Montgomery (2002) does not

constitute a leadership framework, it has been included as it relates to the problems and needs of the leaders within the same cohort as that targeted by Queensland Health's adoption of the NHS Leadership Qualities Framework (National Health Service, 2006) and it provides some useful comparison.

Healthcare Leadership Framework J: Competencies for Nursing and Midwife Managers (Ireland).

Competencies developed by the Office for Health Management (Ireland) describe the management competencies required for nursing and midwifery management positions. The competencies were developed through field research with a representative sample of nurse managers at front line, middle and top level roles and then validated and refined through consultation with groups of nurse managers and other service stakeholders (Office for Health Management, 2000). The competencies are grouped under the headings of: Generic Competencies for Nurse Managers; Competencies for Top-Level Nurse Managers; Competencies for Mid-Level Nurse Managers; and Competencies for Front Line Nurse Managers.

Generic Competencies for Nurse Managers

1. Promotion of Evidence Based Decision Making
2. Building and Maintaining Relationships
3. Communication and Influencing Skills
4. Service Initiation and Innovation
5. Resilience and Composure
6. Integrity and Ethical Stance
7. Sustained Personal Commitment
8. Professional Competence and Credibility.

Competencies for Top-Level Nurse Managers

1. Strategy and Systems Thinking
2. Establishing Policy, Systems and Structures
3. Leading on Vision, Values and Process
4. Stepping up to the Corporate Agenda
5. Developmental Approach to Staff.

Competencies for Mid-Level Nurse Managers

1. Empowering and Enabling Leadership Style
2. Setting and Monitoring Performance Standards
3. Negotiation Skills
4. Proactive Approach to Planning
5. Effective Co-ordination of Resources.

Competencies for Front Line Nurse Managers

1. Planning and Organisation
2. Building and Leading a Team
3. Leading on Clinical Practice and Service Quality.

Each competency has associated behavioural indicators. The competencies are designed to inform the recruitment and selection of nurse managers and to facilitate the process of training and development. More information can be found at http://www.lenus.ie/hse/handle/10147/82534 .

Appendix C: Healthcare leadership frameworks and their alignment with leadership theory

Table 1 of this Appendix represents an overview of the analysis of the alignment of healthcare leadership frameworks with leadership theory. The elements (competencies/qualities/ characteristics) of each of the healthcare leadership frameworks presented in Appendix B were analysed to determine with which cluster of leadership theory they most strongly aligned. This was achieved through a word analysis of the respective elements. It was recognised that there were limitations in this approach, most importantly the researcher's bias and filtering. The authors/creators of the frameworks were not consulted in this analysis and it was recognised that they may have alternative views as to the alignment of their work.

Table 1: Healthcare Leadership Frameworks and their Alignment with Leadership Theory

Frameworks and Elements	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
The NSW Health Leadership Framework (Australia)									
Achieving outcomes									
Building a common vision for future health outcomes							x		
Using outcomes for patients and clients as well as service agreements to drive performance						x			
Focusing on what makes a difference to results						x			
Being accountable for performance and resources						x			
Developing and leading self									
Demonstrating self-awareness		x							
Actively seeking personal growth			x						
Modelling desired behaviours and values			x						
Taking responsibility for own performance and contribution to the service agreement			x						
Engaging people and building relationships									
Facilitating effective team processes				x					
Fostering the development of others				x					
Harnessing talent and diversity				x					
Creating workplace culture environments where people can contribute								x	
Partnering and collaborating across boundaries									
Employing a collaborative approach to transforming the organisation							x		
Mobilising people to undertake collaborative action for service transformation							x		
Creating cross-sectoral collaborations to deliver service agreements				x					
Encouraging fresh insights from diverse sources to foster innovation							x		
Transforming the system									

Table 1: Healthcare Leadership Frameworks and their Alignment with Leadership Theory

Frameworks and Elements	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
Shaping a preferred future for health service delivery							x		
Demonstrating critical and systems thinking		x							
Assessing and working through resistance and other impediments to change				x					
Being politically astute and building support for change				x					
Qualities of a Clinical Director (United Kingdom)									
Context									
have clinical credibility and the confidence of colleagues					x				
respected for their clinical practice by colleagues					x				
acceptable to the Chief Executive					x				
perceived by colleagues to be experienced					x				
Personal stance									
willing to be part of corporate management, to take a corporate view, accept collective responsibility for management decisions					x				
willing to take on the role and to devote time to it					x				
willing and reliable adviser to the Chief Executive					x				
willing to be accountable to the Chief Executive					x				
willing to take collective responsibility for management decisions						x			
hold a patient-centred orientation					x				
Core understanding									
understanding of current management issues, and the broader management role					x				
understanding of the role					x				
understanding of the NHS political climate					x				
understanding of the specialty					x				
Behavioural capabilities									
general leadership qualities – having ideas and taking the department forward							x		
influential with colleagues, able to bring them on board				x					
able to represent their specialty and its staff					x				
team player within their own directorate "triumvirate"					x				
charisma: character and presence		x							
able to balance corporate responsibility with representation of the specialist area					x				
able to take hard decisions, and criticism from colleagues					x				
able to understand how different groups will be affected by their actions						x			
able to demonstrate clinical qualities					x				
Specific skills									
good political skills – political animals – deal with the in-fighting		x							
communication and interpersonal skills				x					
able to argue a case				x					
teaching skills			x						
time management			x						
motivational skills				x					
influencing skills				x					
diplomacy and negotiating skills				x					
even tempered, calm and patient		x							
Canterbury and West Coast DHB Leadership Capabilities (New Zealand)									
Display self knowledge		x							

Table 1: Healthcare Leadership Frameworks and their Alignment with Leadership Theory

Frameworks and Elements	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
Establish the change imperative							x		
Build relationships and mobilise support				x					
Think and act strategically							x		
Communicate a vision and sense of purpose				x					
Empower others to act				x					
Stimulate innovation and create immediate wins							x		
Consolidate and continuously improve on strategic change							x		
Foster a positive culture								x	
Healthcare Leadership Alliance Model (United States of America)									
Communication and relationship management				x					
Professionalism		x							
Leadership			x						
Knowledge of the healthcare system					x				
Business skills and knowledge						x			
Health Leadership Capabilities Framework (Canada)									
Lead Self									
Are Self Aware		x							
Manage Themselves			x						
Develop Themselves			x						
Demonstrate Character		x							
Engage Others									
Foster Development of Others				x					
Contribute to the Creation of Healthy Organisations								x	
Communicate Effectively				x					
Build Teams				x					
Achieve Results									
Set Direction							x		
Strategically Align Decisions with Vision, Values, and Evidence							x		
Take Action to Implement Decisions						x			
Assess and Evaluate			x						
Develop Coalitions									
Purposefully Build Partnerships and Networks to Create Results				x					
Demonstrate a Commitment to Customers and Service		x							
Mobilise Knowledge			x						
Navigate Socio-Political Environments				x					
Systems Transformation									
Demonstrate Systems/Critical Thinking			x						
Encourage and Support Innovation							x		
Orient Themselves Strategically to the Future							x		
Champion and Orchestrate Change							x		
Medical Leadership Competency Framework (United Kingdom)									
Demonstrating Personal Qualities									
Developing self awareness		x							
Managing yourself		x							
Continuing personal development		x							
Acting with integrity		x							
Working with Others									
Developing networks				x					
Building and maintaining relationships				x					
Encouraging contribution				x					
Working within teams				x					
Managing Services									

Table 1: Healthcare Leadership Frameworks and their Alignment with Leadership Theory

Frameworks and Elements	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
Planning						x			
Managing resources						x			
Managing people						x			
Managing performance						x			
Improving Services									
Ensuring patient safety					x				
Critically evaluating						x			
Encouraging improvement and innovation							x		
Facilitating transformation							x		
Setting Direction									
Identifying the contexts for change							x		
Applying knowledge and evidence					x				
Making decisions						x			
Evaluating impact						x			
The NCHL Health Leadership Competency Model (United States of America)									
Transformation									
Achievement Orientation		x							
Analytical Thinking			x						
Community Orientation					x				
Financial Skills						x			
Information Seeking			x						
Innovative Thinking							x		
Strategic Orientation							x		
Execution									
Accountability						x			
Change Leadership							x		
Collaboration				x					
Communication Skills			x						
Impact and Influence				x					
Initiative		x							
Information Technology Management						x			
Organisational Awareness					x				
Performance Measurement						x			
Process Management/Organisational Design						x			
Project Management						x			
People									
Human Resources Management						x			
Interpersonal Understanding				x					
Professionalism		x							
Relationship Building				x					
Self Confidence		x							
Self Development		x							
Talent Development				x					
Team Leadership				x					
The Pan-Canadian Health Leadership Capability Framework (Canada)									
CHAMPION caring									
Inspire and encourage a commitment to health					x				
Show respect for the dignity of all persons		x							
Act with compassion		x							
Exhibit fairness and a sense of justice		x							
CULTIVATE self and others									
Demonstrate self-awareness and self-management		x							
Exhibit character: honesty, integrity, optimism, confidence and resiliency		x							
Enable others to grow				x					
Create engaging environments where people have meaningful opportunities to contribute				x					

Table 1: Healthcare Leadership Frameworks and their Alignment with Leadership Theory

Frameworks and Elements	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
CONNECT with others									
Communicate effectively with a wide variety of stakeholders				x					
Build effective multi-disciplinary teams				x					
Develop networks, coalitions and partnerships				x					
Navigate socio-political environments successfully				x					
CREATE results									
Develop a shared vision and translate it into action							x		
Hold themselves and others accountable for results						x			
Integrate quality improvement and evidence into decision-making					x				
Manage resources responsibly and creatively						x			
CHANGE systems									
Build personal and organisational understanding of the complexity of health systems					x				
Mobilise knowledge to challenge processes and guide change							x		
Lead changes consistent with vision, values and a commitment to health					x				
Orchestrate changes to improve health service delivery					x				
Queensland Public Sector Nurse Executives: Professional Development Needs (Australia)									
Financial management: budget development, support						x			
Education updates: in-service, small group updates, nursing forums					x				
Information technology training and support						x			
Networking: more formal opportunities, state-wide networking, information networks				x					
HRM skills: managing difficult people, conflict management, counselling, mediation training, industrial relations			x						
Communication skills			x						
Acknowledgment of remote nursing					x				
Organisational training: guidance, support						x			
Supportive structures: mentoring				x					
Professional development for Level 3s					x				
Management: skill development, change management, new management practices						x			
Competencies for Nursing and Midwife Managers (Ireland)									
Promotion of Evidence Based Decision Making				x					
Building and Maintaining Relationships				x					
Communication and Influencing Skills				x					
Service Initiation and Innovation							x		
Resilience and Composure		x							
Integrity and Ethical Stance		x							
Sustained Personal Commitment		x							
Professional Competence and Credibility			x						
Strategy and Systems Thinking							x		
Establishing Policy, Systems and Structures						x			
Leading on Vision. Values and Process								x	
Stepping up to the Corporate Agenda						x			
Developmental Approach to Staff				x					
Empowering and Enabling Leadership Style				x					
Setting and Monitoring Performance Standards						x			
Negotiation Skills			x						
Proactive Approach to Planning						x			
Effective Co-ordination of Resources						x			
Planning and Organisation						x			

Table 1: Healthcare Leadership Frameworks and their Alignment with Leadership Theory

Frameworks and Elements	Great Man	Trait	Behaviour	Influence	Contingency	Transactional	Transformational	Culture	Organisational Leadership
Building and Leading a Team				x					
Leading on Clinical Practice and Service Quality						x			

Appendix D: Research ethics approval

University of Southern Queensland

TOOWOOMBA QUEENSLAND 4350 CRICOS: QLD 00244B NSW 02225M
AUSTRALIA
TELEPHONE +61 7 4631 2900

www.usq.edu.au

OFFICE OF RESEARCH AND HIGHER DEGREES
Ashley Steele
Ethics Officer
PHONE (07) 4631 2690 | FAX (07) 4631 2955
EMAIL ethics@usq.edu.au

Friday, 22 January 2010

Stephen Hart
41 Tarrabool Street
Westlake, 4074

Dear Stephen,

Thankyou for submitting your project below for human ethics clearance. The Chair of the USQ Human Research Ethics Committee recently reviewed your responses to the HREC's conditions placed upon the ethical approval for the above project. Your proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and full ethics approval has been granted.

Project Title	The impact of formal education on the leadership development of healthcare executives in Queensland Health
Approval no	H09REA144
Period of Approval	08/01/2010–08/01/2011
HREC Decision	Approved

The standard conditions of this approval are that:

(a) you conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC;
(b) you advise the HREC (email: ethics@usq.edu.au) immediately if any complaints or expressions of concern raised, or any other issue in relation to the project which may warrant review of ethics approval of the project;
(c) You make submission to the HREC for approval of any amendments, or modifications to the approved project before implementing such changes;
(d) in the event you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval;
(e) you provide the HREC with a written "Annual Progress Report" for every year of approval. The first progress report is due 12 months after the start date of this approval (by 08/01/2011);
(f) you provide the HREC with a written "Final Report" when the project is complete;
(g) if the project is discontinued, you advise the HREC in writing of the discontinuation.

For (c) to (f) proformas are available on the USQ ethics website: http://www.usq.edu.au/research/ethics/human

Please note that failure to comply with the conditions of approval and the *National Statement on Ethical Conduct in Human Research* may result in withdrawal of approval for the project.

You may now commence your project. I wish you all the best for the conduct of the project.

Yours sincerely,

Ashley Steele
Ethics Officer
Office of Research and Higher Degrees

Toowoomba • Springfield • Fraser Coast usq.edu.au

Appendix E: Research fact sheet

Research Fact Sheet

The influence of formal education on the leadership development of healthcare executives in Queensland Health.

What is the purpose of the research
The purpose of the research is to better understand the impact that formal education has had on the leadership development of healthcare executives in Queensland Health. There will have been many learning experiences that have contributed to the overall leadership development of executives - this study will focus specifically on formal educational experiences and their influence. It is anticipated that the research will have significant application to the health sector. Health sector executives, and those who aspire to executive leadership roles, will be able to review their development plans and consider the influence that formal education may have on their future leadership development.

Who is conducting the research
Stephen Hart, a Doctoral candidate from the Faculty of Education at the University of Southern Queensland is conducting the research under the supervision of Dr Rick Churchill (Supervisor) and Dr Joan Conway (Associate Supervisor) from the University of Southern Queensland. Stephen is also a Director with People and Culture Corporate in the Corporate Services Division of Queensland Health.

What is the research methodology
A grounded theory methodology will be used for the study. This method involves data collection through interviews and coding of responses that lead to the emergence and generation of theory.

Has the research been approved
The research has Ethics clearance and approval of the Executive Director People and Culture Corporate.

Who will be participating in the research
Healthcare executives in Queensland Health who are recognised as exceptional leaders will be invited to participate in the research. Potential participants will be identified through peer referral, that is, executives will be asked to identify those of their peers who exhibit exceptional leadership characteristics that align with the Queensland Health adopted NHS Leadership Qualities.

Is participation voluntary
Participation is completely voluntary, and participants may withdraw at any stage with no questions asked. All information will be kept strictly confidential, and will only be seen by the researcher and their supervisors. The results of the study will be reported in a thesis being prepared by Mr Hart, and it is hoped that the overall findings will be published in journals. Only group data will be reported in these documents.

What will be expected of participants
Up to three interviews of one hour each may be required with each participant over a six month period to enable all the emerging factors to be explored. Additional data in the form of existing 360^0 survey results for each participant will also be requested.

Appendix F: Research consent form

Research Consent Form

Mr Stephen Hart, a Doctoral candidate from the Faculty of Education at the University of Southern Queensland is conducting a study on the influence of formal education on the leadership development of healthcare executives in Queensland Health. Mr Hart's study will be conducted under the supervision of Dr Rick Churchill (Supervisor) and Dr Joan Conway (Associate Supervisor) from the University of Southern Queensland who will provide relevant advice and assistance to Mr Hart at all stages of the research program.

Mr Hart will be adopting a grounded theory approach to the study. This approach involves data collection through interviews and coding of responses that lead to the emergence and generation of theory. Up to three interviews of one hour each may be required with each participant over a six month period to enable all the emerging factors to be explored. Additional data in the form of existing 360^0 survey results for each participant will also be requested.

Participation is completely voluntary, and you may withdraw at any stage with no questions asked. All information will be kept strictly confidential, and will only be seen by the researcher and their supervisors. The results of the study will be reported in a thesis being prepared by Mr Hart, and it is hoped that the overall findings will be published in journals. Only group data will be reported in these documents. You have our assurance that your name will not be used and that we will not report any personal information that could identify you in any way.

It is anticipated that the research will have significant application to the health sector. Health sector executives, and those who aspire to executive leadership roles, will be able to review their development plans and consider the influence that formal education may have on their future leadership development.

If you wish to take part in the study, please sign the consent form below. This consent form will be stored in a separate location so that your name will not be attached to the interview notes. If you have any queries about the research, please do not hesitate to contact the researcher using the contact details listed below. Thank you for your interest in this study.

Mr Stephen Hart
0438 113 806
stephenvsl@hotmail.com

CONSENT FORM

I have read the information above and agree to take part in the study. I understand that my participation is completely voluntary and that I may withdraw at any time with no questions asked. I understand that the results of the study will be reported in a thesis and journal articles, but that I will not be identified individually. I understand that this consent form will be stored in a separate location so that my name will not be attached to the interview notes. I declare that I am at least 18 years of age and I hereby give my consent to participate in this study.

Signature: _____

Name: _____

Date: _____

Should you have any concern about the conduct of this research project, please contact the USQ Ethics Officer, Office of Research & Higher Degrees, University of Southern Queensland, West Street, Toowoomba QLD 4350, Telephone (07) 4631 2690, email: ethics@usq.edu.au