Experiences of a Clinical Leadership Programme and its subsequent impact: A Constructivist Inquiry

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Abstract

Using a Constructivist methodology, combining elements of Fourth Generation Evaluation and Grounded Theory (Guba and Lincoln, 1989; Charmaz, 2014), this study explored the impact over time of the *Delivering Better Care Leadership Programme*, to better understand the factors that enabled or hindered subsequent changes. The study involved three Phases and data were collected longitudinally, primarily using interviews with a range of stakeholders.

The study was underpinned by the '*Senses Framework'* and '*enriched environments'* (Nolan et al., 2006; Brown, 2005), and resulted in the development of the Five Cs' substantive theory comprising: ***C**ontext, **C**atalyst, **C**hronology, **C**onditions and **C**onsequences.* This theory, when used in conjunction with the *Senses Framework*, illuminates experiences and subsequent ***C**onsequences* of participants, their teams and the wider organisation over time, and highlights the ***C**onditions* needed to create and sustain positive ***C**onsequences* for participants and the wider ***C**ontext*. The importance of *relationships* emerged as being paramount. In order to create the ***C**onditions*, necessary for *enriched environments*, a number of enabling factors were identified, including support from colleagues, the promotion of autonomy, intrinsic motivation and drive, and opportunities for continual learning and development. On the basis of this study, the promotion of *'relationship-centred leadership'* is suggested as a way forward for future initiatives.

Implications for on-going leadership development programmes are considered, particularly in the challenging and complex landscape of the National Health Service (NHS), as are the contribution that the study makes to advancing knowledge. Methodologically, the study also argues for an expansion of the EA Matrix via the addition of two further dimensions: **E**valuate and **E**mbed **A**ction.

The study concludes that the Five C's theory, allied with *Senses Framework,* provides a facilitation mechanism to foster *relationship-centred leadership*, which has the potential to further promote a compassionate, collective leadership culture, so vital for the NHS at this time.

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Glossary

Advanced Nurse Practitioner - a registered nurse who has developed complex decision-making skills, knowledge and clinical competencies, for extended practice.

Allied Health Professionals - a range of staff who work within healthcare teams to provide a range of diagnostic, technical, therapeutic and direct patient care and support services e.g. Physiotherapist, Occupational Therapist

Banding of healthcare staff - the pay system for all healthcare staff except doctors, dentists and very senior managers is called Agenda for Change and consists of nine pay *bands* each of which have a number of pay points e.g. Healthcare Support Worker will be on a Band 2 or 3; Staff Nurse Band 5, Senior Change Nurse Band 7, Clinical Nurse Manager Band 8

Direct Report - is a junior colleague who reports to a senior colleague within the healthcare team e.g. Staff Nurse would report to a Senior Charge Nurse

eKSF - The electronic NHS Knowledge and Skills Framework (KSF) which applies to all staff who are employed under Agenda for Change (AFC) terms and conditions, to identify the knowledge, skills, learning and development needed to do their job, within healthcare.

Leadership and Management Development Framework - a document, which contains all the development options for staff in relation to leadership and management, for individuals and teams and signposts to internal and external resources.

Organisational Development Team - sits within Human Resources Department. Consists of a team of professionals who support the development of individuals and teams within an organisation aiming to enhance effectiveness

through leadership, coaching, mediation, consulting and facilitation of a range to tools and interventions.

Peer - is a colleague who works within the team and may be of equivalent band or may in fact be on a more senior or junior band. The working relationship does not involve management.

PDP - Personal Development Plan- is a structured and supported process, done electronically or written, by a staff member and their manager, to reflect upon their own learning, performance and achievement within their role, to plan for their personal, educational and career development.

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I have thought about writing this many times throughout my PhD journey and hoped I would remember everyone who has supported me and made this opportunity possible. I cannot believe I am actually at this moment in time.

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It has been a journey of discovery, full of learning, and I look forward to the next steps… thank you all so much.

Abbreviations

Advancing Gerontological Education in Nursing	AGEIN
Community Support Worker	CSW
Delivering Better Care Leadership Programme	DBC LP
Delivering Leadership Excellence	DLE
Deputy Charge Nurse	DCN
District Nurse	DN
Edinburgh Napier University	ENU
Enhancing Relationships in Care in Hospitals	EnRiCH
External Reference Group	ERG
Faculty of Research Ethics Committee	FREC
Human Resources	HR
Institute for Healthcare Improvement	IHI
Leadership and Management Development Framework	LMDF
Leadership in Compassionate Care	LCC
Learning Disability	LD
National Health Service	NHS
NHS Education for Scotland	NES
Occupational Therapist	OT
Personal Development Plan	PDP
Physiotherapist	Physio
Quality Improvement	QI
Organisational Development	OD
Registered General Nurse	RGN
Staff Nurse	SN
Researcher Development Programme	RDP
United Kingdom	UK

Author's Declaration

I declare that this Thesis is the result of my own work and has not been submitted for any other degree at De Montfort University or any other institution. The contribution of others' work is explicitly referenced throughout.

Chapter One. Setting the Scene: The importance of Context

1.1 Purpose of Chapter

This Chapter sets the scene for the study that lies at the heart of this thesis. It provides an overview of my motivation for undertaking a doctoral study, highlights why such a study was needed and concludes with a brief summary of the various Chapters that the thesis comprises. It is hoped that this will provide the reader with sufficient contextual understanding for the thesis as a whole. The importance of context arises at numerous points in the thesis and here I pay particular attention to what motivated me to undertake the study because, as will become clear, an appreciation of this is pivotal to interpreting the findings, and is a core element of the reflexivity that is threaded throughout the work. Over my career of 38-years in the National Health Service (NHS), I have had considerable experience in the art and science of nursing, particularly in NHS Lothian, the Board in which the study was undertaken. Although the NHS is a United Kingdom (UK) wide organisation, following devolution, there has emerged an element of national/regional variation that provides a further dimension to the context for my study. This is considered in more detail later. In the section below I provide a brief biography of my professional experience and development.

1.2 My background and motivations for the study

After qualifying as a Registered General Nurse (RGN) in 1983 and a period of practice, I furthered my qualifications and became registered as a District Nurse (DN) in 1987. Following this I worked for a number of years in the community, caring for patients and their families within their own homes. During this period I developed a growing interest in working in partnership with family carers, staff and students. In 2002, the opportunity arose to apply for a secondment as a ‘Leadership Facilitator’, for which I applied and was successful. The initial

secondment was extended over a period of five years and provided me with many new challenges, which contributed to my enhanced confidence and willingness to work outside my comfort zone. In 2008 I was appointed as the 'Lead Practitioner for Clinical Leadership', a new role created within the education and practice development structure in NHS Lothian.

The role as 'Lead Practitioner for Clinical Leadership', located within Human Resources (HR) and Organisational Development (OD), provided me with the opportunity to further develop professionally by becoming a leadership resource for the wider workforce. This experience enabled me to enhance and diversify my skills particularly in relation to facilitation, coaching and engaging with others and in the design, delivery and evaluation of key programmes and work streams within NHS Lothian. In October 2016 I secured a fulltime position as an 'OD Consultant' within NHS Lothian, which provided further new opportunities and learning, whilst enabling NHS Lothian to make maximum use of my experience in leadership, especially how the skills that staff had developed whilst undertaking leadership programmes could be sustained over time. Throughout this whole period, one particular programme of leadership development evolved, and consideration of its 'success' lies at the heart of this thesis. The evolution of this programme and its aims/goals will be described in more detail at a number of points in the Chapters that follow, especially Chapter three that sets the local context for the study.

During the above period I had also been involved in a number of research studies exploring leadership programmes (for example, see below) but I had not conducted such a study myself. The stimulus to do so arose in 2013 when I was acting as a researcher/facilitator to the *Enhancing Relationships in Care in Hospitals* (EnRiCH) research project (Knight et al., 2017). The EnRICH project was a nurse-led culture change programme delivered in partnership with University Hospitals Leicester, De Montfort University and The University of Sheffield, through funding provided by the Burdett Trust for Nursing. The study involved engaging with healthcare staff and helping them to reflect on their practice by involving patients and carers in giving and receiving feedback.

Based on this process, small scale change initiatives were designed and implemented in an effort to try and improve the experiences of receiving and providing care for older people in hospital. Working as a key member of the research team, two of whom later became my supervisor (Professor Jayne Brown), and advisor (Professor Mike Nolan), made me realise that there was much that could be learned about the impact of the programmes I had been delivering for many years in NHS Lothian. Secondment on a part-time basis to the EnRICH team gave me more time to consider enrolling for a part-time Researcher Development Programme (RDP), and with the support of my manager and encouragement from other members of the research team, this is what I did.

As noted above, by this point I had considerable experience of facilitation, leadership and practice development over many years, fuelled by my desire to influence how organisations develop leadership and individual leaders, and how to sustain subsequent changes to both programme participants and wider healthcare practice over time. A better understanding of the factors that might initiate and maintain such changes became the primary aim of my doctoral study. To explore such factors I focused my attention on one particular programme, the *Delivering Better Care Leadership Programme* (DBC LP) that I had been involved with over a number of years. Much more detail on this programme will be provided later in Chapter three, however to help readers put the study into an appropriate context from the outset, a brief overview of the programme is given here.

NHS Lothian and Edinburgh Napier University's (ENU) DBC LP is a leadership programme, which focuses on caring, compassion and quality improvement. The ENU has worked in collaboration with NHS Lothian, for several years in relation to clinical education modules, and in partnership to deliver *The Leadership in Compassionate Care Programme* (see Chapter three section 3.3 for details of how this has evolved). The main aims of the DBC LP are to enable participants, who are healthcare staff, (see Chapter three), to develop their

personal qualities and skills as transformational leaders, to work with others on the programme to exchange ideas, build upon expertise in the group and develop leadership and practice using concepts such as *relationship-centred care* (Brooker and Nolan, 2007; Nolan, 2013), quality improvement (Swensen et al., 2009) and appreciative inquiry (Cooperrider and Whitney, 2011).

This programme builds on earlier work that I had been involved with, when designing and delivering other clinical leadership development programmes in Scotland and Eire over the last ten years, which were in part underpinned by the notion of *relationship-centred care* as captured by the '*Senses Framework'* (Nolan et al., 2004; Nolan et al., 2006; Nolan, 2013). This framework highlights the importance of fostering effective relationships between patients, staff, students and carers/family members in order to create an *enriched environment* of care. This is achieved by helping all parties to experience six '*Senses*', these being**: Security, Belonging, Continuity, Purpose, Significance and Achievement** (Brown et al., 2009; Nolan, 2013). In my experience of using this approach, I had found that the *Senses Framework* was incredibly adaptable, well understood and well received by healthcare staff. It became one of the key conceptual underpinnings for this study and the part it played will be described further at a number of points in this thesis. The '*Senses*', '*enriched environments'* and '*relationship-centred care'* became the main sensitising concepts underpinning my study and will be described in Chapter two.

Having provided a brief overview of my motivations for undertaking the study and suggesting some of the key ideas behind it, I now go on to consider why my study is important.

1.3 Why is such a study important?

Clinical leadership and developing a leadership culture have become central to debates about how to improve care within the NHS locally, nationally and internationally over many years. While these debates have been fuelled by

recent concerns about patient safety, patient care, and healthcare governance (United Kingdom Government, 2010; Howieson, 2011; Edmonstone, 2013b; United Kingdom Government, 2013; Dalton, 2014; NHS England, 2014; NHS Scotland, 2017a), their origins can be traced back at least thirty years to the Griffiths Report (Wing, 1988) and subsequent studies exploring older people's care (Nolan, 1996; Nolan, 1997; Nolan et al., 2004; Nolan et al., 2006; Nolan, 2013), the quality of which remains a major concern (Royal College of Nursing, 2013; United Kingdom Government, 2013; Naylor, 2015). Reports continue to highlight: harm to patients; ineffective processes and systems resulting in waste and variation; issues around safe staffing levels; failures to listen to staff and poor staff engagement, resulting in lack of dignity, respect, openness and transparency for staff, including incidents of bullying and harassment. Such deficits have been attributed to organisations focusing on targets and finance, rather than safety, reliability, relationships and quality (Patterson et al., 2011). Changing the 'culture' of care by promoting effective leadership, compassion and honesty at all levels have been advocated as part of the solution to such challenges (Alimo-Metcalfe and Alban-Metcalfe, 2013; United Kingdom Government, 2013; Keogh, 2013a; Department of Health, 2013; Rose, 2015).

In the face of mounting financial limitations and increasing expectations, all organisations delivering healthcare in the UK are constantly being urged to develop new ways of delivering sustainable, whole system working. The success of this seems to hinge largely upon developing effective leaders who can navigate the complexities of modern day services, whilst maintaining a focus on continuous quality improvement and innovation (Scharmer and Kaufer, 2013; Rose, 2015; NHS Scotland, 2017a). However, sustaining change, whilst maintaining motivation, resilience and energy, in the face of ever escalating expectations and demands, pose significant challenges, met by leaders at all levels on a daily basis. Such challenges have been described as 'wicked' problems, where there is no known answer or solution and these problems often prove resistant to change (Argyris, 1993; Heifetz, Grashow and Linsky, 2009; Grint and Holt, 2011). Considering how such 'wicked problems' might be overcome was something that I hoped my study might address.

The identification and development of effective leaders remains a considerable challenge for all healthcare organisations, as does developing ways of ensuring that good practice can be introduced and sustained (Wong and Cummings, 2007; Dierckx de C.B. et al., 2008; Avolio, Walumbwa and Weber, 2009; Westphal, 2012). Over the past decades, numerous studies have highlighted the vital role of nursing leadership in delivering high quality patient care (Stetler et al., 1998; Antrobus and Kitson, 1999; Boykin and Schoenhofer, 2001; Lucero, Lake and Aiken, 2010; Sandström et al., 2011). However, despite the increasing interest in developing healthcare practice, there is limited evidence of any subsequent or sustained impact following clinical leadership development programmes (Burgoyne, Hirsch and Williams, 2004; Hayward and Voller, 2010). One approach that has been extensively promoted is that of 'practice development'.

The concept of practice development as a means of facilitating change and learning in practice has been extensively researched (McCormack and Wright, 1999; Unsworth, 2000; McCormack et al., 2002; McCormack et al., 2009b), with evidence suggesting that organisational leadership culture can be enhanced through culture change programmes (Braithwaite, Hyde and Pope, 2009; Davies, Nutley and Mannion, 2000). However, there have been very few in depth studies which have explored how any such change can be sustained over time (Wong and Cummings, 2007; Dierckx de C.B. et al., 2008; Patterson et al., 2011).

The study described in this thesis aimed to begin to address this gap in our understanding, through providing a critical exploration of one particular clinical leadership development programme, DBC LP and its subsequent impact, the consequences of which MacArthur (2014) recommended needed further investigation.

As noted earlier, the study has as its main conceptual underpinning, the *Senses Framework* (Nolan et al., 2004; Brown, 2005; Nolan et al., 2006; Brown et al., 2009; Nolan, 2013). It is hoped that the insights gained will not only drive local developments but also inform policy and practice debates in healthcare leadership more widely.

In brief therefore, the study aimed to explore if the DBC LP impacted, or not, on individuals, their clinical practice, their teams and the wider healthcare organisation. If any impact resulted, I also wanted to consider if it was sustained over time and explore the factors that promoted any resulting sustained change. My initial broad aims for the study are set out in **Table 1.1** below. However, in line with the methodology selected (Constructivism, see later in Chapter four), these initial aims or *foreshadowed questions* were liable to evolve as the study progressed.

Table 1.1 Study Aims/*Foreshadowed questions*

Study Aims/*Foreshadowed questions*
• To explore the expectations and motivations of Nurses and Allied Health Professionals, (participants) for undertaking the clinical leadership programme (and expectations of their managers). • To discover how participants experienced the programme and whether or not their expectations (of self and programme) changed over time (and explore views of their managers, peers and junior colleagues). • To develop an understanding of potential impacts following participation in a clinical leadership programme and the factors that both facilitated and hindered any subsequent changes over time.

As will be considered in detail later, in order to address these broad aims, the study had three Phases. Phase one involved two Elements, A and B. Element A consisted of interviews with 'new' participants as they embarked on the DBC LP*,* and their managers. Element B explored the impact of the programme over time, through case studies of past participants, including data from their managers and colleagues.

Phase two collected data from the 'new' participants' from Phase one, at the end of the programme, using interviews to explore their perceptions of any emergent skills that had resulted from the programme. Data were also collected from a purposive sample of their managers, peers and junior colleagues.

Phase three was the longitudinal element of the study, which followed the 'new' participants' of the programme, their managers and colleagues back into practice several months later. See **Diagram 1.1** for an illustration of the three Phases (and see later in Chapter four Temporal **Diagram 4.1** of the study).

Diagram 1.1 Three Phases of the study

Whilst I wanted to better understand if a particular programme (the DBC LP), had achieved its desired aims, I also wanted to see if the insights that emerged could have wider implications beyond the local context, in the hope that these could inform the development of other leadership programmes. This influenced the Methodology (Constructivism) that I adopted. How the study was planned and implemented is considered in more detail in Chapter four.

Having provided a brief context for the study as a whole, this Chapter concludes with an overview of the thesis structure.

1.4 Overview of the Thesis structure

Chapter one has provided an introduction to the thesis and given a brief overview: of my rationale and motivation for undertaking the study, including the initial research aims/foreshadowed questions; why the study is considered important; and an outline of the various phases of the study.

Chapter two will describe the wider context for the study as a whole by considering a number of challenges that the NHS now faces. There is a particular focus on concerns about the quality of care received by patients and their families. In considering how such care might be improved, I will draw on the *Senses Framework* and the notions of *enriched environments* of care and *relationship-centred care*. These provide the main sensitising concepts underpinning both the DBC LP, that is the focus of the study, and the ways in which my findings were interpreted. What leadership means and why leadership is important in modern day healthcare will also be considered.

Chapter three describes in detail, the local context for the study and how DBC LP has developed and evolved over the past ten years. An explanation of why the original pilot programme was developed, and an outline of its aims and programme design are provided. The Chapter concludes with consideration given to the importance of the ways in which creating the right conditions can influence impact and experiences.

Chapter four considers the Methodology and Methods selected and my rationale for choosing a *Constructivist Grounded Theory* approach (Charmaz, 2014) embedded within a Fourth Generation Evaluation framework (Guba and Lincoln, 1989). Consideration is given to research design, data analysis, quality and ethics. Decisions regarding how rigour and reflexivity are addressed are

described, and a particular quality matrix the Äldre-Väst Sjuhärad (AVS) model, now referred to as the EA Matrix, is introduced (Wilson and Clissett, 2011; Hanson et al., 2006; Nolan et al., 2003). The possibility of further developing and expanding this EA framework is one of the potential methodological contributions of this thesis.

Chapter five introduces the substantive 'theory': The **Five C's**[1]*; **C**ontext, **C**atalyst, **C**hronology, **C**onditions and **C**onsequences,* which emerged, grounded in the data, and was developed from the study. The immediate ***C**ontext* of the programme is also explored. This Chapter then brings to life the 'Element A' participants of the research study, through short narratives. A discussion of both *personal* and *professional* ***C**ontext* of the participants is provided. Initial expectations of the participants, and motivations for applying to engage in clinical leadership development are illustrated, concluding with a summary of their immediate perceptions about whether or not their initial expectations have been met is highlighted. The notion of *timing* (***C**hronology*) is subsequently introduced, and a summary of how the **Five C's** theory illuminated the participants' experiences concludes the Chapter.

Chapter six discusses the longer-term ***C**onsequences* of the programme experiences and describes the *personal* ***C**onsequences,* as well as ***C**onsequences* on the team and wider organisation. The enabling factors are explored, to creating the ***C**onditions* to ensure positive ***C**onsequences* are sustained over time, and the importance of *relationships* is illuminated. Using case studies of the 'Element B' participants through the use of narratives, factors are described which supported participants to build, develop and sustain [2]*relationships* and connections and overcome challenges to creating such *enriched **C**onditions.*

[1] The words **Five C's** will appear in **Bold** throughout the thesis from Chapter five onwards and each **'C'** will be in bold capitals and the full word in italics, for ease of reference i.e. ***C**ontext, **C**atalyst, **C**hronology, **C**onditions and **C**onsequences.*

[2] Key words will be in italics throughout the thesis: *enriched environments, sensitising concepts, foreshadowed questions, Senses Framework. From Chapter five onwards, the following significant words will also be in italics: personal/personally, professional/ professionally, relationships, relationship-centred leadership, timing/time.*

Chapter seven reflects on the quality of the study overall, considering the *Constructivist Grounded Theory* inquiry process and hybrid approach adopted, which is based upon the work of Charmaz (2014). The EA model (Wilson and Clissett, 2011; Hanson et al., 2006; Nolan et al., 2003) is instrumental in providing the reflective lens on quality of the processes involved in the research and a suggestion is provided of an extension of the EA model. Lessons learned are explored, and the EA model also provided a lens to reflect on the quality of the DBC LP as a whole. A range of quality criteria are compared and consequently the quality of the **Five C's** substantive theory is explored. Limitations and strengths of the study are outlined and the Chapter concludes with a description of my personal reflections and insights on the research study and my role within it, with an emphasis on the importance of reflexivity.

Chapter eight discusses the main findings from the study and how the substantive mid-range **Five C's** theory has advanced the concept of the *Senses Framework,* towards a 'formal' mid-range theory and will illuminate the significance of creating *enriched environments* to enable *relationship-centred leadership.* The discussion refers to current literature and suggests what this means for leaders and leadership in healthcare.

Chapter nine provides evidence of how this study has extended and contributed knowledge and understanding of the enabling and hindering factors to sustaining impact following leadership development. Implications for policy, practice, education, research, NHS organisations, individual leaders and teams are suggested. Consideration is given to the implications for leadership and leaders beyond the NHS and healthcare in relation to the immediate, local, national and wider contexts - leadership, is leadership, is leadership! Recommendations for future research and final key messages/best hopes conclude this Chapter.

Chapter Two. Introducing the Wider Context for the Study

2.1 Chapter overview

In some respects this thesis might be said to adopt a rather unconventional approach, and I feel that it is important to set out my position from the outset. Firstly, undertaking a review of the existing literature is normally integral to healthcare research, with Bryman (2012) suggesting that it serves a number of useful purposes including:

- Making clear what is already known about the topic under investigation and highlighting any existing theories.
- Alerting the researcher to the research methods that have previously been used.
- Identifying any contentious issues and key contributors to the field.
- Within positivist studies in particular, the literature review aims to make clear the quality of the existing 'evidence' in a given area, with the most privileged seen to be that arising from 'scientific' studies, typically the randomised controlled trial.

Although I will seek to meet the above aims in the next two Chapters, I will not be providing a 'traditional' review of the literature (although given its central importance, a synthesis of current understanding of clinical leadership within healthcare will be presented), nor will I be drawing upon the notion of 'evidence'. Rather, consistent with the Constructivist approach adopted (see Chapter four in particular), I will seek to make clear the varying forms of 'knowledge' that influenced the *sensitising concepts* which informed not only my initial *foreshadowed questions*, but also subsequent data collection, analysis and the presentation of my findings. I will refer to the literature in my discussion within Chapter eight. My own 'knowledge' of the subject based on my extensive experience, has already been highlighted, for acknowledging this is essential, because as Corbin and Strauss (2008) cogently note "*Researchers bring to the*

inquiry a considerable background in professional and disciplinary literature" (2008, p.134) and consequently no researcher enters the field with a blank piece of paper (Charmaz, 2014).

Within a Constructivist study the primary role of prior knowledge is to identify *sensitising concepts* that help to shape the initial *foreshadowed questions* (Rodwell, 1998), which guide the study at the outset. A *sensitising concept* in qualitative Constructivist research is seen as providing the initial direction for a study, often captured in the form of *foreshadowed questions, (*as introduced in **Table 1.1** and will be described in Chapter three section 3.5), (Glaser, 1978a; Patton, 2002; Padgett, 2004; Patton, 2005), as described by Gilgun (2002, p.4), who noted that *"Research usually begins with such concepts, whether researchers state this or not and whether they are aware of them or not*". In relation to Constructivist research, *sensitising concepts* go beyond this and also influence what is observed and how the researcher interprets this (Charmaz, Denzin and Lincoln, 2008). Sensitising concepts may be derived from a wide variety of sources, including the researcher themself (Charmaz, 2014). One purpose of the next two Chapters is to make clear the *sensitising concepts* that played a significant role in my study.

My study may also be considered by some to be 'unconventional' in another sense. As will be described later, it adopts a Constructivist approach, informed by both Fourth Generation Evaluation (Guba and Lincoln, 1989) and Constructivist Grounded Theory (Charmaz, 2006; Charmaz, 2014). Whilst Constructivist studies encourage a wider role for existing knowledge than does traditional Grounded Theory, it is still recommended that such knowledge should primarily 'inform' rather than 'direct' the study (Charmaz, 2006; Charmaz, 2014). I have taken a slightly different stance in that the notions of the *Senses Framework* and *enriched environments* (Brown, 2005; Nolan et al., 2006; Nolan, 2013) (see later in this Chapter), not only provided the main *sensitising concepts* for my study, but also were explicitly used to frame

(however not to dictate) data collection, analysis and the presentation of my findings. Whilst this might be seen by some to be contrary to the tenets of grounded theory studies, which should be primarily about developing theory (Glaser and Strauss, 1967; Glaser, 1978a; Strauss and Corbin, 1997; Corbin and Strauss, 2014), I will argue that my approach is quite consistent with the widely accepted principle that a grounded theory should be modifiable (Glaser and Strauss, 1967). Consequently, my study is best to be viewed as a piece of work that moves towards the development of a formal mid-range theory, as well as developing a mid-range substantive grounded theory (see Chapter five and later in Chapter eight for a fuller discussion). Given the central role played by the *Senses Framework* and *enriched environments* in this thesis, these will be considered in some detail later in this Chapter.

In summary, this Chapter explores the wider context for the study, by considering the challenges that the NHS currently faces across the UK. A descriptive overview of the NHS in the UK as a whole is provided, including a brief exploration of the current healthcare landscape, highlighting key influencing factors. This, it is hoped, will begin to illuminate the complex and multifaceted challenges that those occupying a clinical leadership role now face. Many of these challenges are not new but have been exacerbated in recent years by increasing demands and scarcity of resources. One frequently cited solution to these challenges is the need to change the culture of the NHS and to develop leadership capacity in order to do so, especially at a clinical level (Patterson et al., 2011; West et al., 2014b). Consideration is given to these suggestions; especially how clinical leadership in healthcare is currently construed.

However, as noted in the previous Chapter, the challenges now facing the NHS are increasingly recognised as being ‘wicked’ problems that often prove resistant to change (Argyris, 1993; Heifetz, Grashow and Linsky, 2009; Grint and Holt, 2011). Therefore, whilst developing leadership capacity will undoubtedly make an important contribution, others have called for a

fundamental re-think of the way in which healthcare is delivered. This, it is suggested, will require moving away from a focus on efficiency and the meeting of 'targets,' towards a service underpinned by what has been termed '*relationship-centred care'* (Nolan et al., 2004; Nolan et al., 2006; Ryan et al., 2008; Nolan, 2013; Dewar and Nolan, 2013) which promotes a leadership culture based on compassion (Ham, 2012; West et al., 2014b).

The complexity of the challenges now faced by the NHS is perhaps best exemplified when considering the care that older people receive. This has been the subject of concern for many years, and such concerns remain. In suggesting a way of improving such care a '*relationship-centred'* approach, using the *Senses Framework* as a means of promoting *enriched environments* of care has been advocated (Davies et al., 1999a; Nolan et al., 2002a; Nolan et al., 2004; Nolan et al., 2006; Ryan et al., 2008; Dewar and Nolan, 2013). As will become clear, this approach underpinned the leadership programme that was the focus of this study and this Chapter will also therefore provide an overview of how the *Senses Framework* evolved. Its influence on this particular study will be considered in greater detail when the local context is presented in the next Chapter. The following section turns attention to the national context for the NHS at the time my study commenced.

2.2 Placing the study within the Context of the wider NHS

The NHS, which was inaugurated in July 1948, is the Government funded healthcare service for the population of the UK. UK residents pay tax, which contributes to paying for medical care and health services, which are '*free at the point of delivery*' (Sutherland and Coyle, 2009). Sir David Dalton in his review called 'NHS Challenges' described the NHS as "*the best healthcare system in the world"* (2014, p.4)

Whilst the NHS is a UK wide organisation, since devolution in 1999 there have been differences in how healthcare is delivered, governed and funded in the

four home countries, with such variations increasing over time (Connolly, Bevan and Mays, 2010; Timmins, 2012; Bevan et al., 2014). Some of these differences are briefly outlined below.

The NHS in England comprises of organisations called 'Trusts,' which are responsible for a particular geographical area or specialist function. These include; Acute Non Specialists Trusts (n=135), Foundation Trusts (n=148), Acute Specialist Trusts (n=17), Mental Health Trusts (n=54) and Community providers (n= 35). Foundation Trusts in NHS England, which aim to enable local communities and organisations to hold responsibility and ownership, provide over 50% of NHS hospital care, Mental Health Services and Ambulance services (Addicott et al., 2015; NHS Confederation, 2018).

In Northern Ireland (NI), healthcare services are integrated and exist as Health and Social Care Services (HSCS). There are six HSCS's, five of which provide all aspects of integrated health and social care services and support the delivery of care in hospitals, clinics and residential care homes. The sixth HSCS is the Northern Ireland Ambulance service. A separate Public Health Agency is responsible for health protection and improving health and well being of the NI population. Other supporting bodies include the Patient and Client Council, Business Services Organisation, Regulation and Quality Improvement Authority and NI Social Care Council (Health and Social Care, 2018).

Healthcare in Wales, provided by NHS Wales, is delivered by seven Health Boards and three NHS Trusts, the latter comprising the Welsh Ambulance Service, Velindre NHS Trust supporting cancer care and national services, and Public Health Wales, plus seven Community Health Councils (NHS Wales, 2018).

As this study took place in Scotland, a somewhat more detailed description of how the NHS is organised here is provided.

NHS Scotland consists of fourteen Regional NHS Boards and employs circa 140,000 staff. Each NHS Board has responsibility for health improvement and protection, plus the delivery of healthcare services for the people living within that region of Scotland. Boards are accountable to Scottish Ministers within the Scottish Government Health and Social Care Directorate. There are also seven Special NHS Boards and one Public Health Body, which provide specialist national services to support the Regional Boards, these are:

- *NHS Education for Scotland* - responsible for supporting NHS services by developing and delivering education and training resources for NHS Scotland workforce
- *NHS Health Scotland* - working to reduce health inequalities and improve health
- *Golden Jubilee Foundation* - a national resource for Scotland providing regional and national heart and lung services, major centre for orthopaedics, elective surgical specialties for reducing waiting times
- *NHS 24* - provides urgent health advice out of hours when General Practitioners (GPs) and Dentists' practices are closed; provides a range of health information services, for example web chat services
- *Scottish Ambulance Service* - Provides emergency response service and deals with major incidents; provides patient transport services
- *State Hospitals Board for Scotland* - cares for and protects very ill detained patients and protects the public and staff from harm
- *NHS National Services Scotland* - provides a range of support and information including health protection, specialist healthcare, logistics, procurement, legal and Information Technology
- *Healthcare Improvement Scotland* (Public Health Body) - broad work programmes supporting health and social care services to improve, including Healthcare Environment Inspectorate, iHub, Scottish Health Council, Technologies Group, Scottish Intercollegiate Guidelines Network, Medicines Consortium, Scottish Patient Safety Programme (NHS Scotland, 2019)

NHS Lothian, the NHS Board in which I am employed, and in which the study took place, is the second largest Health Board in Scotland, with a workforce of approximately 24,000, providing healthcare services for around 800,000 people. A range of Acute, Primary and Community Care, Mental Health, Learning Disabilities, Paediatrics and Women's services, are delivered across Edinburgh, Midlothian, East Lothian and West Lothian (NHS Scotland, 2017a; NHS Lothian, 2018; NHS Scotland, 2018a).

However, despite these differences, all four countries face similar challenges posed by demographic changes, especially the growing older population, ever increasing public expectations and the advent of advanced, but costly, technological solutions. Such challenges have long existed but have been exacerbated in recent years by financial constraints and the present focus, at the time of writing, on austerity. Consequently the considerable difficulties of trying to balance demand and supply while sustaining acceptable care have been described in numerous reports over many years (Greer, 2004; The Kings Fund, 2012; Keogh, 2013b; Keogh, 2013a; Daly et al., 2014; The Kings Fund, 2014; NHS Scotland, 2017a). The complexities that this poses are described in greater detail below.

2.3 The complex healthcare landscape

As outlined above the NHS, which is now 70 years old, continues to face ever increasing challenges and demands on its resources (NHS Scotland, 2017a; Storey and Holti, 2013; Ham, Berwick and Dixon, 2016; NHS England, 2018; NHS Scotland, 2018a), whilst trying to meet the overarching policy aspiration of enabling people to live longer, healthier lives, in a homely setting of their choice (NHS Scotland, 2017a; NHS England, 2014).

In the face of such demands, one of the biggest changes in the history of the NHS to date, was the introduction of the Health and Social Care Act (Department of Health, 2012; NHS Improvement, 2016), which required levels

of collaboration and collective responsibility for finances and cross boundary working not previously seen. Achieving such aspirations has required far greater collaborative working, with there being calls for a shared learning approach in order to enhance the exchange of excellent practice at a local, regional and national level (Heifetz, Grashow and Linsky, 2009; Scottish Government, 2010; NHS Scotland, 2017a; Rose, 2015). As Ham (2012) advocated, this will mean a shift in the NHS culture, away from the current focus on meeting targets towards a model based on compassion, mutual respect and understanding.

One solution to the current challenges has been an ever-increasing focus on developing leadership capacity at all levels of the NHS. At a national level, organisations such as NHS Improvement, Healthcare Improvement Scotland (HIS), The Health Foundation, Institute for Healthcare Improvement (IHI in United States of America), The Advancing Quality Alliance (AQuA) and NHS Quest, have evolved to provide support and resources to assist in building leadership capacity and capability across healthcare systems (Dixon-Woods et al., 2014). There has also been an increasing emphasis on engaging patients and their families in decision making over health and well-being choices, based on the principles of coproduction, collaboration and enhanced partnership working. It is argued that these should become the ‘norm’ for future models of care (The Kings Fund, 2013a; NHS England, 2014; NHS Scotland, 2017a; Sharp, 2018).

Such recent pronouncements have given renewed impetus to the development of collective, compassionate leadership throughout the NHS in order to ensure the delivery of a healthcare service which is focussed on improvement, safety and quality (Great Britain. Secretary of State for Health, 2008; United Kingdom Government, 2010; Verma and Moran, 2014; West et al., 2014a; Senge, Hamilton and Kania, 2015; West et al., 2015b; West et al., 2015c; NHS Scotland, 2017a). Consequently, it is increasingly asserted that delivering high quality, safe, effective, compassionate and person-centred care for patients,

carers and their families requires robust professional and clinical leadership that is consistent, authentic and effective (West, 2013; Dalton, 2014; Ham, 2014; West et al., 2015b). Given this emphasis, it is important that we consider how clinical leadership is currently conceptualised in the healthcare field. Attention is turned to this is the next sub-section.

2.3.1 What do we mean by clinical leadership and why is it seen to be important?

The importance of leadership has been recognised for centuries, from Aristotle onwards (Kodish, 2006) and yet a consensus as to an exact definition remains elusive. However, the two widely cited definitions below capture a common element, that of influencing others:

'Leadership is a process whereby an individual influences a group of individuals to achieve a common goal' (Northouse, 2007, p.3)

'Leadership is the art of influencing others to their maximum performance to accomplish any task, objective or project' (Cohen, 1990, p.9)

Often the words leadership and management are used interchangeably, but there are subtle, yet important, differences. Management is said to focus more upon the delivery of a certain task to achieve a specific aim, by providing direction and guidance, especially in utilising resources (Swanwick and McKimm, 2012; Edmonstone, 2013a). On the other hand, according to Heifetz and Laurie (2001, pp.124-134), leadership is an activity, not a role or position, the purpose of which is to enable people to do adaptive work, when faced with complex problems to which there are no easy solutions or answers available. These are just the sorts of 'wicked' problems now seen to face the NHS. Leaders need to facilitate change and to motivate others to promote new ways of working and new behaviours. Therefore developing clinical leaders has become a priority not only in the UK, but also across the developed world (The

Kings Fund, 2012; Department of Health, 2013; Daly et al., 2014; Ham, 2014; West et al., 2015a; West et al., 2015b).

Within a practice context, the emphasis has been on developing clinical leadership, the focus of the programme I deliver. This has emerged as a priority over the past 15-20 years and has required the clinical leader / clinician to role model a values-based approach, that enables and encourages others to deliver highly effective care and services, which focuses on the patient (Cook, 2001; Cook and Leathard, 2004; Curtis, de Vries and Sheerin, 2011; Pepin et al., 2011; Mannix, Wilkes and Daly, 2013). Indeed clinical leadership is widely promoted as being crucial to the delivery of effective healthcare in the 21st century, and a pre-requisite for the provision of safe, effective person-centred care (United Kingdom Government, 2013; The Kings Fund, 2013b; The Kings Fund, 2014; West et al., 2015c).

Stanley (2006, p.111) who has undertaken qualitative research to explore leadership qualities in nurses, defines a clinical leader as *" a clinician who is an expert in their field and who because they are approachable, effective communicators and empowered, are able to act as a role model, motivating others by matching their values and beliefs about nursing and care to their practice."*

Effective clinical leadership is seen as the *golden thread* (Timmins, 2015), that is central to all areas of healthcare, whether it be community and primary care, general practice, acute care, mental health, private and voluntary sectors and social care. Not surprisingly, the demands on leaders are complex, variable and erratic, so that leaders need to not only focus on *what* effective leadership is, but they must also become adept at *how* to create the conditions to enable others cope with the rapid pace of change and complexity (Heifetz, 1994; Benington and Turbitt, 2007; Scharmer, 2009; Heifetz, Grashow, and Linsky 2009; Young, 2011). Problems or issues faced by leaders have been described as either: 'tame', where a management response with a known solution is required; 'critical', when a command and control action is essential to respond

to an emergency or urgent issue or event; or 'wicked', where a leadership response is necessary and there is no known solution or answer to the complex issue or situation (Heifetz, 1994; Heifetz, Grashow and Linsky, 2009; Grint and Holt, 2011).

There is a growing international evidence base, which suggests that highly effective and well performing healthcare organisations invest in and promote staff engagement and clinical leadership, and that leadership is the key to effective change (Swanwick and McKimm, 2012; Swensen et al., 2013a; Dalton, 2014; Perlo et al., 2017; Swanwick and McKimm, 2017). This requires not only considerable investment in developing leadership capacity but crucially the need to create the '*desired culture',* as succinctly captured in the quote below:

"It needs investment in a sustained programme of cultural change based on clear and explicit values. It needs to be supported by investment not only in service and quality improvement, engagement, leadership development, education and training and appraisal but also governance arrangements that facilitate and promote the desired culture." (Clark and Nath, 2014, p.41)

Part of this emerging cultural shift is an expanded vision of what we mean by leadership. Traditionally leadership has tended to focus on an individual who is seen to possess key leadership qualities, attributes or behaviours, but more recently there has been moves towards an emphasis on collective leadership, which recognises the importance of relationships and relational dynamics (Bolden and Gosling, 2006; Edmonstone, 2013b). Collective leadership recognises the important interplay between organisational culture and leadership (Manley, 1997; Mannion, Davies and Marshall, 2005; Patterson et al., 2011; Manley et al., 2011), particularly in light of numerous reports of poor care and ineffective leadership in healthcare systems in the UK and internationally (United Kingdom Government, 2010; Department of Health, 2013; Keogh, 2013b; Royal College of Nursing, 2013; Dixon-Woods et al.,

2014; Gillen, 2014; General Medical Council, 2014; NHS Healthcare Improvement Scotland, 2014; Scottish Government, 2014a; Scottish Government, 2014b; Kirkup, 2015; Barts Health NHS Trust, 2015). Being cognisant of this dynamic also informed my thinking during the study and will be returned to later.

However, as was highlighted in the introductory Chapter one, the identification and development of effective clinical leaders remains a considerable challenge for all professions, including nursing. While numerous studies have highlighted the vital role of nursing leadership in delivering high quality patient care, and several initiatives have been documented (Stetler et al., 1998; Antrobus and Kitson, 1999; Boykin and Schoenhofer, 2001; Sandström et al., 2011; Lucero, Lake and Aiken, 2010), there is limited evidence to suggest long lasting improvements following clinical leadership development programmes aimed at promoting culture change.

In summary, one of the biggest challenges currently facing the NHS is the constant need to respond to a diverse range of demands brought on by demographic changes, leading to a surge in long-term conditions, together with additional challenges such as obesity, type two diabetes and increasing drug and alcohol problems (NHS England, 2014; NHS Scotland, 2017c). At the same time, new and often expensive treatment options are becoming available. In response to these factors, culture change and the development of clinical leaders, are seen as pre-requisites to the delivery of safe, effective, high quality and compassionate health and social care.

However, there are dissenting voices who recognise that whilst culture change is essential, and that developing leaders will be important to achieving this, nevertheless argue that something far more fundamental is required if lasting change is to be achieved. This was highlighted in one of the largest studies of culture change in healthcare ever undertaken in the UK (Patterson et al., 2011). This study comprised an in-depth review and narrative synthesis of the

extensive literature on culture change, together with large-scale surveys of staff, patients and family carers on 70 wards/units and four in-depth case studies. The authors concluded that the NHS is currently driven by a focus on achieving service targets and that consequently a 'quick' fix solution is seen to be the answer to any problems. Building on prior theoretical work by Williams *et al.* (2009), Patterson *et al.* (2011) suggested that the current emphasis on 'pace' (rapid throughput/flow of patients and short hospital stays) within the healthcare system, fails to account for the 'complexity' of many patients' needs, especially those of older patients. The NHS, they argued, is currently dominated by a *'perform or perish'* culture, and that achieving lasting change will require a shift towards a culture that is '*relational and responsive'*. In their study on culture change they discovered that good leadership at all levels is indeed essential to creating such a culture, and that the most important leader was at the level of the individual unit or ward. Such a leader created *enriched environments* of care for staff, patients and family carers, by implementing a *relationship-centred* approach underpinned by the *Senses Framework*. These concepts played a very significant part throughout my study and they are therefore described in greater detail below.

2.4 The Theoretical Context for my study: Exploring the evolution of *Relationship-Centred Care* and the *Senses Framework*

As noted earlier, over recent years there has been an ever-increasing emphasis on engaging patients and their families in decision making over health and well-being choices, with it being argued that these aspirations should become the 'norm' for future models of health care (The Kings Fund, 2013a; NHS England, 2014; NHS Scotland, 2017a). This emphasis is the end point of the evolution of 'person centred' care that has become the 'mantra' for services over the last 20 years or so. A critique of such an approach emerged with Nolan et al (2004) arguing that to focus on the 'person' overlooks the central role played by the interactions and relationships that reflect the dynamic and complex nature of healthcare, as described previously in this Chapter. These authors promoted instead, a '*relationship-centred'* model of care.

The concept of '*relationship-centred care'*, was originally proposed by a taskforce set up in the United States of America, the *Pew-Fetzer Taskforce*, which recognised that the then dominant focus on acute care was not the best service model to address future health challenges (Tresolini and Pew-Fetzer Taskforce, 1994). They proposed the development of a system based on '*relationship-centred care'* that encapsulated the significance of the interactions between individuals, as the fundamental elements of any beneficial pursuit. The taskforce recognised that *relationships* are crucial to the care provided and create satisfaction and positive outcomes for patients and care givers. Although advocating a *relationship-centred* model, the task force did not provide a means of delivering such an approach.

Working in the UK, Nolan (1996; 1997) was simultaneously seeking to develop a model of care that recognised and responded to the needs of very frail older people for whom cure and rehabilitation were no longer valid goals. He argued that staff working with such individuals lacked a therapeutic framework to guide their care and consequently, as he had argued for many years (Nolan, 1996; Davies et al., 1999a; Nolan, Davies and Grant, 2001), work in long-term care settings had been accorded little value and provided staff with no real job satisfaction. As a potential solution, Nolan (1996) proposed a model of care, the goals of which were to ensure that older people in formal care settings experienced six 'Senses'[3]. He first presented this model when delivering a keynote address to the RCN European Older Person's Conference in 1996, where he named the Senses as: **Security, Belonging, Purpose, Fulfilment, Continuity** and **Significance.**

At point, the nascent *Senses Framework*, as it became called, was purely theoretical but has subsequently been built upon over many years of research with older people, family carers, staff and students, initially mainly within care homes and long-term care settings. Subsequently its reach has been extended

[3] The actual six 'Senses' will appear in **Bold** throughout the thesis for ease of reference (**Achievement, Belonging, Continuity, Purpose, Significance, Security**). *Senses Framework* will appear in italics

to include acute hospital environments caring for older people (Nolan, 1997; Davies et al., 1999b; Nolan et al., 2002b) and community settings for people with dementia and their carers, both family and formal (Ryan et al., 2008). In the process, a Sense of '**Fulfilment**' was replaced with a Sense of '**Achievement'**. Furthermore, as the Senses were exposed to empirical scrutiny, it became apparent that they did not apply only to older people and for excellent care to be provided, staff and family carers also had to experience the Senses, so the notion of 'relationships' was added to the Framework. In addition a major national study AGEIN (Advancing Gerontological Education in Nursing- see below for further detail) (Nolan et al, 2002b), demonstrated that the Senses were not only relevant to care settings, but to educational ones also. The framework therefore suggests that safe, effective care, of a high quality, for older people, and satisfaction with that care amongst staff and family carers, requires that each experience six Senses as outlined below:

- A Sense of ***Security***- feeling safe and receiving or delivering competent and sensitive care
- A Sense of ***Continuity-*** the recognition of biography, using the past to contextualise the present
- A Sense of ***Belonging***- opportunities to form meaningful *relationships* or feel part of a team
- A Sense of ***Purpose***- opportunities to engage in purposeful activities or have a clear set of goals
- A Sense of ***Achievement*** – achieving meaningful or valued goals and feeling satisfied
- A Sense of ***Significance***- to feel that you matter, and that you are valued as a person (Nolan et al., 2002b)

Building on this foundation, extensive research over decades, particularly in older people's care services, has affirmed that *relationship-centred care* can be achieved through creating the six Senses for older people, their carers including the staff and students, and this is linked to high quality care for older people, that addresses many of the concerns family carers often voice, and also

provides staff at all levels with job satisfaction (Davies et al., 1999b; Davies et al., 2000; Nolan et al., 2002b; Nolan et al., 2004; Nolan et al., 2006). As noted above, later work also demonstrated the value of creating the 'Senses' for student nurses (Brown, 2005; Brown et al., 2008; Brown et al., 2009) and others have applied the concept to differing groups of older people, especially those with dementia (Ryan et al., 2008). As a result of this further work, it was suggested that a setting in which all parties experienced the 'Senses' could be conceived of as being *enriched* (Brown, 2005; Nolan et al., 2006; Nolan, 2013) and that consequently when the six Senses are created, relationship centred-care is enabled for all parties (older people, family carers, staff and students). The concept of an *enriched environment*, and its opposite, an *impoverished environment*, are now integral to the *Senses Framework*.

Of particular relevance to my study was the large multi-method, multi-phase longitudinal study called *Advancing Gerontological Education in Nursing* (AGEIN) (Nolan et al., 2002b), which explored the experiences of pre-registration student nurses, and what might encourage them to seek a career with older people. As a result of this work, Brown's PhD (2008; 2009) further developed the way in which the 'Senses' might be applied in educational settings, and she expanded the notions of *enriched* and *impoverished environments* of care, dependent upon the extent to which the 'Senses' were created or not. An *enriched environment* has been demonstrated to positively influence the experience of all individuals in a given care setting, be they patients, carers, staff or students. This highlights the benefit of focusing on the *relationships* and interactions between individuals, the environment of care and the processes enacted between them (Baillie, Gallagher and Wainwright, 2008; Baillie and Gallagher, 2009). *Impoverished* is the opposite of '*enriched'* and describes environments where there are ineffective *relationships*, interactions and poor experiences.

The 'Senses' have never been considered to be a hierarchy, with one being more important than the other, however Brown's work (2005; 2008) did suggest

that there might be a temporal ordering. She found that when students first went to a new placement that they needed to feel safe (have a Sense of **Security)** and also feel welcomed (a Sense of **Belonging**), before they could go on and experience the other 'Senses'.

In the next Chapter, it will become clear that the *Senses Framework* largely underpins the DBC LP*,* and the role it plays in creating an *enriched environment*, in which leadership might flourish, will be explored.

2.5 Chapter summary

This Chapter has described the unconventional approach I adopted and my reasons for this. Consideration has been given to the challenging and complex healthcare landscape, and places the study within the context of the NHS. Given the current leadership challenges within the NHS, the national context in relation to NHS Scotland in particular is explored, since this study is positioned in NHS Lothian, the second largest Health Board in Scotland. The **Significance** of the theoretical context and the *relationship-centred* approach to my study illuminated the importance of my *sensitising concepts,* the *Senses Framework* and *enriched environments,* which will be described in more detail in the following Chapter, which introduces the local context for my study.

The extensive research undertaken by Nolan, Brown, Davies et al (Davies et al., 1999, Davies et al., 2000, Nolan et al., 2002b, Nolan et al., 2004, Nolan et al., 2006, Brown, 2006, Brown et al., 2008a, Brown et al, 2009) has affirmed that *relationship-centred* care and the creation of *enriched environments*, are achieved when the six Senses are created concurrently for patients, their carers, staff and students. However, it was Brown's work looking at the application of the *Senses Framework* to educational environments that led me to believe that it might be very useful in understanding how the delivery of DBC LP might be experienced and evaluated.

The implications and importance of context will be further explored later in Chapter five.

Chapter Three. Local Context

3.1 Chapter overview

The previous Chapter sought to provide the national context for my study, by considering current day healthcare in the UK as a whole, and particularly Scotland. This Chapter aims to provide readers with a detailed understanding of the local context. In order to do so, it will explore the origins and evolution over the last ten years, of the DBC LP*,* beginning with the original pilot, which was called the *Leading into the Future* programme.

3.2 The Local Context: Background to the Delivering Better Care Leadership Programme

This section of the Chapter provides the background to the DBC LP by describing how and why the pilot programme *'Leading into the Future'* originated, its original aims and the results of the evaluation of this initial programme.

In 2005, NHS Lothian Board was becoming increasingly aware through complaints and incidents, of examples of poor quality care occurring in relation to older people's services. In response to these, an External Reference Group (ERG) was established, with the former Chief Nursing Officer for NHS Scotland identified as chair of the group. Its remit was to review services and care provided for older people, in light of serious concerns and complaints, and to make any recommendations for remedial action.

Following an in-depth investigation, similar to that of the more recent Mid Staffordshire Inquiry (United Kingdom Government, 2013), detailed recommendations for service improvement were produced for NHS Lothian to implement as a matter of urgency (Jarvie and Mackie, 2006). A number of initiatives followed, one of which was the development of a leadership programme specifically for staff working within older people's services. This pilot programme, called *Leading into the Future,* aimed to enable practitioners to

take a lead role in developing effective partnerships with older people and their families, colleagues, students and other agencies. The intention was, that if successful, this 'pilot' programme would provide a platform, to develop future leaders to positively impact upon on-going service change, improvement and innovation for older people.

The ERG's final report specifically recommended the adoption of a values-based approach to identify and underpin appropriate outcomes for older people. In seeking an appropriate set of values, a decision was made to adopt a *relationship-centred* approach, because the evidence in the literature affirmed that high quality care for older people was linked to the provision of *relationship-centred care* (Davies et al., 1999b; Davies et al., 2000; Nolan et al., 2000; Nolan, Davies and Grant, 2001; Nolan et al., 2002a; Nolan et al., 2006). This approach would also support an exploration of the dynamics of *relationships* and interactions between older people, staff, students and their carers, as well as ensure quality remained at the forefront (Maxwell, 1992; Goodrich and Cornwell, 2008).

Subsequently, funding was allocated to NHS Lothian from NHS Education for Scotland (NES), to enable the development of a leadership programme for older people's services, and in 2007, within my role of 'Lead Practitioner Clinical Leadership,' I was invited to design, develop and implement a 'pilot' leadership programme. As noted above, in the early stages of designing and planning the programme, through reading the literature, the theoretical framework based upon *relationship-centred care* and the *Senses Framework* (Nolan et al., 2006), was identified as a possible way forward. In order to affirm this, the literature around older people's services and *relationship-centred care* was then critically analysed, and opportunities for implementing the *Senses Framework* across NHS Lothian were explored, in collaboration with several of the original authors, including Professor Mike Nolan, Professor Sue Davies, Professor Jayne Brown and Janet Nolan, through initially making direct contact with Professor Nolan, who was known to one of the senior nurses, through previous research work.

Professor Sue Davies led on the co-design of the programme with myself, with the others named above helping with the delivery and evaluation of the pilot. This is described in the next sub-section.

It should be noted at this point that Professor Jayne Brown and Professor Mike Nolan, who played a significant role in the design and evaluation of the original pilot programme remained involved with future developments to the programme and eventually became my doctorate Supervisor and Advisor.

3.2.1 The Pilot Programme- *Leading into the Future*

2007-2008

The initial pilot programme *Leading into the Future* (see Appendix 2 pilot descriptor) was delivered over a twelve-month period (December 2007 to November 2008) and was available to multi-disciplinary, multi-agency staff within NHS Lothian, with a commitment to improving older people's services. Applicants were also invited from West Lothian Council, Edinburgh City Council and Private/ Voluntary Care Homes within the Lothian's, to widen the scope across health and social care and extend the pilot reach, resulting in an initial group of seventeen participants. Five participants from Care Homes commenced the pilot programme, however only one was able to fully engage, commit and complete the programme, due to staffing issues and lack of management support, which was disappointing.

The group of thirteen who fully participated on the entire programme, consisted of eleven nurses; ten who worked in older people's care wards within Hospitals, Day Hospital or Community settings, and one who worked in a Care Home run by a Voluntary Charity for visually impaired residents; as well as two Occupational Therapists who worked with older people in the Community. The levels of experience and stages of their careers varied amongst the participants, however the majority were senior healthcare professionals with

vast experience, who were willing to explore ways to further develop to enhance their leadership skills and the care their services provided for older people.
The programme aimed to provide participants with the skills '*to challenge and question current thinking and practice and to engage in courageous conversations that facilitated change in teams and lead to change in practice'*. Underpinning these aspirations were the concepts of *relationship-centred care* and the *Senses Framework* (Nolan et al, 2006), which it was hoped would help to demonstrate ways in which healthcare professionals could take the lead in developing *enriched environments* of care for older people, whilst also developing colleagues with whom they worked. This was based on the principles of 'transformational' leadership, which focuses on role modelling, enabling, encouraging, inspiring and challenging others; leading by personal values and intrinsic motivation, to enhance the collective interests of the team or organisation (Bass and Stogdill, 1990; Avolio, Bass and Jung, 1999; Northouse, 2007; Kouzes and Posner, 2012; West et al., 2015c).

Therefor*e, Leading into the Future* focused primarily on *how* we could better care for older people. For individuals participating in the programme, experiencing a transformational approach to leadership potentially offered them a means to personal growth. For NHS Lothian and partner organisations it provided an opportunity to maximise human potential, identity and nurture talent and modernise the care it delivered.

To promote a more complete understanding of the potential impact of the pilot programme, a model of participatory evaluation was used, underpinned by the principles of Constructivism and based on research and development work undertaken by the Äldre-Väst Sjuhärad Research Centre in Sweden (Nolan et al, 2003). This model, which subsequently played a significant role in my own work, will be discussed in more detail in Chapters four and seven.
Using this co-constructed approach, and consistent with the principles of a *relationship-centred care* model, the participants were encouraged to contribute to the evaluation of the pilot by considering the extent to which an *enriched*

learning environment had been created for them by the facilitators. Overall the pilot programme evaluated positively, with the *Senses Framework* playing a significant role for participants both personally and professionally. An *enriched environment* had been created and participants had been enabled and encouraged into action. Personal qualities such as self-confidence and self-awareness had been enhanced, which impacted on participant's leadership styles. Managers and colleagues described similar changes in the participants, which had resulted in improved staff morale and job satisfaction. The synergy between the findings from the pilot and the findings from this study will be discussed later in Chapter eight and within the proposed implications within Chapter nine.

NHS Lothian was impressed by the positive evaluation of the pilot and therefore supported the on-going development and subsequent delivery of *Leading into the Future Leadership Programme* over time, as is described below. Contact was maintained beyond the pilot with many of the participants, through connections with on-going work streams in NHS Lothian at the time, such as *Leading Better Care* (Scottish Government, 2008). Within my leadership practitioner role I became aware of examples of potential longer-term impact, and in particular, how the pilot experience had influenced two individuals to postpone their retirement from the NHS and to continue to work as senior nurses for several more years, which contributed to my curiosity and motivations, as outlined in Chapter one, and these insights subsequently fed into my study, as will become clearer later in Chapters five and six.

3.3 How Leading into the Future evolved to become Delivering Better Care Leadership Programme

The following section will describe how *Leading into the Future* programme evolved over the years to become DBC LP, and how these developments shaped my own '*foreshadowed*' questions.

2009-2010

In 2009 and 2010 *Leading into the Future Leadership Programme* (see Appendix 3 Participant Information Booklet*)* was enhanced further by connecting with the leadership strand of a high profile research and practice development initiative called '*Leadership in Compassionate Care'* (LCC) Programme, that was underway in NHS Lothian in collaboration with ENU (Adamson et al., 2011). The LCC Programme aimed to '*embed compassionate care as an integral aspect of all nursing practice and education in NHS Lothian and beyond'* (Adamson et al., 2011, p14).

This synergy with *Leading into the Future Leadership Programme* strengthened the leadership strand of the LCC, which had previously comprised of two days of workshops, and also provided additional facilitator capacity, whilst building leadership capability in the participants. Access to *'Leading into the Future in conjunction with the LCC'* was extended beyond older people's services, to include staff from all areas of practice, such as acute wards, community, mental health, paediatrics and midwifery. The rationale for this was to enhance the opportunity to develop leaders across the whole system or organisation, and provide all clinical areas with development and networking opportunities, in order to build organisational leadership capability and capacity.

The newly evolved programme, *Leading into the Future in conjunction with the LCC,* focused on the importance of utilising an appreciative inquiry approach (Dewar and Nolan, 2013) concentrating on what was working well, how this might happen more frequently, as the evidence suggested that appreciating positive aspects in situations and people could result in effective and sustainable change (Cooperrider and Whitney, 2011). Fundamental to the ethos of this newly merged programme was to continue to involve staff in the process of change through application of learning to practice (Winter, 2001).

2010-2011

In 2010-2011, the *Leading into the Future in conjunction with the LCC* programme was adapted and delivered in response to similar challenges and concerns within older people's care services in Limerick, Ireland. Healthcare challenges had heightened around this time in Ireland, exacerbated by the worldwide economic crisis, which resulted in staff experiencing periods of uncertainty and rapid change. New inspection processes and systems had been initiated, which contributed to difficulties faced by nurses due to staffing shortages; in particular within older people's care services. Nurse leaders were aware of the subsequent low staff morale, and consulted with Professor Mike Nolan, an Honorary Lecturer at Limerick University at the time, who was commissioned to co-deliver a leadership development programme for nursing staff. The decision was made to deliver *Leading into the Future in Limerick programme* (see **Table 3.1**), based on the experiences within NHS Lothian.

Due to logistical challenges of geographic distances for the facilitation team (Professor Nolan, Professor Brown and myself), the model was delivered over eight full days: three full days in September 2010, one full day in January 2011, three full days in April 2011, followed by a full day for celebration and project presentations in September 2011.

The participants (n=18, all nurses), who worked across a widespread area, in a number of residential homes or care home environments, caring for older people, welcomed this longitudinal model of delivery. Initially however, levels of enthusiasm and motivation were notably low in many participants within the group, who despite being invited to complete an application had described 'being sent' on the programme by their managers. Creating the conditions for a safe environment, where all individuals were respected and valued, enabled participants to be open, honest and transparent about how they felt and allowed

them time to trust the process. This required skilful facilitation and professionalism.

The overarching hopes and expectations of the participants were to develop supportive working *relationships* with their colleagues, to enable them to manage change more effectively, and to enhance their leadership and practice; all of which aligned with the 'programme' aims (which are detailed later in this Chapter).

Feedback during the *Leading into the Future in Limerick* programme and evaluation following the ten-month programme was once again positive, with the *Senses Framework* and the creation of an *enriched learning environment* having a significant impact on the nurses who participated. Examples of impact included improvements in team communication at handover; enhanced care planning for patients and significant increased self-confidence as leaders, when leading and managing change. A *Sense* of **Belonging** had been created within the group of nurses, who felt they had 'bonded together' and 'were not alone'. For many of the participants, the most significant impact had been on a personal level, the benefits of which also had a positive effect on their professional role. One participant described herself as completely transformed and re-engaged in both her family and work life, which was affirmed by her colleagues who had observed the transformation over time (see Chapter six narrative, which describes *Mary*, an Element B, past participant, who referred to this).

Contact was maintained by electronic mail, over the following years, with many of the participants, who often referred back to the programme as having had a significant impact on them *professionally* and *personally*, which subsequently influenced my motivation for undertaking the study as described earlier in Chapter one, and thus fed into my study within Element B.

The experience of delivering the programme model using the *Senses Framework*, in a different country and political environment, affirmed the facilitators' belief that the programme approach was transferrable, having wider relevance outside of the original context and in differing circumstances. This was timeous with the growing organisational support for the programme, which was developing across service areas and specialities.

2011

In 2011 *Leading into the Future in conjunction with LCC,* continued to be delivered as previously, however it was renamed the *Delivering Better Care Leadership Programme,* as the title (*Leading into the Future in conjunction with LCC)* was too lengthy, and the Executive Nurse Director at the time, was keen to further promote the programme, whilst maintaining Executive support and sponsorship, particularly when the on-going feedback and evaluation data from participants remained positive.

Further development of the programme *resulted in Delivering Leadership Excellence* (DLE) *for Allied Health Professionals Programme (*AHPs) such *as* Physiotherapists, Occupational Therapists, Speech and Language Therapists, Podiatrists, Dieticians, which was designed in response to local and national drivers specifically for AHPs, and commenced in 2011. DLE for AHPs utilised a similar model, timeframe and incorporated the same underpinning theories and tools as DBC LP. At the time of writing, the two programmes run in parallel in order to develop leadership capacity and capability across the workforce. AHPs at any level can participate in DBC LP, *which* is a multi-disciplinary programme, whereas DLE for AHPs is prioritised for senior AHPs Bands 6-7. The reason for this specific focus was in response to a national priority to support the leadership development of senior AHPs; therefore the programme supported national policy and was in line with other NHS Boards in Scotland at the time (NHS Education for Scotland, 2012).

2015 onwards

At the start of my doctoral studies in April 2015, based on ongoing positive evaluations and the success of a *relationship-centred* approach underpinned by the *Senses Framework,* NHS Lothian continued to support and invest in the development of leaders at all levels. The organisation valued the programme highly, as evidenced in discussions at education and development governance meetings, and had a desire to continue to build leadership capacity and capability at all levels. Therefore from September 2016, the programme was opened to all staff groups including Administration and Clerical, Facilities and Corporate services such as Human Resources and Finance. Applications from colleagues across Health and Social Care settings were also invited, which supported the integration agenda, collective leadership and collaboration (West et al., 2014a; West et al., 2015b). To date numbers of participants from specifically Health and Social Care areas, are small, albeit this is gradually increasing at the time of writing and remains an area for development.

In summary, DBC LP has evolved over a period of ten years. In 2017, NHS Lothian developed a *Leadership and Management Development Framework* (LMDF)(NHS Lothian, 2017) to further support leaders at all levels of the organisation and DBC LP was positioned firmly within the LMDF as a fundamental development intervention, with a robust reputation and credibility across the diverse workforce of healthcare staff.

Table 3.1 captures the programme timeline as it evolved.
The consistent number of full day workshops is twelve, per programme, delivered 0930-1600.

Table 3.1 DBC LP Programme Timeline

Year	Programme Name	Number of participants	Timescale of programme	Target group
2007-2008	Leading into the Future Pilot	13	12 months	Older People's Services, (Registered Nurses and 2

				Occupational Therapists) NHS Hospitals and a selection of Care Homes were invited to apply (4 Care Home staff started and did not complete) 1 staff member from a Charity run Care Home for Visually Impaired Residents participated
2009-2010	Leading into the Future in conjunction with Leadership in Compassionate Care Programme	59	9 months	Older People's Services and Acute Hospital wards, Primary Care, Mental Health, Paediatrics and Women's Services (Open to all clinical staff at all levels- including Health Care Support Workers, Midwives) (Small number of Allied Health Professionals began applying) *1 place is offered annually to staff from a Care Home for Visually Impaired residents and has continued over the years since the pilot*
2010-2011	Leading into the Future in Limerick	18	10 months	Older People's services -Registered Nurses (Care Homes/Residential Care)

2011-2012	Delivering Better Care Leadership Programme	22	12 months	All clinical areas- all staff at all levels
2011-2012	Delivering Leadership Excellence for Allied Health Professionals (AHPs)	24 *(Delivered annually in parallel to DBC LP)*	12 months	Same programme model, for senior AHPs Bands 6-7. (Physiotherapists, Occupational Therapists, Dieticians, Speech and Language Therapists, Art Therapists, Podiatrists, Sonographers, Radiographers, Orthoptists, Prosthetists)
2012-2013	Delivering Better Care Leadership Programme	21	12 months	All clinical staff at all levels
2013-2014	Delivering Better Care Leadership Programme	26	12 months	All clinical staff at all levels
2014-2015	Delivering Better Care Leadership Programme	29	12 months	All clinical staff at all levels
2015-2016 (Element A Study sample)	Delivering Better Care Leadership Programme	23	10 months (*Reduced to 10 months to avoid peak summer months July/Aug. So commenced Sept-June)*	Emphasis on all levels and extending beyond clinical staff
2016-2017	Delivering Better Care Leadership Programme	24	10 months	Continued emphasis to invite applicants from non- clinical roles e.g.

				Facilities, Administrative and Clerical, Catering, Laboratories and all clinical roles at all levels
2017-2018	Delivering Better Care Leadership Programme	34	10 months	Continued emphasis to invite applicants from all staff at all levels
2018-2019	Delivering Better Care Leadership Programme	35	10 months	Continued emphasis to invite applicants from all staff at all levels

3.4 Delivering Better Care Leadership Programme- the main focus of the study

Currently, DBC LP (see Appendix 1) focuses on caring, compassion and quality improvement. Using an appreciative inquiry (Cooperrider, Whitney and Stavros, 2008) approach and ethos, participants are supported to apply theory to practice, whilst taking forward work-based activities and small change projects, using tools and quality improvement techniques that promote engagement with patients, families and staff within teams (Swensen et al., 2009; West, 2013).

The Programme runs over ten months and is delivered every year starting in September. Feedback from participants influenced the programme model being reduced in 2015, from twelve months to ten months, to avoid workshops during peak summer holiday time in July and August. Applications are invited from staff of all levels and roles from across all areas and specialties. Successful applicants, include Nurses (Staff Nurses, Deputy Charge Nurses and Senior Charge Nurses), Health Care Support Workers, Midwives, Allied Health Professionals such as Physiotherapists and Occupational Therapists, who work in NHS Lothian. Staff within NHS Borders and a Lothian based Care Home for visually impaired residents, are each invited to apply for a place on the

programme, which promotes collaboration and geographical working. Senior leaders at this particular Care Home had expressed an interest in the programme at the very onset of the pilot and have remained pivotal to the evolving programme, remaining connected to leaders at NHS Lothian and contributing to workshops by sharing experiences of their application of learning to practice over the years. A participant from NHS Borders and the Care Home has successfully completed the programme most years. All applicants will have completed an application process involving an informal interview and confirmed that they have their line manager's full support to undertake the programme. Medical staff can apply but tend to prioritise other shorter programmes. To date one Psychiatrist has completed the programme.

An overview of the programme model, workshop content, tools and delivery approach is now provided in the next section.

3.4.1 Delivering Better Care Leadership Programme Aims

As described above, the DBC LP is a leadership programme focused on caring, compassion and quality improvement, which actively supports key drivers in NHS Scotland, as previously discussed within section 1.3 of Chapter one and section 2.3 of Chapter two, such as Everyone Matters: 2020 Workforce Vision and the Quadruple Aim (NHS Scotland, 2017a; Perlo et al., 2017).

Aims of the programme are that participants will:

- Develop their personal qualities and skills as transformational compassionate leaders
- Work with others on the programme to exchange ideas, build upon expertise in the group and develop collective leadership and practice
- Develop an increased understanding of compassionate, safe, person-centred and *relationship-centred care* and actively use these concepts within their role

- Develop skills of using an appreciative inquiry approach to quality improvement
- Develop skills in engaging members of their team and leading a small test of change
- Develop a working understanding of policy that relates to quality in health and social care
- Share their learning and development and celebrate success

The above aims informed my '*foreshadowed questions*,' and the extent to which they were achieved for the study participants, is explored in Chapter five, and again in Chapter seven, which reflects on the quality of the DBC LP overall.

There is an organisational expectation, that participants on the programme will be supported by their managers, to work and engage with their teams. Participants are encouraged to be open to ideas, work with possibilities rather than focus on limitations, and to challenge their own values, beliefs and assumptions. This intensive programme includes twelve full day workshops over ten months, with two workshop days at the beginning of the programme in September and October, to enable the participants to connect as a group and grasp an understanding of the underpinning concepts. Workshops are then delivered on one day each month and are held at various venues across NHS Lothian sites.

Participation involves a real commitment to attend each workshop and to carry out the activities between sessions in their work area, which include taking stories from patients, carers, families, staff members and students, and observing practice. If participants are unable to attend any workshops or omit to undertake any of the activities, due to illness or unforeseen circumstances, they are encouraged and supported by the facilitators and their peers within the group to catch up on the content and activities at a later date. One to one conversations within the workshop setting and on occasion on the telephone in between workshops, provides the opportunity for the participants to maintain

their commitment and keep abreast of the programme as it evolves. The work-based activities are suggested and encouraged, however they are not dictated as mandatory, in the spirit of adult experiential learning. The vast majority of participants do actually undertake the work-based activities as they tend to be motivated to do so, and this will be explored later in the findings and discussion Chapters.

The programme has required a significant investment by NHS Lothian, as part of its aim to build leadership capacity and capability, and enable safe, effective, person-centred, compassionate care for patients and families; therefore participants are encouraged to embrace and capitalise on the development opportunity.

Partnership working has continued with ENU ever since the programme was aligned with the LCC Programme (Adamson et al., 2011). Opportunities to undertake work based learning modules at ENU following completion of the programme are explored with participants who wish to consider gaining academic accreditation at any point throughout their leadership journey. Only a small number of participants have taken up this opportunity over the years, as the main emphasis of this particular programme is the practical application to work role rather than an academic focus. The pros and cons of this have been discussed at an organisational level and with healthcare staff, many times over the years, with the consensus being that there are other programmes available within NHS Lothian's LMDF, which offer accreditation, should staff wish to gain academic qualifications. Therefore, having the additional option for this more practice based model is deemed to provide choice.

Having outlined the aims of the DBC LP, attention is now turned to the workshops themselves.

3.4.2 Content of the DBC LP workshops

The programme workshops are interactive, with the exact content being flexible and bespoke to the needs of each group (Boud and Walker, 1991; Hogan, 2005; McCormack et al., 2009a; McCormack and Garbett, 2003b). The *Senses Framework* (Nolan et al., 2006), underpins the overall programme and also provides a facilitation and delivery mechanism for the facilitation team. This will be explored in sub-section 3.4.5 of this Chapter, which describes creating the conditions for the participants to learn and develop. **Table 3.2** below, illustrates the key workshop topics.

Table 3.2 Workshop topics

Workshop topics
• Contracting for success
• Developing leadership and compassionate care, through feedback and learning from other's experiences
• Relationship-Centred Compassionate Care and the Senses Framework
• Understanding quality improvement and leading small tests of change
• Exploring leading and managing- 'demystifying leadership'
• Compassionate Leadership
• Valuing and working with feedback
• Having meaningful conversations at work
• Engaging the team
• Equality, person-centred care and leadership: Balancing rights, responsibilities and risks
• Inquiring and acting appreciatively- improving quality and safety
• The power of observation
• Enhancing the patient and staff experience
• Celebration of learning and sharing best practice

Key themes (see **Table 3.3**) from the LCC Programme, which was completed in 2012 (Adamson et al., 2011) are threaded through the programme workshops, which are facilitated using an appreciative inquiry approach (Cooperrider and Whitney, 2011; Cooperrider, Whitney and Stavros, 2008; Hall and Hammond, 2011; Sharp et al., 2017)

Table 3.3 Compassionate Care Themes (Adamson et al., 2011)

Compassionate Care Themes
• Creating spaces that work (Environment)
• Caring conversations
• Flexible person centred risk taking
• Knowing me knowing you
• Feedback
• Involving, valuing and transparency

Quality Improvement methodologies (Perlo et al., 2017) are also pivotal to the programme delivery, which is focused on collective compassionate leadership (West, 2013; West et al., 2014a). All workshops have synergy with key political drivers and organisational priorities and initiatives, for example, Scottish Patient Safety Programme (Haraden and Leitch, 2011; NHS Scotland, 2018b), Quality Strategy and Integration agenda (NHS Scotland, 2017a), Staff Engagement and Experience national iMatter tool (NHS Scotland, 2017a), and Equality, Diversity and Human Rights agenda (Èzbilgin, 2009; Wadham and Edmundson, 2009; Eagly and Chin, 2010). Guest speakers are invited along to the workshops to contribute to the discussion around a particular topic or to share their leadership story. Speakers include past participants of the programme, which provides a rich learning experience and also key stakeholders within the organisation such as Executive Directors and lead practitioners on specific work streams, for example Carers' Lead and Equality and Diversity Lead.

3.4.3 Self directed elements of the programme

The ethos of the DBC LP is based upon experiential, adult learning (Kolb, 1984; Malinen, 2000; Kolb and Kolb, 2005; Moon, 2013), therefore participants are encouraged and supported to undertake self-directed activities based upon their personal areas for development, which have been identified prior to them applying for the programme in conjunction with their manager. Examples of such activities will be provided within the next Chapter, where participants are introduced. A

range of self-directed options is signposted to participants, which compliment the work-based activities and enable application to practice following each workshop. This also requires the participants to take responsibility for their own learning and encourages continued learning in between workshops, which it is hoped then sustains their interest and motivation. Time management and prioritisation of activities is therefore required and will vary depending on individual's personal and professional circumstances. Often participants who work clinically on wards or in the community for example, find they have to undertake any additional self-directed work in their own time when off duty.

Although this is explored during the application process, as applicants are requested to describe in their supporting statement, how they will commit to the programme activities and manage their time, and again during the telephone interview conversation, this is continually explored during the programme, to support and encourage the participants to sustain their level of commitment.

Because the work-based activities are practically based and focussed on their particular role, this enables participants to be thinking and reflecting on the programme tools and activities whilst at work and undertaking their leadership role. This is important as it creates the conditions within the programme for participants to care for themselves as a leader, thus promoting an effective work-life balance (Covey, 2015).

An online resource compiled in modular sections, is available to participants, and includes all tools and concepts covered within the workshops, as well as suggested reading materials and references. In the past this was a hard copy folder, which was provided on day one to participants. Feedback from participants confirmed that an electronic version would be of preference, which was also environmentally friendly. Examples of self directed elements are included in **Table 3.4**.

Table 3.4 Self directed elements of DBC LP

Self directed elements of DBC LP
• One to one 'coaching' conversations with DBC LP facilitator and /or with manager to link with Personal Development Plan (PDP)
• Writing a letter to self (capturing expectations, hopes, concerns, aims, what will success look like, and whatever message the individual wishes to write to self. This letter is sealed and locked away by the facilitator until the end of the programme when it is then given back to the participant to open and read in private. They are able to see what they have achieved or not and reflect on how and what they are thinking after the 10 month programme. This supports their next steps and planning to sustain their development and can be a powerful and emotive exercise). This data is not shared with the facilitator team.
• LMDF self directed questions, which promote discussion and self reflection
• Leadership Zone/TURAS Learn available via NHS Education for Scotland website
• DBC LP Online resource which participants are directed to following specific topics and encouraged to read, test out tools for example

3.4.4 Work-based practical elements of the programme

Work based activities and practical application of the tools are key to the implementation and development of learning throughout the programme. Participant's feedback and share their learning at the start of each workshop, which encourages engagement and participation, enables participants to hear their voice and speak up about their experiences, which also enhances their self-confidence in presenting informally to peers. This also is useful preparation for the celebration of learning and presentation of projects workshop at the end of the programme. Key tools and activities are illustrated in **Table 3.5**.

Table 3.5 Examples of work-based activities

Examples of work-based activities
• Using adapted 360-degree feedback tools or online 360 tools (available within DBC LP online resource) (Tornow, 1993; Carson, 2006; NHS Leadership Academy, 2013).
• Using a range of Feedback tools with teams, patients, carers and students including 'Fast feedback form' (Dog and Rose form), Imagery, Emotional Touchpoints stories and 'Values cards' to seek, hear and act upon feedback (Dewar et al., 2010; Adamson et al., 2011; MacArthur, 2014; Smith et al., 2017).
• Completing Personal Indicators self-questionnaire at the start and end of the programme (Adamson et al., 2011).
• Testing out Quality Improvement tools with teams, such as Project charter, driver diagram, Model for Improvement, Plan/Do/Study/Act (PDSA) template, Fishbone tool, Pareto chart, run charts and process mapping (Healthcare Improvement Scotland, 2018).
• Using Impact Assessment tools for project work.
• Reflecting on the Senses Framework and exploring its application with the team (Nolan and Caldock, 1996; Nolan et al., 2006; Nolan, 2013).
• Observing practice and practising giving and receiving feedback (Cunningham and Kitson, 2000; Schnelle, Ouslander and Simmons, 2006; Ferguson et al., 2007).
• Practising having meaningful conversations using tools and techniques- reflecting on dealing with conflict/change/stress and interpersonal skills (Stober, Wildflower and Drake, 2006; Covey, 2015; Rahim, 2017; Smith et al., 2017).
• Engaging the team to explore values, attitudes and behaviours- considering the Fish Philosophy, team roles, organisational values, communication (Lundin, Paul and Christensen, 2018).

One of the keys to the success of the programme to date is often seen as being the creation of an *enriched environment* based upon a set of values that drive the programme. These are derived from those proposed by the Pew-Fetzer Task Force (1994) as indicated in **Table 3.6**.

The *Leading into the Future* pilot and subsequent DBC LP, built upon the knowledge, skills and values required for *relationship-centred care* as identified by Pew Fetzer et al (1994) (See **Table 3.6).**

These relate to the following areas:

- Self awareness
- Patient experience of health and illness
- Developing and maintaining caring relationships
- Effective communication

Table 3.6 Knowledge, Skills and Values required for the patient-practitioner relationship in order to achieve *relationship-centred care* (Tresolini and Pew-Fetzer Taskforce, 1994, p.30).

AREA	KNOWLEDGE	SKILLS	VALUES
Self-awareness	Knowledge of self; understanding self as a resource to others	Reflect on self at work	Importance of self-awareness, self-care and self-growth
Patient experience of health and illness	Role of family, culture, community in development; Multiple components of health; Multiple threats and contributors to health as dimensions of one reality	Recognise patient's life story and its meaning; View health and illness as part of human development	Appreciation of the patient as a whole person; Appreciation of the patient's life story and the meaning of the health-illness condition
Developing and maintaining caring *relationships*	Understanding of threats to the integrity of the relationship (e.g. power, inequalities)	Attend fully to the patient; Accept and respond to distress in patient and self	Respect for patient's dignity, uniqueness and integrity (mind, body, spirit, unity); Respect for self-determination;

			Respect for person's own power and self-healing processes
Effective communication	Elements of effective communication	Listen; Impart information; Learn; Facilitate the learning of others; Promote and accept patient's emotions	Importance of being open and non-judgemental

How the facilitation team aims to achieve this within DBC LP is now considered in the following sub-section.

3.4.5 Creating the Conditions for an enriched learning experience

Within the DBC LP workshop settings, there is an implicit emphasis by the facilitators on role modelling and demonstrating the values, which underpin the working ethos, and which NHS Lothian aspires to create consistently across the organisation.

The *Senses Framework* (Nolan et al., 2006) provides the facilitation mechanism to enable this to happen, as described in Chapter two, section 2.4, where the concept of *enriched environments* is introduced. By aspiring to live the values of *care and compassion, dignity and respect, quality, openness, honesty and responsibility and teamwork,* the facilitation team*,* the composition of which is described in the next section of this Chapter, strive to create the conditions, which are conducive to an *enriched learning experience.*

This begins by striving to create a Sense of **Security** and **Belonging** within the workshops, something that continues throughout the timeline of the programme. Once the participants begin to feel safe and that they belong, the emphasis shifts

to helping participants to feel that they matter by creating a Sense of **Significance**. This then enables them to create a clearer **Purpose** in terms of their role and their participation on the programme, which subsequently contributes to creating a Sense of **Achievement**. The safe environment and supportive community of peers within the group, which is experienced on a regular basis monthly, enables a Sense of **Continuity** to be created, thus developing and creating the conditions for an *enriched learning environment* and leadership development experience.

The following sections begin to describe *how* and *what* contributes to creating such conditions. The hope is that participants are then enabled to implement their learning from this *enriched* experience, back in the workplace with their teams.
How successful the facilitation team actually are, in creating the condition*s* for an *enriched learning experience*, will be explored further within the findings and in the discussion Chapters seven and eight.

3.4.6 Facilitating and creating a Sense of Security, Belonging and Significance

The facilitator team has varied in personnel and size over the years, due to role changes and retirements. However, a Sense of **Continuity** has been created with the Lead Nurse for Compassionate Care, who is also a senior lecturer within ENU and has an Honorary contract within NHS Lothian, being a key facilitator within the team, along with myself. To develop facilitator capacity and capability another two part-time facilitators support the programme delivery, as their work commitments allow. The most significant impact on the programme caused by the reduced facilitator team over the past five years, is that regular one-to-one coaching support to participants within the work place is no longer possible. This individualised support now takes place within the workshops and is minimal in comparison to previous years. Although this seems to have had no obvious detrimental effect on the participants, it does have a negative impact upon the facilitators, as they valued the time with participants in their workplaces and now miss the opportunity to do so, as it supported the development of *relationships*

with the participants. However, participants have the opportunity to engage in coaching through the in-house Coach Bank, which consists of a resource of qualified coaches who work across a variety of areas in NHS Lothian and provide coaching support for staff through an application process. Should they wish additional support, participants can also request coaching support from the Clinical Quality teams, in relation to their work based Quality Improvement project, which many of the participants actually do.

As stated above, the *Senses Framework* (Nolan et al., 2006) provides a facilitation and delivery mechanism for the DBC LP facilitator team. Time is given at the start of the programme during workshop one, to hear all participants' expectations, hopes and concerns, and to agree ways of working for the group. Investing time at the start of the programme, 'beginning with the end in mind', allows clarification of focus and **Purpose** (Covey, 2015). This enables participants and facilitators to co-create a 'contract', which facilitates participants to feel safe and secure, as they embark on their leadership journeys and also clarifies personal and collective goals.

The working contract is reviewed at each subsequent workshop to ensure full engagement and attention is given to the agreement. This creates a Sense of **Continuity** and enables the emerging *enriched environment* to be developed, as the agreed ways of working within the 'contract' become a consistent reality. Previous evaluations of the programme over the past ten years and participants' on-going feedback have provided evidence that the creation of an *enriched* learning *environment* is significant and very often unique to their experience of this programme.

3.4.7 Creating a shared learning experience

As already noted, the participants on the programme are multidisciplinary healthcare staff from across various areas of the organisation, occupying differing roles, with varying pay bands or levels. This diversity provides a rich shared learning experience. Participants often develop supportive *relationships* with each

other over the ten-month programme, which sometimes extend way beyond the timeline of the actual leadership programme. This is explored and evidenced in further detail in Chapter six, section 6.6. The value of sharing learning experiences and comparing real life examples of challenges and good practice, is undoubtedly one of the key benefits of the programme experience, whilst also creating a Sense of **Belonging,** and will be explored later in Chapter six.

The programme is unique within the LMDF in NHS Lothian, in that in addition to the key underpinning principles and theories, there is also a bespoke element to the facilitation of the workshops content, which allows a tailored approach to the tools and focus, according to the specific group's needs. During the initial workshops and when contracting to agree ways of working at workshop one, the hopes, concerns and expectations of all participants are explored. This allows any key topics or scenarios to be explored in more detail or additional sessions to be planned into the programme. For example, if time management or delegation is a significant challenge, more emphasis will be prioritised to cover these topics.

To ensure quality and **Continuity**, a consistent approach is adopted using the key models, however more focus can be given to workshop content depending on the conversations and development areas that emerge from the group as they experience the programme, which means a more co-created approach is provided. Sometimes the participants 'don't know what they don't know', and so these areas for development and learning usually emerge over time, through self reflection and having conversations with each other, to share aspects of development areas they would like to explore. One example was where participants shared that they found managing conflict and dealing with difficult behaviours, which are incongruous to the organisation's values, challenging. This resulted in a deeper focus and time given to facilitation of workshop sessions on having meaningful conversations and using transactional analysis when engaging the team (Stewart and Joines, 1987).

The practical application and implementation of learning, results in a work based small test of change/project, which contributes to the organisational aims of improving quality, learning and *personal* and *professional* leadership. Throughout the programme this is enabled by the **Continuity** of an experienced facilitation team, which is described later in Chapter five sub-section 5.5.2 (McCormack and Hopkins, 1995; Kotter, 1996; Kitson, Harvey and McCormack, 1998; Harvey et al., 2002; McCormack and Garbett, 2003a; Hogan, 2005; Knight et al., 2017). Celebration of success and learning at the final workshop provides the organisation with an opportunity to promote joy in work, which it is hoped enables participants to feel appreciated and valued and therefore creates a Sense of **Achievement** at a personal, team, service and wider organisational level (Swensen et al., 2012; Swensen et al., 2013a).

In summary, the *Senses Framework* plays a pivotal role in the DBC LP in providing a significant facilitation and delivery mechanism, as well as an underpinning theory. Through creating the Senses within the workshops and during the programme timeline, there are opportunities for an *enriched* learning experience to be created and maximised.

3.5 Moving from sensitising concepts to foreshadowed questions

One of the primary aims of the preceding two Chapters has been to identify the key '*sensitising concepts'* that informed the '*foreshadowed questions*,' that gave initial direction to my study. At the beginning of Chapter two the role that '*sensitising concepts'* play in qualitative research, was highlighted. At that point I also suggested two ways in which my study might be considered by some to be 'unconventional'. One was that rather than include a traditional literature review, I sought to identify a range of differing forms of knowledge (as opposed to 'evidence'), including my own, that were influential. The second potentially unconventional element was the greater role that I have accorded existing knowledge (specifically in the form of *relationship-centred care*, the *Senses Framework* and an *enriched environment*) in my Constructivist study (see next

Chapter). I would hope that by now, my reasons for doing so are quite clear, in that, as described in detail in the preceding pages, these frameworks lie at the heart of the whole enterprise. To accord them a role simply in identifying my '*foreshadowed questions'* would have been to deny the pivotal part that they have played. Therefore, in addition to acting as my primary '*sensitising concepts*,' the *Senses Framework* and *enriched environments* also played a key part in my data analysis and the presentation of my findings. However, as I hope to demonstrate, they have not been adopted uncritically and have had to 'earn' their way into my work, as is consistent with the idea of 'modifiability' in Grounded Theory (Glaser and Strauss, 1967).

Over the last ten years there have been numerous anecdotal accounts of the success of the DBC LP, together with some more 'formal' evaluations (Nolan and Nolan, 2009). Indeed, it is hard to imagine that NHS Lothian would have continued to invest in the programme, if it were not seen to be 'successful'. In large, part of this success has been attributed to the ethos of the programme and its ability to create an e*nriched environment* that enables participants to develop as leaders. Again, we have many anecdotal accounts suggesting that this is true. However, I believed that a deeper understanding was required, of whether this was actually the case and if it was, what were the factors that might explain this? If these factors could be teased out and brought together, there were likely to be implications that potentially would extend beyond the local context to a wider one.

In Chapter one I gave an indication of what my early '*foreshadowed questions'* were, and these are reiterated below in **Table 3.7**.

Table 3.7 Early Study Aims/Foreshadowed questions

Early Study Aims/Foreshadowed questions
• To explore the expectations and motivations of Nurses and Allied Health Professionals (participants), for undertaking the clinical leadership programme (and expectations of their managers). • To discover how participants experienced the programme and whether or not their expectations (of self and the programme) changed over time (and explore views of their managers, peers and junior colleagues). • To develop an understanding of potential impacts following participation in a clinical leadership programme and the factors that both facilitated and hindered any subsequent changes over time.

Based on the content of the preceding text, these ***foreshadowed questions*** are now expanded as illustrated below:

- What are the expectations and motivations of Nurses and Allied Health Professionals (participants), for undertaking the clinical leadership programme? What are the expectations of their managers?
- How do participants experience the programme? Do their expectations change over time and how do they feel that their expectations have been met? What do their managers, peers and junior colleagues notice about the participants after their experience of the programme?
- How have the programme Aims been met? How do these aims fully reflect what the programme has achieved?
- What are the potential impacts following participation in the clinical leadership programme and what factors either facilitated or hindered any subsequent changes over time?
- How can the participants' experiences of the programme and/or any subsequent changes be understood using the *Senses Framework* and an e*nriched environment*?
- How can any insights that emerge from the study be used to inform the development of similar programmes in differing contexts*?*

As will hopefully be clear by now, the programme that lies at the heart of this study is underpinned by a relational and collaborative approach. In seeking to address the above questions I wanted to adopt a methodology that would be true to this approach. The decisions I made and how I reached them are explored in the next Chapter.

3.6 Chapter summary

In conclusion, this Chapter has described the local context for the study, and illuminated the **Significance** of the evolving DBC LP through highlighting the background to the programme since the initial pilot *Leading into the Future* programme, ten years ago. The philosophy underpinning the programme was illustrated and details of the aims, workshop content, topics, self-directed elements and work-based activities were outlined. How the conditions are created within the programme, to facilitate an *enriched environment*, were described, which led to the importance of how my *sensitising concepts* informed and significantly expanded the *foreshadowed questions*.

In summary, the first three Chapters of this thesis have 'set the scene', through detailed descriptions of the wider and local context for my study. The complexities of the current healthcare leadership landscape have been outlined, which provided the platform to illuminate the importance of this study. The influence of the key '*sensitising concepts'*, the *Senses Framework*, *relationship-centred care* and *enriched environments,* resulted in more detailed *foreshadowed questions* being developed, which were presented in the previous section, the **Significance** of which will continue to be explored throughout the thesis.

Attention is now given to Chapter four, where I will describe my chosen Methodology and Methods, my rationale for choosing a Constructivist Grounded Theory approach, embedded within a Fourth Generation Evaluation framework, and how this was implemented to address the *foreshadowed questions* within my study.

Chapter Four. Research Methodology

4.1 Introduction

This Chapter describes why and how I adopted an evolving Constructivist methodological approach, informed by Constructivist Grounded Theory (Charmaz, Denzin and Lincoln, 2008; Charmaz, 2006; Charmaz, 2011; Charmaz, 2014) and embedded within a Fourth Generation Evaluation framework (Guba and Lincoln, 1989), to address the foreshadowed questions presented at the end of the previous Chapter three. I will argue why this research strategy was the most appropriate to address my aims and consider the main ontological and epistemological assumptions underpinning my study. Subsequently details of the research design are described in relation to the three Phases of the study, with particular emphasis on how the underpinning hermeneutic dialectic process unfolded and influenced data collection and analysis. The Chapter concludes with a consideration of ethical issues, the central role that reflexivity played in the study and how rigour was addressed. Attention is turned first as to why a qualitative approach was considered the most appropriate.

4.2 Why Qualitative research?

There are numerous research approaches that can potentially be used to address a given question or issue, and one of the first considerations to make is to determine which particular approach is the best for the question or issue under consideration. There is not necessarily one 'correct' answer to this question, as a case can often be made for a variety of approaches. Here I describe why I felt that the approach I chose to adopt was, in my view, the most appropriate. Debates about *methodology* (the overall philosophical approach adopted) and *methods* (how the study was enacted) (Wainwright, 1997) are often complex and turn on a number of assumptions about the nature of 'reality' (*ontological* assumptions), how we can understand and 'know' this reality (*epistemological* assumptions) and how we can best explore such reality

(*methodological* assumptions) (Wainwright, 1997). As a relatively new researcher, understanding such issues was not straightforward; moreover as my reading progressed, it became clear that I had also to take my own personal ontological and epistemological views into account (Grix, 2010; Parahoo, 2014). This was considered particularly important given the central role that I played in both delivering and researching the programme at the heart of my study. Reflexivity is therefore a central concern and is something that I will give more attention to later within this Chapter and again in Chapter seven.

Generally speaking there have traditionally been two broad schools of research, quantitative and qualitative, with differing ontological, epistemological and methodological assumptions, which define the 'paradigm' within which a study is located (Denzin and Lincoln, 1994). The most obvious distinction is that qualitative studies generally seek to explore meaning and generate understanding of experiences, whereas quantitative studies focus on measuring and analysing variables (Denzin and Lincoln, 1994; Morse and Field, 1995; Creswell and Miller, 2000; Denzin and Lincoln, 2002; Morehouse and Maykut, 2002; Twycross and Shields, 2005). Within healthcare it is generally the quantitative paradigm, especially the Randomised Controlled Trial (RCT) that is seen as the 'gold standard' model. Quantitative research methodologies, coming from a positivist stance aim to explain, predict and control, using statistical analysis to 'objectively' deduce conclusions and ideally to 'prove' a given hypothesis (Purdon et al., 2001; Greene, 2009). For the purposes of this study, given the leadership challenges and complexities within healthcare, already outlined in Chapter two, controlling variables and measuring outcomes to generate quantitative data was not deemed the appropriate focus of inquiry. To explore the individual experiences of healthcare staff and a particular clinical leadership programme, adopting a qualitative approach was therefore required for this study.

For qualitative researchers, positivist approaches limit the depth and richness of the information gleaned, particularly from an individual's perspective (Pope,

Mays and Popay, 2007; Schneider et al., 2016). In contrast qualitative approaches allow for a more nuanced understanding of the interaction of experiences, views and beliefs that shape social situations (Van Maanen, 1979; Denzin and Lincoln, 2008). However, qualitative approaches comprise a very broad range of options and there are numerous variants that could have been adopted, therefore selecting what appeared to be the best method for my study was a major consideration.

Determining the actual qualitative approach to the research study was influenced and guided by several factors. As a researcher, my mental models and views of the world, referred to as 'paradigms' or 'interpretive frameworks' (Guba and Lincoln, 1994; Covey, 2015), would be influenced by my own values, beliefs and life experiences and I recognised that these would impact upon how I conducted my study. My personal ideas and views of leadership built on my experiences to date would be very important and likely to influence the methodological approach I adopted (Guba, 1990; Denzin and Lincoln, 1994; Guba and Lincoln, 1994; Mills, Bonner and Francis, 2006; Maxwell, 2012). Moreover my central role in both delivering the programme and exploring its impact needed to be taken into consideration. These issues are explored further when reflexivity is addressed later, in this Chapter and also in Chapter seven as stated earlier.

In choosing a way forward I drew heavily on the work of Guba and Lincoln (1994). These authors argued that qualitative research can be interpreted through four key lenses or 'interpretive paradigms': positivist, post-positivist, constructivist-interpretive and critical theory (Guba and Lincoln, 1994), as captured in **Table 4.1**, which illustrates each lens' assumptions and overall philosophical stance.

Table 4.1 Interpretive Paradigms of Qualitative research

	Ontological stance *(what is reality?)*	**Epistemological stance** *(How can I know reality?)*	**Methodological stance**	**Aim of inquiry**
Positivism	Belief is there is a single reality which can be measured and known	Objectivist belief that knowledge is gained through reason; awareness gained through seeing, hearing, smelling, tasting and feeling reality (i.e. via senses)	Quantitative methods using hypotheses, statistics and experiments	Prediction Explanation Control
Post-Positivism	Belief is critical realism	Critical realism acknowledges that certainty is unlikely as all observation is open to imperfection and review	Modified experimental methods	Prediction Explanation Control
Critical theory	Belief is history shapes reality over time and there is no objective truth- influenced by socio/political/cultural/economical/ equality and diversity factors	Subjectivist – which suggests individual 's views	Dialogue	Critique Liberation Restoration
Constructivist-Interpretive	Belief is relativism- no single reality or truth; reality is created by individuals or groups	Discovery of underlying meaning through interpretation of reality- Interpretivism	Hermeneutic Dialogue	Inquiry Understanding Reconstruction

Adapted from (Guba and Lincoln, 1994; Charmaz, 2014).

Inquiries that adopt a positivist or post-positivist perspective aim to explain and predict the circumstances under investigation, with an element of control from the inquirer, who is deemed to be an expert. Cause and effect linkages are explored and knowledge is believed to be in the form of 'facts' (Lincoln and Guba, 1985; Guba, 1990; Guba and Lincoln, 1994; Charmaz, 1995).

Given the research questions for this particular longitudinal study, which aimed to explore a range of expectations, motivations and experiences of healthcare professionals over a period of time, as well as engaging them in the research process, it was clear at the outset that following a positivist or post-positivist stance was not appropriate, nor congruent with my intent.

Critical theory (Mezirow, 1981; Hoffman, 1989; Annells, 1996; Healy and Perry, 2000), holds advocacy and activism as key concepts within the inquiry, with the researcher holding an authoritative facilitative position and infers that knowledge of what needs to occur is already known (Guba and Lincoln, 1994). Whilst there were elements of this approach that might potentially be relevant (for example, I could be viewed as an 'authoritative facilitator'), the emphasis on action for change and 'liberation' as a central goal of the study was again not congruent with my aims. Thus critical theory approach was also therefore not applicable.

The fourth qualitative research paradigm is Constructivism, which provides a philosophical framework, and research style that supports the emergence of themes or 'constructs', which develop and progress to become new frameworks and structures as the study evolves (Rodwell, 1998; Charmaz, 2006), therefore seemed the most appropriate option. However Constructivism itself comprises a number of possible approaches that required consideration and will be explored in more detail later within this Chapter.

Given that I was interested in the 'impact' of a particular programme over time, a consideration of potential evaluative methodologies was also important. However, the field of evaluation research is extensive and reading all possible variants was beyond the resources and time available to me. To further complicate matters there is a wide body of literature on 'evaluation' research, which was again of potential relevance. Evaluation research, often with a focus on scientific social studies, involves the collation, analysis, interpretation and dissemination of outcomes and impact that are the result of a particular targeted

intervention or initiative (Rossi and Berk, 1981; Scriven, 1991; Shadish, Cook, and Leviton, 1991; Weiss, 1997; Rossi, Lipsey and Freeman, 2004). 'Impact evaluation' in particular, aims to measure the impact of a specific programme or policy on explicit outcomes and can involve a mixed methodological approach potentially comprising both qualitative and quantitative methods (Purdon et al., 2001; Greene, 2009).

I therefore needed to be selective and pragmatic, so I turned to the writings of Guba and Lincoln (1989), cited widely in nursing research, and their exposition of 'Fourth Generation Evaluation', which is described in the next section.

4.3 The emergence of Fourth Generation Evaluation

The meaning of 'evaluation' and how it has evolved, is important to explore within this Chapter, as it was a major influencing factor in the decision making process in relation to my chosen methodology, Constructivism.

Evaluation is a type of inquiry, which focuses upon something of interest, such as a person, a programme, an organisation or a process, and acquires 'results' in terms of quality or value, to enable assessment and formulation of a conclusion (Guba and Lincoln, 2001; Lincoln and Guba, 2004). Guba and Lincoln (1989) refer to evaluation as 'human constructions' and suggest there is no specific definition of evaluation, with numerous applications, reviews and purposes impacting upon how evaluation has evolved. These authors were dissatisfied with existing approaches to evaluation, which they considered to be too 'expert' driven, silencing the voices of many people with an interest (termed 'stakeholders') in a given initiative. They therefore proposed a new model that they termed 'Fourth Generation Evaluation' (Guba and Lincoln, 1989), which they argued would offer a more inclusive approach. They contrasted this to prior approaches to evaluation as summarised in **Table 4.2**.

Table 4.2 'Fourth Generation Evaluation' key descriptive factors (Guba and Lincoln, 1989)

	Referred to as	Influenced by	Philosophical view
1st Generation Evaluation	'*Measurement*' Generation	• Schooling • Children's tests • Memory tests • IQ test developed • Pre-screening military leaders pre World war 1, Army Alpha 1st group intelligence test administered • Evolution of social sciences • Development of psychometric labs • Psychology adopting scientific approaches resulting in precise quantitative measures • Analytical tools and maths tables • Business and Industry focusing on efficiency and effectiveness of managers ***Involves humans***	• 'Learning what was known to be true' • Test scores taken as evidence of degree of achievement • Time and motion/ productivity focus • 'Evaluator' role required to know a range of tools to measure any variable and also create new measurement tools • ***Still exists today- School /Uni exams, measurement in quality improvement methodology***
2nd Generation Evaluation	'Description'	• Learning Objectives emerged, stating expectations of learning	• Flaws in schooling become apparent • Evaluator role as describer of strengths

		• Programme evaluation developed- formative evaluation ***Involves materials, strategies and programmes***	and weaknesses; retained measurement though not seen in isolation
3rd Generation Evaluation	'Judgement'	• Found to be inadequate in assessing governments response to American education gaps • Standards required to assess objectives • Discrepancy evaluation models and decision orientated models developed ***Intrinsic and extrinsic values are 'judged'***	• Evaluator required to act as 'judge' and continue with measurement and description to reach judgements • ***Each generation representing a step forward in progressing evaluation***
4th Generation Evaluation	'Responsive Constructivist'	• Boundaries are agreed at outset by evaluator and sponsor • Boundaries become part of the design process • Negotiation becomes part of sampling process • Initially proposed parallel criteria to judge rigour of process; internal validity, external	• Recommend engagement over period of time, observation, peer review and challenge, cross checking • Explores how and why constructions emerge- supports perceptual positioning allowing perspectives to be seen from all constructors

		validity, reliability and objectivity • Developed Authenticity Criteria to reflect constructivist principles; credibility, transferability, dependability, confirmability	

As the above table highlights, for Guba and Lincoln (1989), evaluation has evolved from an initial focus on *measurement* in '1st' generation, progressing to *description* in '2nd' generation evaluation, *and judgement* in '3rd' generation. The '4th' generation that they proposed, aimed to be far more inclusive and had *negotiation* between stakeholders at its heart, in the form of a hermeneutic dialogue. This interpretive method will be described in more detail later in sub-section 4.10.4. Guba and Lincoln (1989) believed that this latter approach was more inclusive, fair and empowering for all stakeholders involved, as well as being values-based, realistic, valuable and relevant. These ideals aligned with my own aspirations for my study and the precepts of *Fourth Generation Evaluation* inclined me towards a Constructivist approach, the adoption of which I will elaborate upon below. Later in this Chapter the 'Authenticity criteria' developed by Guba and Lincoln (1989) for evaluating the conduct of Constructivist inquiry, including *Fourth Generation Evaluation*, will be discussed, and the implications for this study explored.

Before providing further details of the particular Constructivist approach I chose to employ, attention is turned to other potential models that I considered.

4.4 Other approaches considered

A significant part of my journey of discovery and learning in relation to selecting the appropriate methodology for my study involved an exploration of various potential approaches, theories and methods that I might have adopted. I have described some of these decisions above. Here I focus on three approaches that were given more serious consideration, these were:

- *Ethnography*
- *Phenomenology*
- *Realistic Evaluation*

Ethnography

Ethnography, where the researcher becomes immersed in the situation under investigation, which is often people in their living or working environments, has a central focus on culture and description (Creswell et al., 2007; LoBiondo-Wood et al., 2013). Contemporary Ethnography is characterised by the following epistemologies: symbolic interactionism, critical theory, feminism and phenomenology, therefore is a versatile methodology, which proposes a variety of perspectives (Harper and La Fontaine, 2009).

Ethnography has been used extensively in health and social care contexts to develop understanding and inform practice through the generation of rich qualitative data (Brewer, 2000; Hammersley and Atkinson, 2007). It was therefore considered at an early stage, as its pragmatic, reflexive and emergent approach resonated with me, especially as I had previous experience of observations of care in practice (Greenhalgh and Swinglehurst, 2011). However the prospect of undertaking field work in a range of clinical areas across the organisation was deemed impractical, due to the lengthy periods of time this would require and also the potential sensitivity of observing healthcare practitioners caring for patients, which would also likely have had ethical implications (Murphy and Dingwall, 2007).

Moreover, whilst culture was likely to be an important factor in my work, it was not my primary focus, as I was also interested in a wide range of factors that might influence the impact of the programme. Furthermore, my direct involvement in the delivery of the programme itself and the influence I would have on its outcomes seemed to me to preclude Ethnography as the most appropriate approach.

Phenomenology

Phenomenology, founded originally by Husserl (1859-1938), explores lived experience rather than complex analysis and construction of meaning (Starks and Brown, 2007; Lewis, 2015), and comprises various 'schools of thought'.

Descriptive (Husserlian) Phenomenology explores every day experiences or situations in order to enhance understanding. For example, in nursing the phenomenon under study, such as 'giving an injection,' will involve the actual procedure itself and also the nurse's lived experience of giving the actual injection (Field, 1981).

Heidegger (1889-1976) developed *Interpretive* Phenomenology, as an alternative approach, which aims to uncover potentially hidden meanings in something (Watson et al., 2008). Heidegger was also concerned with '*Hermeneutic Phenomenology'* with the focus being on interpretation, in order that meaning and understanding might be achieved.

Although Phenomenology has also been used extensively within research in healthcare, for example to explore a patient's experience of receiving care or coping with a long-term condition, I was keen to undertake a deeper analysis. Furthermore, from my reading, it was not clear to me how the results of a phenomenological study, with its focus largely on individual experience, could be related to the complex situation I was exploring (Creswell et al., 2007;

Munhall and Chenail, 2008; Pringle, Hendry and McLafferty, 2011). I therefore did not consider Phenomenology an appropriate approach.

Realistic Evaluation

Given the nature of my study Pawson and Tilley's (1997) Realistic Evaluation approach, *'Outcome = Mechanism + Context'*, was of more specific interest, although on initial impressions it appeared to be rather too structured and specific, and perhaps more suited to deconstructing complex situations, in order to begin to determine cause and effect *relationships*. This seemed to be reinforced by the language used to describe the approach, that was often rather 'technical', for example, referring to 'CMO configurations', hypothesis generation, testing and refinement. This seemed to me to be incongruent with my desire for a flexible and relational approach, as described in Chapter three.

In line with an appreciative inquiry model (Cooperrider and Whitney, 2011), Realistic Evaluation seeks to explore the reasons why a programme is effective, for whom, when and how. It is theory-led, in that the researcher investigates the programme context, mechanisms and outcomes from the basis of a defined theory (Coryn et al., 2011). Many healthcare policy establishments such as Health Services Management Centre, Health Scotland and the University of Glasgow (Blamey and Mackenzie, 2007) utilise theory-led evaluation for evaluating health policy and practice. Whilst I was loosely applying an existing theoretical framework (the *Senses Framework*), researchers adopting a Realistic Evaluation approach tend to specify exactly what 'mechanisms' will generate the 'outcomes' and state what features of the context will affect those 'mechanisms'. These are made explicit at the outset and the resultant theory is 'tested' in a different context in a subsequent study, often adopting a case study approach (Pawson and Tilley, 1997). This again did not resonate with my desire for an inclusive approach.

Consequently, while there may have been some advantages to adopting a Realistic Evaluation approach to this study, it did not offer the flexibility that I hoped for. I therefore chose to adopt and evolving Constructivist approach, as described in more detail below.

4.5 Constructivist Inquiry

Constructivist inquiry, referred to originally as naturalistic inquiry (Lincoln and Guba, 1985; Guba and Lincoln, 1989; Guba and Lincoln, 1994), was also developed by Guba and Lincoln, and is closely related to *Fourth Generation Evaluation.* The aims of Constructivist inquiry are to understand constructions of the reality and experiences of a person or people, and these include those of the researcher themself. This marked a shift away from the 'neutral' role accorded the researcher in most other approaches and recognised that the beliefs held by the researcher and their interactions with participants would play an important part in shaping the results of a study. Given my own central role in this study this characteristic had strong appeal. A Constructivist inquiry remains open to possibilities as new data emerges and information is shared and discussed, with the aim of ideally developing a shared and co-created construction of a given reality (Lincoln and Guba, 1985; Guba and Lincoln, 1989; Guba and Lincoln, 1994).

In Constructivist research a relativist stance is taken, which suggests, '*there is no objective truth to know*' (Hugly and Sayward, 1987, p. 278). Therefore in my study the truth is what the participants and myself as researcher, say it is. '*The investigator (me) and the object of investigation (participants on the programme and their nominated colleagues) are interactively linked, so that the findings are literally created as the investigation proceeds'* (Lincoln and Guba, 1985, p. 207).

In reading more about Constructivism, I was impressed by the work of Rodwell (1998), a Social Worker and experienced researcher, who advocated using Constructivist inquiry to engage with colleagues in co-producing knowledge,

which was understandable and applicable to their practice. Such a stance had influenced many previous research studies, including those exploring the *Senses Framework* (Nolan et al., 2004; Nolan et al., 2006; Brown et al., 2008; Nolan et al., 2007; Patterson et al., 2011). The aim of engaging with practitioners and involving them as co-participants was fully congruent with the way in which the leadership programme was delivered and this further re-affirmed the appeal of a Constructivist approach.

My study is informed by the principles of *Fourth Generation Evaluation*, and the overall Constructivist model within which it is located. The writings of Rodwell (1998), further reinforced the value of such an approach, for the following reasons:

- Constructivism is values-based and situational, which aligned with an inquiry around leadership experiences of a particular programme (DBC LP).

- Individuals construct their own perspective and view of their reality based upon their experiences and situation. I was curious to explore the personal and professional experiences of individual healthcare leaders through on-going dialogue over time, to gain a deeper and shared understanding of a particular leadership programme and any subsequent impact.

- Researchers using a Constructivist approach aspire to understand others' experiences in an uncontrolled, naturalistic setting, from an insider's context- an *emic* view, which was congruent with my position as researcher and facilitator within the organisation (Morse and Field, 1995). Taking an *etic* view, as an outsider was not appropriate.

- The inquiry process is an evolving one and is influenced and shaped as the study unfolds. This longitudinal nature of my study would provide the vehicle for discovery, continuity and learning.

- The insights gained from a Constructivist inquiry are a shared product and they should have wide relevance and applicability in 'real world' settings. This was important because I hoped to inform not only local developments but also wider debates about the value of educational initiatives in health care.

As I read further, I explored the work of Charmaz (2006; 2014), in relation to the development of *Constructivist Grounded Theory*. This also seemed to have considerable relevance to my work and I consider this below, beginning with the emergence of Grounded Theory itself and the subsequent modifications proposed by Charmaz (2006; 2014).

4.6 The emergence of Grounded Theory

Barney Glaser and Anselm Strauss initially developed Grounded Theory in the 1960s (Glaser and Strauss, 1967; Glaser, 1978a; Strauss, 1987; Glaser, 1992) as an alternative to the then largely positivist approaches to social research. These authors were dissatisfied with the existing paradigm and wished to develop a differing but still robust means of exploring and better understanding the 'social processes', that they believed largely shaped human interactions (Starks and Brown, 2007). They hoped that this would counter the emphasis on logic and objectivity, quantification and measurement that was then dominant (Glaser, 1992; Charmaz, 1995). To do so they developed an approach that they termed 'Grounded Theory,' that was underpinned by symbolic interactionism. This philosophical stance argues that 'meaning' arises from social interactions between individuals in their day-to-day lives and that research therefore has to take account of the context and background that shape such interactions (Blumer, 1969; Baker, Wuest, and Stern, 1992; Schwandt, 1998; Charmaz, 2006; Gardner, Fedoruk and McCutcheon, 2012).

These aspects appealed to me, and I adopted a number of the original foundations of Grounded Theory suggested by Glaser and Strauss (1967), notably 'theoretical sampling' and 'constant comparison', which are considered below.

- ***Theoretical sampling***

In all research, sampling is important to ensure quality, rigour and meaningful representation (Patton, 1987; Sandelowski, 1995; Patton, 1990; Coyne, 1997; Patton, 1999). In quantitative research the focus is primarily on representation and ideally the generation of a statistically representative sample to allow generalisation to a population as a whole. This is not the case in qualitative studies, but as Morse (1991) suggests, the flexibility in qualitative research sampling methods can be confusing for researchers and there is a need to make clear the strategy that was adopted in any particular study. I adopted theoretical sampling. Theoretical sampling, which is a central feature of Grounded Theory is defined by Glaser (1978b, p. 36), as '*the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides which data to collect next and where to find them, in order to develop his theory as it emerges'.*

There is often confusion amongst qualitative researchers in relation to sampling, partly because the terms 'theoretical' and 'purposive or purposeful' are described interchangeably within the literature. This can be misleading and result in assumptions being made in terms of the criteria set for sampling, resulting in unnecessary data collection in an attempt to achieve representation, similar to quantitative approaches (Coyne, 1997; Charmaz, 2014; Nagel et al., 2015). All sampling in qualitative research is 'purposive' or 'purposeful,' as it seeks to meet the needs of the particular study, whilst extending the range of potential information and involvement (Rodwell, 1998; Guba and Lincoln, 1989). Theoretical sampling is one of the diverse types of purposive sampling, which is

associated with Grounded Theory inquiries (Morse, 1991; Coyne, 1997; Patton, 2005; Charmaz, 2014).

Theoretical sampling provided a guide and strategy for decision-making in relation to data collection and evolving ideas throughout my entire study. As I collected data and analysed it simultaneously, initial codes highlighted potential themes and suggested new areas for consideration and refinement (Charmaz, 2014). I referred to this in my reflective diary as 'piecing a jigsaw together' and found this analogy a helpful visualisation tool in the early stages of my study.

'Theoretical sampling involves starting with data, constructing tentative ideas about the data, and then examining these ideas through further empirical inquiry' (Charmaz, 2014, p. 199).

Memo writing, which will be discussed later in the Chapter, was a fundamental strategy I adopted, which enabled systematic theoretical sampling, to build on the early themes and emerging potential categories I had identified in phase one of my study (see later in section 4.10.1). This also highlighted gaps and areas of inconsistency, which subsequent interview questions explored.

Theoretical sampling requires a type of analysis and thinking referred to as *abduction*, which allows the researcher to understand and explain unexpected findings in relation to experiences in the data and consider '*what does the data infer?*' (Charmaz, 2014). A question I regularly wrote and asked myself in my reflexive memos was '*what are the participants telling me*? I used the analogy of '*stepping off the dance floor and onto the balcony'* (Heifetz and Laurie, 2001; Heifetz, Grashow and Linsky, 2009), which literally enabled me to pause, reflect and critically review the transcripts and memos, as I attempted to illuminate my analysis. Through hermeneutic dialogue and member checking, further exploration of thoughts, insights and ideas with subsequent participants contributed significantly to the emergent process of discovery, imagination and

creative interpretation (Charmaz, 2014; Corbin and Strauss, 2014). This is closely linked to the process of constant comparison that I consider next.

- ***Constant comparison of data***

Constant comparison of data, another core characteristic of Grounded Theory, played a significant role alongside theoretical sampling, in ensuring the on-going relationship between the data collection and analysis processes, with the ultimate goal of developing a theory grounded in the data (Kolb, 2012). Glaser and Strauss (1967, p. 105) described four steps to implementing a constant comparison strategy:

- 'Comparing incidents applicable to each category'
- 'Integrating categories and their properties'
- 'Delimiting the theory'
- 'Writing the theory'

Adopting a constant comparative method enabled the development of coding and themes, whilst simultaneously analysing what was emerging from the data as the study progressed over the three phases (see later in this Chapter). Theory generation was reinforced through theoretical sampling as already described above, and hermeneutic dialectic processes, in collaboration with all study participants throughout the inquiry (Kolb, 2012). This required time and patience, which was supported through supervision and reflexivity, which is discussed later in the Chapter. However, as Charmaz (2014) suggests, constant comparison was essential:

'*Whatever unit of data you begin coding in grounded theory, you use constant comparative methods to establish analytic distinctions and thus make comparisons at each level of analytic work'* (Charmaz, 2014).

During each phase of my study, data was constantly compared, for statements that were alike and also different, within the same interview and subsequent interviews with the same participant, as well as comparing interview data of other participants. Capturing sequential comparisons within memos was a useful strategy that I adopted when also comparing managers' data with that of other managers, and data from participants' colleagues with other colleagues. This illustrated congruence within data and also any variations, which created new insights and enabled me to limit any assumptions I may have held based on my personal views, interpretations and perspectives (Charmaz, 2014). The importance of employing a constant comparative method is described in more detail in section 4.10.1 and illustrated in diagram 4.3 later within this Chapter.

In addition, two other characteristics of classical Grounded Theory were adopted, as described next.

- ***Naturalistic setting and context for the inquiry.*** Rodwell highlighted the importance of the research being undertaken in a natural setting: "*The research is done in the usual context of the phenomenon because reality cannot be understood in isolation from the context that gives it meaning"* (1998, p. 35). The significance of context within this study was introduced in Chapter one and subsequently described in more detail in Chapters two and three of this thesis.

- ***A focus on building a mid-range theory*** rather than testing a specific hypothesis, affirming a conclusion or discovering reality (Meleis, 2010; Swanson, 2012). Mid-range theories are generally considered to fall into one or two categories, 'substantive' and 'formal'. Substantive theories seek to explain a certain phenomenon in a given context. For example, Glaser and Strauss' original work (1967) explored death and dying in acute hospitals in the 1960's. However, one of the characteristics of grounded theories is that they are 'modifiable', that is the original theory can be explored in a like but slightly differing

context/issue and potentially expanded to account for variations in that setting also. During this process the theory is modified to explain a greater range of settings/issues and in doing so becomes a 'formal' theory. For instance, in explaining why patients in the 1960's were often not told that they were dying, Glaser and Strauss (1967) proposed the idea of an 'awareness context'. They argued that whilst staff and family often knew a patient was dying, the patient usually did not and so a 'closed' awareness context existed. Since that time attitudes to the disclosure of a terminal diagnosis have changed, and patients are usually informed, resulting in an 'open' awareness context. However, the idea of awareness contexts has been applied to other diagnoses, such as dementia, which still remain taboo for many (Hellström, Nolan and Lundh, 2005). Consequently 'awareness context' theory has been 'modified' and moved towards a formal level.

As my study is underpinned in part by the '*Senses Framework*,' it is perhaps best conceived of as being involved in the further development of a 'formal' mid-range theory. However, it is also worth noting at this point, that an additional 'substantive theory' also emerged, which was subsequently developed, and will be described in the next Chapter five, thus making this study 'unusual'.

4.6.1 Why Constructivist Grounded Theory appealed

The following section argues why Grounded Theory appealed to me, and describes what I hoped it would add over and above a Constructivist inquiry approach.

At the early stages of my research journey it was important to reflect and focus upon the challenges and opportunities, in relation to considering and selecting between the various versions of Grounded Theory that exist. This was a steep learning curve (Alammar et al., 2018). I was particularly taken with the Constructivist approach to Grounded Theory advocated by Charmaz (2006; 2014).

There have been significant developments in Grounded Theory since it originated, with more recent iterations promoting a Constructivist approach (Mills, Bonner and Francis, 2006; Bryant, 2009; Charmaz and Bryant, 2011; Breckenridge et al., 2012; Thornberg, 2012). Prior to this Strauss and Corbin (2014) modified the original Grounded Theory model by adopting a more interpretive approach that they believed would make the methodology more approachable for novice researchers. Subsequently others, especially Charmaz (1995; 2014) and Bryant (2009), have worked on the evolution of Constructivist Grounded theory (Charmaz, 1995; Charmaz, Denzin and Lincoln, 2008; Charmaz and Belgrave, 2007; Charmaz, 2011; Charmaz, 2006; Charmaz, 2014). This was underpinned by the belief that the approach promoted by Glaser was too 'objectivist' and cast the researcher as the 'expert,' with the role of participants being confined largely to that of providing data. One of the main differences in Constructivist Grounded Theory is the specific involvement of all participants, including the researcher, across the entire research process. This is consistent with the tenets of *Fourth Generation Evaluation* as outlined earlier.

Therefore, adopting a Constructivist Grounded Theory approach for this study involved incorporating the following specific elements (Rodwell, 1998; Charmaz, 2006; Bryant, 2009; Gardner, Fedoruk and McCutcheon, 2012):

- Identification of *foreshadowed questions* and *sensitising concepts* at the outset.
- Adopting the central elements of Grounded Theory specifically theoretical sampling and constant comparison to ensure the interactive relationship between data collection and analysis.
- Developing and sustaining a collaborative, interactive relationship between researcher and participants based on mutuality, during concurrent data collection and data analysis.
- Flexibility in relation to practices, tools and guidelines with an emphasis on co-creation, co-construction and emergent conceptualisation of data analysis rather than objectivity and descriptions.

- Exploring all possibilities and giving consideration to everyone's views, including my values, beliefs, experiences, prior knowledge and perceptions as researcher of the study.
- The use of an on-going Hermeneutic dialogue to facilitate a shared understanding and co-creation of the meaning, which aimed to ensure that all parties, agreed with the emerging theory (Rodwell, 1998; Charmaz, 2006; Bryant, 2009; Gardner, Fedoruk and McCutcheon, 2012). The Hermeneutic dialectic process is an interpretive method, which compares constructions from the data in a way that synergises perspectives and ideas through mutual exploration and engagement by everyone involved in the inquiry, which is fundamental and central to Constructivist inquiry.
- The use of simple, easily understood language to ensure that multiple audiences readily understood the theory.

In adopting the above elements to my study, I was influenced by the words of Charmaz (2014, p.34), about the need to '*discover what our research participants take for granted or do not state, as well as what they say and do'.*

In summary, by adopting a Constructivist approach I hoped to be able to remain close to the data whilst conducting the inquiry, and in doing so, to create a joint construction with the participants (Appleton and King, 1997; Manning, 1997; Healy and Perry, 2000), that acknowledged the part that my existing beliefs, values, experiences and those of participants, managers and colleagues played.

Having argued why I adopted a Constructivist grounded theory approach, I now consider the methods of data collection that I used.

4.7 Data Collection Methods chosen and why

Considering the most appropriate data collection tools, techniques or 'methods,' required time and attention during the early stages of my study, to ensure the research questions I posed would be answered effectively (Charmaz, 2006). Rodwell (1998) suggests that the fundamental data collection tool for Constructivist research is the 'interview', which provides the context for a 'conversation with a purpose' and has the potential to generate rich data, which is co-created with the interviewees i.e. the participants of the study (Charmaz, Denzin and Lincoln, 2008).

Interviews can be structured, semi-structured or unstructured (Creswell et al., 2007; Cohen, Manion and Morrison, 2013; Corbin and Strauss, 2014). I chose to adopt interactive semi-structured interviews, which I hoped would enable a deeper understanding of participants' experiences to emerge and also facilitate the hermeneutic dialectic process, which is described later in this Chapter within section 4.10.4.

Within my study, flexibility was required and whilst I used an 'interview guide' for each phase of the study (see Appendices 7-10) to provide some direction, this comprised an open-ended set of questions, influenced by my 'foreshadowed questions' (Morse and Field, 1995). However, consistent with the principles of theoretical sampling and constant comparison, this guide evolved as the study progressed (Charmaz, 2006; Corbin and Strauss, 2014).

Many qualitative researchers hold face-to-face interviews as the assumed 'gold standard', however increasingly across a range of disciplines, interviews are being undertaken by telephone (Sturges and Hanrahan, 2004; Vogl, 2013). Extensive empirical investigation into face-to-face versus telephone interviews, has focussed mainly on structured, quantitative research interviews (Fontana and Frey, 1994; Rubin and Rubin, 1995), however debate continues in the literature (Ward et al, 2015; Hershberger and Kavanaugh, 2017), with

researchers suggesting that telephone interviews can facilitate a more nuanced understanding of the participant's experience (Carduff et al, 2015).

The interviews with my participants were carried out face-to-face or on the telephone (see **Table 4.3**), on a date and time that was mutually convenient and held at a venue that was away from the workplace and allowed privacy. Each interview lasted between 60-90 minutes, was digitally recorded then fully transcribed (see sections 4.8.1- 4.8.4 and 4.10 for more detail).

Table 4.3 Interviews- numbers which were face to face or on telephone

Interviews	Face to face	On telephone
Phase 1		
Element A (n=17)	12	5
Element B (n=12)	8	4
Phase 2		
Element A (n= 26)	16	10
Phase 3		
Element A (n=17)	6	11

Grant (2011) noted that the length of interview did not differ to those carried out face-to-face and this aligned with my experience within my study. All participants who engaged in telephone interviews within my study; chose to do so, had access to a telephone and reported a positive interview experience (see section 7.3.1.2).

The primary concern which remains, is in relation to the lack of visual cues, which potentially reduces the ability of the researcher to observe non-verbal and contextual data, limits probing and interpretation of responses and may compromise on establishing rapport (Opdenakker, 2006; Novick, 2008). In my experience, as researcher, I was able to note hesitation, hurried responses, tone, and repeated specific words, whilst I also paid attention to ensuring clear articulation of the questions I asked during the interview (Stephens, 2007).

As described earlier in Chapter one, this longitudinal study provided the opportunity for relationships to be established with the participants over time, which had a positive impact on the interview process and limited any potential challenges of employing both telephone and face to face interviews, as participants stated that they felt comfortable to be interviewed on the telephone or face to face, having established rapport and trust with myself as researcher. Therefore, if a telephone interview suited their situation and reduced time commitments of travel, this was agreed and arranged accordingly. Another strategy, which supported my use of telephone interviews, was my experience of telephone coaching, which had enabled me to develop active listening skills, which are even more crucially important, as there is no non-verbal communication to be seen in the moment, and this was affirmed during my experience of the research study interview process. Environmental conditions were also taken into consideration for the interview process, particularly when telephone interviews took place, to ensure no interruptions, quietness and privacy, as all interviews were digitally recorded. Fortunately no technical issues arose during the interviews, and I was always prepared with extra batteries for the digital recorder, which on one occasion were required and involved a short pause in the interview. Data management and practicalities of the on-going analysis of the vast volumes of interview transcripts that were created are described in later sections of this Chapter.

Therefore both telephone and face-to-face interviews can yield good quality data with an increased benefit of offering choice to participants (Tausig and Freeman, 1988; Miller, 1995; Greenfield et al, 2000; Sturges and Hanrahan, 2004; Novick, 2008).

In addition to interviews, focus groups were also considered at an early stage of the study design as an additional or alternative means of data gathering particularly for phases two and three, as these would have provided the opportunity to hear shared perspectives and experiences (Mack et al., 2005;

Patton, 2005; Lewis, 2015). However a pragmatic approach was adopted and individual interviews were chosen as the preferred method, particularly as they created a safe and confidential space for reflection, interaction, conversation and co-construction of themes (Patton, 1990; Charmaz, 2014). Focus groups would have required coordinating convenient dates, times and venues for clinical staff working long shifts across various sites, to coincide with my availability, which was already limited with me working full-time and studying part-time. Focus groups were therefore deemed less appropriate than negotiating individual diary times, albeit this was itself time consuming.

As an established coach and facilitator, I was fortunate to already have experience of working with individuals and groups, and I have developed over time, the core skills required for interviewing, such as active listening, paying attention to the individual's contribution, creating a safe space and building rapport, being empathetic and flexible (Fontana and Frey, 2000). This enabled me to feel confident when adapting to the research interview setting and to be able to reflect upon my skills objectively to limit making assumptions. Therefore the interview process also provided an additional analytical tool to enable me to practice reflexivity and consider my impact upon the research process.

In the discussion Chapters seven and eight I will highlight the unforeseen benefits for participants, gleaned from this approach to data collection.

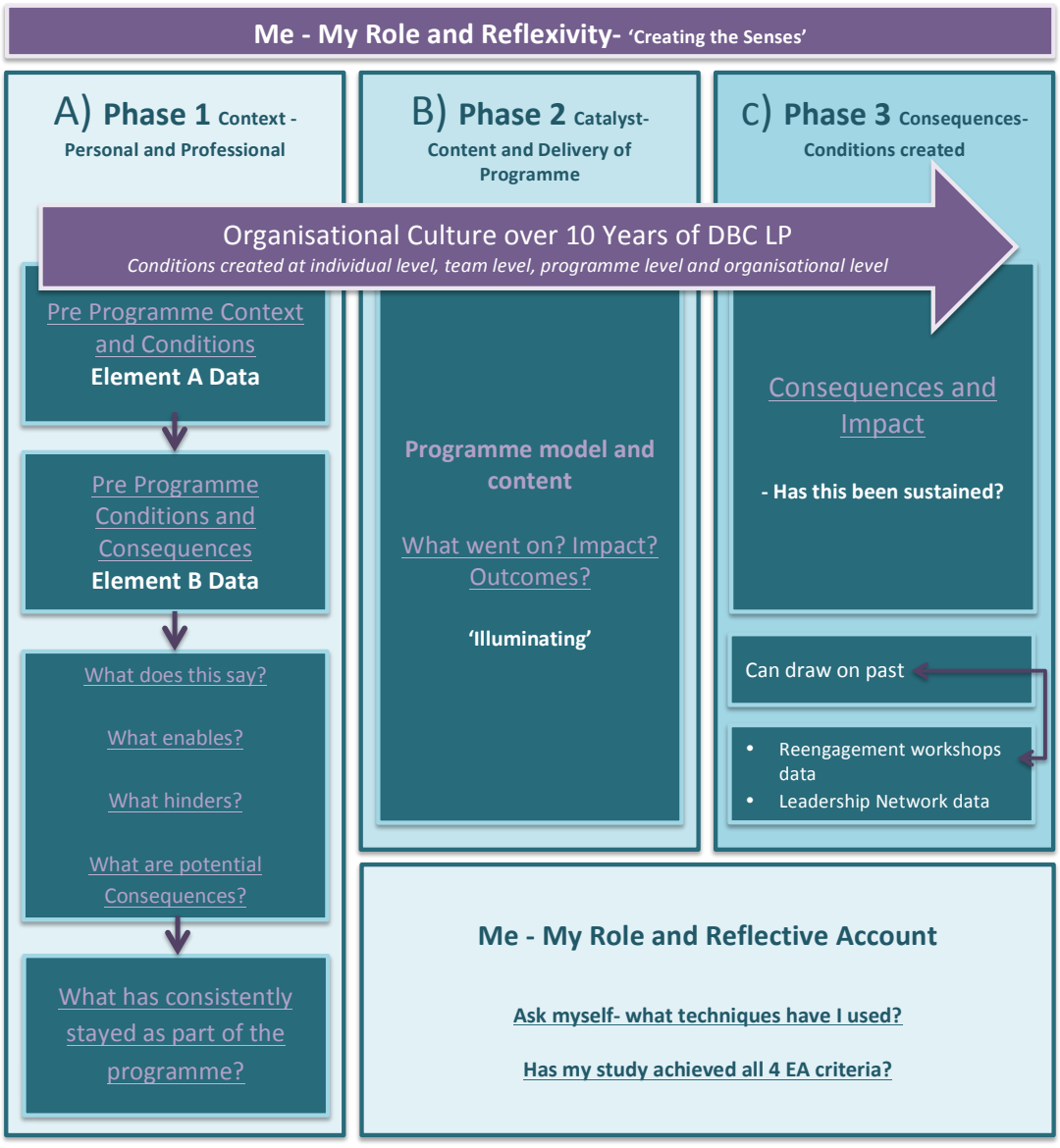
Attention is now turned to the research design for my study.

4.8 Research Design

This section describes the research plan and design for the study as well as the recruitment process, and the data generation and data management processes of the three Phases of the study. To develop my understanding of the potential impacts of the programme over time, a longitudinal study consisting of three Phases as illustrated in **Diagram 4.1** was adopted, employing a range of data

collection techniques as described above. (See also Appendix 4 for detailed diagram of temporal dimensions of the study Phases.)

Diagram 4.1 Temporal Dimensions of the study



As illustrated in **Diagram 4.1**, my study comprised of three Phases, which are described below in sub-sections 4.8.2- 4.8.4:

- Phase One was from September 2015 to April 2016
- Phase Two was from September 2016 to April 2017
- Phase Three was from September 2017 to March 2018

There were two Elements to Phase one, which I described as Element A, and Element B. *Element A* involved new programme participants, who engaged in the study at three points in time: the start of their programme experience, at the end of the programme and a year later. The Element A participants also included managers, peers and junior colleagues of the 'programme' participants.

Element B involved a sample of past participants of the 'programme', as well as a sample of their managers, peers and junior colleagues. The reasons for having both Elements A and B are explained in the following sections below.

I now consider how the study unfolded, starting with the recruitment process.

4.8.1 Recruitment to the study

Recruitment to Phase one of the study involved sending all participants commencing the DBC LP in September 2015 (n=23) an invitation and information sheet (see Appendix 5) via electronic mail, and hard copies posted via internal mail, prior to them starting the programme.

Six participants in total opted in to the study and were involved in Element A (details will follow within the next section 4.8.2). Participants are introduced individually in Chapter five, which includes details of their roles, motivations and expectations of the programme. To broaden the scope of the study and to ensure that more senior AHPs had an opportunity to participate in this research required an amendment to the study that was approved by the Faculty of Research Ethics Committee at De Montfort University. Following this an invitation was also sent to all participants of DLE for AHPs Programme (n=25) (as previously described in Chapter 3). Three participants from DLE for AHPs opted in to the study. The main difference in the two programmes is that DLE for AHPs is for senior AHPs only, whereas DBC LP is for nurses, midwives and AHPs of any level or grade. Experiences of both leadership development

programmes were considered to be broadly comparable as they are based on the same underpinning models, theories, content, and have similar, consistent facilitation and delivery (DLE for AHPs could be referred to as 'twin' of DBC LP). For ease of reference, throughout the thesis, when referring to experiences of the 'programme,' it was not deemed necessary to specify each programme separately, therefore the programme will refer to DBC LP.

Although I had concerns at the onset of the study that the majority of participants would opt in, which would have had serious implications for my capacity, this did not prove to be the case. Reasons for participants of the DBC LP not opting in to the study related mainly to the demands this might make on their time as they had also just committed to a new development programme, which required considerable time, focus and participation in work based activities and self-directed interventions. Many participants imparted this information voluntarily during conversations later in the programme, saying that they had considered taking on any additional demands to be too challenging.

Although I was initially a little disappointed at what I saw to be a limited uptake, sample size is not the main consideration in qualitative research and when the participants' colleagues were also included, extensive volumes of data were generated, augmented by theoretical sampling and constant comparison as the study progressed (Charmaz, 2014). The total number of participants engaged in Element A was therefore nine. It must be recognised that these participants were self-selecting and the potential impact of this will be considered later.

Theoretical sampling in Element B involved a selection of past participants who had continued to make significant changes and had maintained engagement and contact with the programme and facilitation team, as well as past participants who had not, for various reasons, including moving jobs or gaining promoted roles outwith the organisation for example.

Understanding what was the perceived longer term impact of the programme on an individual's leadership skills and practice, then exploring what factors had enabled and hindered the sustainability of any impact on practice, was at the centre of Phase one Element B.

For recruitment to Element B of Phase one, twelve past participants of the programme over the last ten years were sent an invitation and information sheet via electronic mail and hard copies were posted via internal mail (see Appendix 5), and five nurses agreed to participate. Further information and written consent (see Consent form in Appendix 6) followed, once they had confirmed their willingness to take part.

Recruitment of the participants' managers, peers and junior colleagues in both Element A and B of the study, involved gaining the permission of each participant first of all, then making contact with the managers and colleagues by electronic mail, in collaboration with participants, to invite them to also take part in the study (see Appendix 5).

Each Phase provided the opportunity to ask questions to uncover new aspects and meaning to the emergent inquiry.

4.8.2 Data Collection Phase One (September 2015 - April 2016)

As noted above, **Phase one** consisted of two Elements, **A** (***new*** participants, their managers, peers and junior colleagues) and **B** (***past*** participants, their managers, peers and junior colleagues). These ran concurrently, and consistent with the principles of theoretical sampling and constant comparison, data from Phase one significantly informed Phases two and three of the study. Although Elements A and B ran concurrently they are considered separately below for ease of presentation.

Element A

Phase one Element A involved engaging with new programme participants (5 Nurses and 1 Occupational Therapist[4], n=6) in September 2015, at the start of the DBC LP 2015-2016, and their managers (n=6). In addition to this, 2 Physiotherapists and 1 Occupational Therapist (n=3), who started DLE for AHPs, also in September 2015, were involved, and their managers (n=2) also took part. One manager chose not to opt in to the study at this Phase. Qualitative data was gathered using semi-structured interviews as detailed previously in section 4.7. Each individual participant (n=9) and manager (n=8) was interviewed once, face-to-face or on the telephone, for a period of 60-90 minutes (see Appendix 7 Phase one Element A interview questions).

The focus of enquiry was an exploration of each individual programme participant's expectations of the programme and motivations for applying.

During Phase one, further data was also collected from the managers of the participants, exploring their reasons for supporting the participant's application, their expectations of the anticipated development and benefits to the individual participant and their practice, outcomes hoped for and indicators for success.
Chapter five introduces the participants and their managers and illuminates their initial expectations and motivations in the form of short narratives.

Element B

Element B engaged with past participants (n=5) of the DBC LP delivered between 2007-2014 and a purposive sample of their managers (n=4), junior colleagues (n=2) and peers (any professional colleague) (n=1); to explore their experiences, particularly in relation to subsequent or long-term impact of the programme on their individual leadership skills and practice.

[4] It is worth noting that participants of DBC LP, at the time of the study, included mainly nurses, as they tend to comprise the biggest professional group within the NHS workforce, however also included a small number of AHPs.
AHPs of all levels tend to apply for DBC LP rather than DLE for AHPs, which is specifically for senior AHPs.

Each past participant, manager or colleague took part in one semi-structured interview (see Appendix 8 Phase one Element B interview questions) either face to face or on the telephone. Interviews lasted 60-90 minutes and provided a comprehensive range of perspectives and observations, which were crucial to gaining a better understanding of the impact on practice following clinical leadership development.

In summary, Phase one comprised of a total of **29** interviews, involving nine new participants, plus eight of their managers (Element A); and five participants, four managers, one peer and two junior colleagues of past participants (Element B). All names were anonymised and individual participants; their managers, peers and junior colleagues were assigned a code and a pseudonym (illustrated in **Table 5.1** in Chapter five), to ensure anonymity. For example, Phase 1 Element A 'Dave' (01), coded as P1EA01 and the Manager would be coded as P1EAM01. See **Table 4.4** for summary of interviews undertaken in Phase one Elements A and B.

Table 4.4 Interviews in Phase one Element A and B

Interviews in Phase one **Element A** Total=17		
Participant		Manager
EA01	✔	✔
EA02	✔	✔
EA03	✔	✔
EA04	✔	✔
EA05	✔	✔
EA06	✔	✔
EA07	✔	
EA08	✔	✔
EA09	✔	✔
= 9 Interviews		= 8 Interviews
Interviews in Phase one **Element B** Total=12		

Participant	Manager	Peer	Junior Colleague
EB01 ✔	✔	✔	
EB02 ✔	✔		
EB03 ✔			
EB04 ✔	✔		✔
EB05 ✔	✔		✔
= 5 Interviews	= 4 Interviews	=1 Interview	=2 Interviews
Total Interviews in Phase one=**29**			

4.8.3 Data Collection Phase Two (September 2016- April 2017)

The purpose of Phase two was to re-interview participants on completion of the DBC LP (or DLE for AHPs) and to explore the perceived impact on self, team and the organisation. Understanding how the participants had experienced the programme and which aspects had been most helpful, what could have been improved and if their expectations had been met were important considerations. Moreover as the programme itself had involved the introduction of changes to practice I wanted to explore if these had been successful or not.

Phase two involved all of the participants from Phase one Element A (n=9), and a purposive sample of their managers, peers and junior colleagues (n=27). Invitations to participate in one semi-structured interview lasting 60-90 minutes were sent via electronic mail to participants, as in Phase one. At the end of their interview (see Appendix 9 Phase two interview questions), I requested permission to invite their manager to also engage in a second interview, as well as requesting that each participant provide me with the name of one junior colleague and one peer who they felt would be willing to be invited by email to take part in the study.

In summary, nine participants, nine managers, four peers and four junior colleagues, were interviewed as part of Phase two, a total of **26** interviews. See **Table 4.5** for a summary of interviews undertaken in Phase two.

Table 4.5 Interviews in Phase two

Participant	Manager	Peer	Junior Colleague
EA01 ✔	✔		✔
EA02 ✔	✔	✔	
EA03 ✔	✔		
EA04 ✔	✔		
EA05 ✔	✔	✔	✔
EA06 ✔	✔		
EA07 ✔	✔	✔	✔
EA08 ✔	✔	✔	✔
EA09 ✔	✔		
= 9 Interviews	= 9 Interviews	= 4 Interviews	= 4 Interviews
Total Interviews in Phase two=**26**			

4.8.4 Data Collection Phase Three (September 2017- March 2018)

The main emphasis in Phase three was to explore what long-term impact, if any, participants, managers and colleagues had observed in terms of leadership qualities, enabling others within the team, and enhancing clinical practice, since completion of the programme. Specific examples of impact were explored during the interview and will be detailed in Chapters five and six.

Phase three started in September 2017 and involved further qualitative data collection (see Appendix 10 Phase three interview questions) using semi structured interviews with seven of the nine people who participated in the study as new participants on the DBC LP programme (i.e. participated in Element A Phases one and two), over a year after the end of the programme. One of the original participants was unable to participate in Phase three as their promotion to a new post required their full attention and one participant failed to reply to invitations. Further interviews with managers, peers and junior colleagues of those who did participate, enabled a detailed exploration of perceptions of any

further impact and changes observed in the participants, as well as their views about how this had been evolved over time.

Invitations were sent to participants initially by email at the end of August 2017. By March 2018 **seventeen** interviews had taken place involving seven participants, five managers, two peers and three junior colleagues. Furthermore, contact with all study participants had been maintained via email, telephone and face-to-face meetings, throughout the year following Phase two (from April 2017 onwards).

I maintained engagement via email during September 2018 with four Element B participants and four managers, to ensure constant comparison and further refinement of emerging categories, as I continued to develop my findings (Charmaz, 2014). As I had already affirmed and refined the analysis emerging from Phases one and two with all participants, their managers and peers and did so again during interviews in Phase three, this was deemed as sufficient. See **Table 4.6** below for a summary of interviews undertaken in Phase three.

Table 4.6 Interviews in Phase three

Participant	Manager	Peer	Junior Colleague
EA01 ✔			
EA02 ✔	✔		✔
EA03 x			
EA04 x			
EA05 ✔	✔		
EA06 ✔	✔		
EA07 ✔	✔	✔	✔
EA08 ✔	✔	✔	✔
EA09 ✔			
= 7 Interviews	= 5 Interviews	= 2 Interviews	= 3 Interviews
Total Interviews in Phase Three = **17**			

See Appendix 11 for an overall summary of interviews at each Phase of the study, which includes an illustration of the coding matrix adopted.

Attention is now turned to how I managed the considerable volumes of data that were generated.

4.9 Data management

Interviews with both Element A and B participants, colleagues and managers, were digitally audio-recorded and where possible, each individual interview was transcribed verbatim within 48 hours. This allowed me to be fully present and focused during the interview, eliminating the need for note taking during the actual interview itself. According to Charmaz (2006), this decreases the possibility of the data being 'forced' or unduly influenced by any pre-conceived ideas I may have held.

The process of transcribing all **72** interviews personally, albeit time-consuming, allowed me to remain close to the data, also to 'relive' the conversations with the individuals and remember non verbal communication signals, whilst allowing me to play back the recordings as many times as I wished, for constant comparison analysis. It also enabled me to actively listen to the tone and content of the dialogue, as well as noticing what was not said and what was repeatedly said during the conversation.

The considerable volumes of data were managed using computer-assisted qualitative data analysis software NVIVO version 11, which stores, retrieves and establishes links between data (Gibbs, 2002; Bringer, Johnston and Brackenridge, 2004; Hutchison, Johnston and Breckon, 2010). All 72 transcripts were uploaded and stored on NVIVO, which allowed secure storage and password-protected access to be able to systematically analyse the data.

Data management using NVIVO was a significant element of my research-learning journey. Once I was able to navigate the system it was invaluable in

supporting the organisation and management of all my data. NVIVO also supported the process of reflexivity with the use of memos, which were pivotal throughout my study and provided the 'bridge' between the data and the emerging grounded theory (Charmaz, 2014; Mills, Bonner and Francis, 2006).

Different types of 'nodes' were used to 'hold' ideas and these were linked to highlighted areas within the transcripts, allowing the formation of 'tree nodes', which facilitated constant comparisons between emerging themes and concepts. These themes were then stored and text-searching properties utilised to cross check transcripts. Visualisation using hierarchy charts, mind maps, word trees, search queries and word frequency tools, supported the discovery of patterns within the data.

Using NVivo provided a foundation to the data analysis process, however synthesis of the data was also achieved manually, using iterative methods based upon personal experience, intuition and through the conceptual lens of the Senses Framework and key sensitising concepts (Charmaz, 2014). Regular supervision discussions facilitated the refinement and discovery of insights, patterns and connections, as well as limiting potential assumptions. Written memos (see later section 4.10.1 and Appendix 14) capturing key elements of the participants' stories further enriched the emerging themes and supported the development of links between participants' perspectives and those of their manager and colleagues. The process of analysis is described in more detail below.

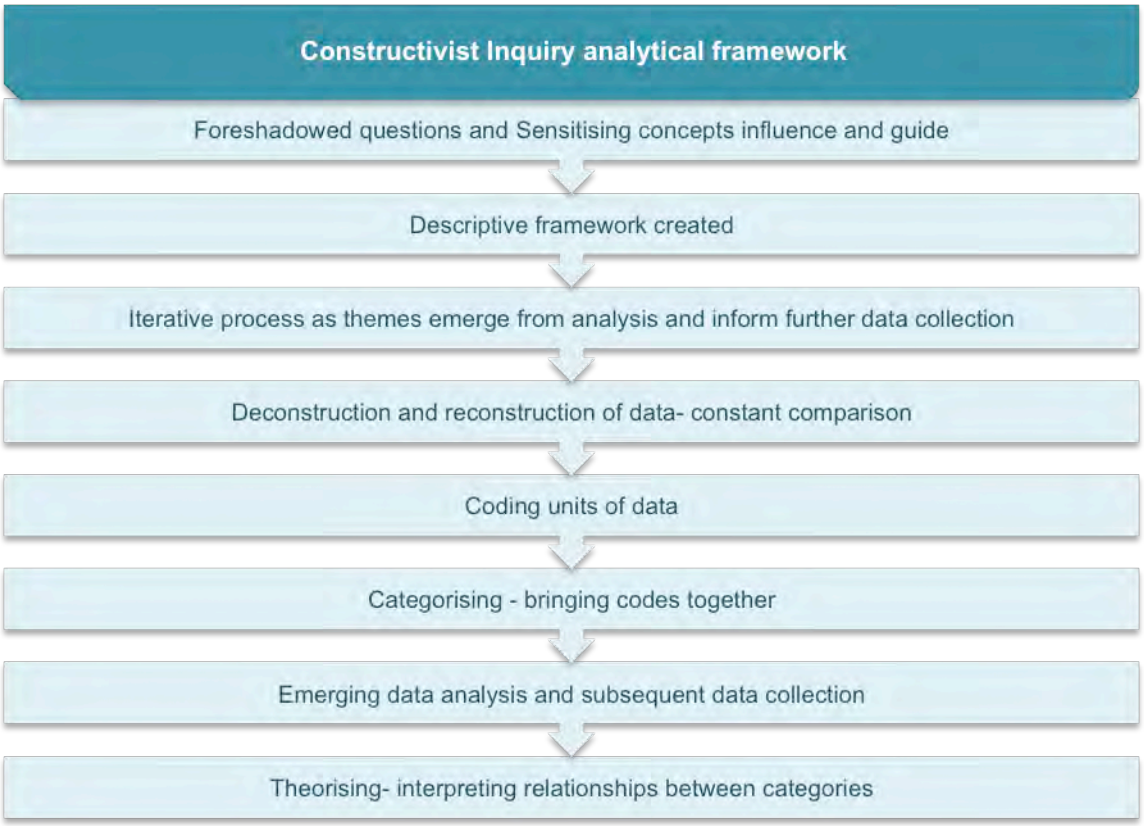
4.10 Data Analysis processes

As described previously, qualitative research involves an interpretative, intuitive approach to analysis in which the researcher is closely involved, rather than adopting an objective and distant stance (Denzin and Lincoln, 1994; Pope, Ziebland and Mays, 2000; Creswell et al., 2007; Denzin and Lincoln, 2008; Cohen, Manion and Morrison, 2013). The methodological framework

underpinning this inquiry required simultaneous data collection and data analysis and as Gilgun and Abrams (2002) suggest, there is an iterative process between the data and the foreshadowed questions/sensitising concepts, which can help to highlight emerging themes that guide both further analysis and data collection. This is the essence of theoretical sampling and constant comparison (McMillan and Schumacher, 1993; Rodwell, 1998). During the initial data analysis a 'descriptive framework', underpinned by the *Senses Framework*, guided the on-going iterative process of concurrent data collection and analysis (Rodwell, 1998).

The ultimate aim of the data analysis within a Constructivist Grounded Theory inquiry is to produce categories, which become integrated into a theory that emerges from, and is 'grounded' in the data (Glaser, 1978a; Glaser, 1992; Mills, Bonner and Francis, 2006). The whole process involves the construction, deconstruction and reconstruction of pieces of data, whilst constantly comparing emerging categories and themes working towards the creation of a grounded theory (Glaser, 1978a; Rodwell, 1998; Charmaz, 2014). This complex process is summarised in **Diagram 4.2**.

Diagram 4.2 Constructivist Inquiry analytical framework



Coding of each segment of data required time, focus and preparation to identify emerging categories and potential sub-categories, whilst seeking to identify potential relationships between particular categories, and highlighting codes, which may not have initially seemed to fit any category (Guba and Lincoln, 1994).

Progressively the concurrent data collection and analysis became more focused and through continual hermeneutic dialogue with participants, themes and categories were co-constructed and their meanings were checked, which enhanced the trustworthiness and quality of the Constructivist inquiry (Rodwell, 1998). Theorising commenced once key categories and an understanding of the emergent relationships between categories was evident (Morse, 1994; Rodwell, 1998).

The following sub-sections describe how this approach to data analysis was implemented in my study.

4.10.1 Coding processes

- ***Initial Coding***

The coding of qualitative data is pivotal to the analysis process and developing competence in coding requires continual practice so that confidence and speed increase as the study progresses (Strauss, 1987). Initial analysis of the interviews from Phase one of my study enhanced my understanding of participants' expectations and motivations for undertaking the DBC LP, as well as their managers' reasons for supporting the participants' applications and their expectations, hoped for outcomes and indicators of success.

Following each interview, initial notes of first impressions and thoughts were captured within memos using mind-maps (see example illustrated in Appendix 12). Transcripts were re-read many times during the initial coding process and the mind-maps, which were created, captured a summary of overarching words and themes emerging from the transcript. (See Appendix 13 for an example of initial coding, an extract taken from a Phase one transcript.)
Each Phase of the study followed a similar process of initial data exploration, which involved breaking down the data into meaningful codes and elements, whilst constantly comparing words and potentially implicit meanings, with other descriptive codes and ideas, which progressed to become tentative analytic categories. Phase one data analysis informed Phase two data collection and analysis, which then informed Phase three, where the core categories were identified, as will be illustrated in the subsequent findings in Chapters five and six.

To facilitate this process transcripts were re-read line by line and words, sentences or paragraphs, which stood out, were highlighted. This inductive process of coding or indexing allowed me to consider and reflect upon previous reading of transcripts and the literature (Charmaz, 2006). Separating and reducing data to understandable components, scanning transcripts, making comparisons with other data parts and beginning to develop descriptive codes

and categories, all contributed to initial coding and the process of understanding meaning and gaining insights from the participant's perspectives (Glaser, 1978a; Glaser, 1992).

As DBC LP is predicated on the Senses Framework, and this was the initial conceptual framework guiding the study, analysis was informed but not dominated by this framework. I was mindful to ensure that my analysis was not constrained by the Senses Framework and remained open to new possibilities (McMillan and Schumacher, 1993; Denscombe, 2003).

Table 4.7 illustrates examples taken from Amy's Phase one analysis of her transcript, using line-by-line coding and mapping to the six Senses.

Table 4.7 Line by line coding mapped to Senses

Examples of line-by-line coding taken from Amy's transcript	**Mapping to the Senses**
'Aria had said you would really enjoy this, you would absolutely thrive on it'	Creating a Sense of ***Significance***
'The opportunity to take a step back from what we are doing on a day to day basis and kind of think what is this all about, what are we doing here?'	Creating a Sense of ***Significance***, ***Purpose*** and ***Achievement***
'There was somebody already from the ward on the course'	Creating a Sense of ***Continuity***
'We have a staff support meeting every fortnight when we can talk about things, we have our handovers every morning but you're talking about individual care you're not talking about all the processes, all the people we meet on a day to day basis so it felt a great opportunity to take stock of what's going on'	Creating a Sense of ***Significance***, ***Security*** and ***Belonging***
'Not just doing your shift but really thinking about the impact we are having on the patients we are with'	Creating a Sense of ***Purpose***
*'*So that's why I wanted to get involved really cos I absolutely love the ward I am on and I have a fantastic team so anything we can do to improve the care for our patients and also to make our job, not easier but to make it more meaningful'	Creating a Sense of ***Significance*** and ***Purpose***

- ***In Vivo Coding***

Using *In Vivo* coding, which incorporated the participant's exact words or sentence, facilitated a deeper understanding of the meanings (Charmaz, 2014). Initial Codes were continually reviewed and categories or 'themes' were created as the data was conceptualised, a process that continued throughout analysis (Charmaz, 2014). Analytic categories began to develop, which were continually compared with other categories in order to help to illuminate any emerging relationships. One such pattern, initially termed 'getting the *timing* right' is illustrated in **Table 4.8**. This idea of 'getting the *timing* right' eventually emerged as one of the 'core categories', that of '**C**hronology' (see later in Chapters five and six).

Table 4.8 Analytical categories example

Extracts from transcripts which illuminate 'timing' as a category	***Analytical categories***
'I just felt the time was right for her because she has been in acute psychiatry now and when you come into acute psychiatry it takes you a wee bit of time, cos it's busy, it's busy so takes time to adjust. So the year prior to that, I sent somebody on it, the timing wasn't right for Amy ' (Aria)	*Getting the timing right*
'*So the programme comes at a pivotal time for him and I think it will be one of the few factors which will see him emerge as a butterfly'* (Babs)	*Getting the timing right*

'I think it came along at the right time although at the time I remember thinking how can I do this plus this new job em but actually when I look back now I think doing the 2 together probably was the right thing and it probably did help me a lot more' (Tina)	*Getting the timing right*
'So actually having a kind of monthly session of right this is what I have got to do today, I'm not going to turn my work phone on, it's in the diary, you're out the office, it's just time for me em, which doesn't happen very often in my life em, so I think that it came along at a good time em so yeh it's been really good' (Jane)	*Making time for me* *Getting the timing right*
'It just wasn't the right thing at the right time for Jane' (Jackie)	*Getting the timing right*

- **Focused Coding**

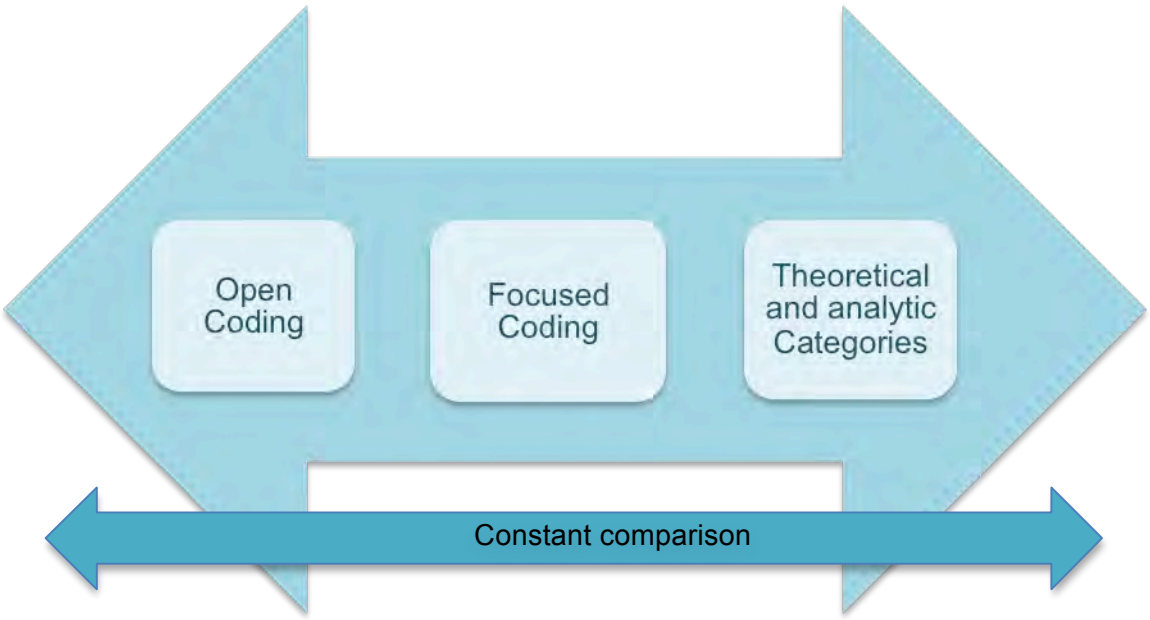
Coding then progressed on to focused coding, which involved collating similar codes to develop and refine these into more conceptually dense categories, something essential to the refinement of the emerging theory (Charmaz, 2014). Constant comparison and cross checking of transcripts both manually using paper copies and also transcripts uploaded onto NVivo, provided a systematic, focussed approach to this stage of the analysing during which I '*stepped onto the balcony'* (Heifetz, Grashow and Linsky, 2009), paused and asked myself questions such as:

- *'What are the participants telling me?'*
- *'What does this data contribute to my study?'*
- *'How does this fit with emerging themes and categories?'*

(Heifetz, Grashow and Linsky, 2009)

Comparing participants with other participants, managers with managers, colleagues with colleagues and participants with managers, created a network of potentially related categories, all of which fed into the emerging theory. This process is illustrated in **Diagram 4.3**.

Diagram 4.3 Constant comparison of coding



- ***Discovery of Categories***

Through continual coding and recoding, potential categories, which aimed to explain and make sense of what the participants were saying, began to emerge and become clearer. Although a written description of this process makes it sound quite straightforward, in reality I found it to be complex and 'messy', and I referred to it in my reflexive diary as 'trying to piece a jigsaw together' *(taken from extract from diary 29/3/16).* Continually reflecting on the data and having regular discussions at supervision sessions were invaluable. In addition to this, reflecting at the end of each interview with the participants at all three Phases of the study enabled all participants to contribute to this intricate process of discovery. I found adopting Charmaz's approach (2006) of coding with gerunds (verbs with 'ing' added, which become nouns in the text), helped me to stay close to the data and uncover processes. As Charmaz suggested '*we gain a strong sense of action and sequence with gerunds'* (Charmaz, 2006, p.120).

As described above, the '*Senses*' played an important part in helping to shape the analysis and as this progressed I became even more curious as to how the *Senses* were being created for participants not only during the programme but also subsequently after their experience of DBC LP. Understanding the experiences of participants, all of whom had leadership roles within a complex healthcare system, could not be fully achieved without giving consideration to the environment within which they worked. The idea of an *enriched environment* therefore remained relevant throughout the inquiry and an indication of how this fed into the on-going analysis is illustrated in **Table 4.9**.

Table 4.9 Emerging categories appearing to create the '*Senses*' and maintain an *enriched environment*.

Emerging categories/creating the Senses	Security	Belonging	Significance	Purpose	Achievement	Continuity
Creating and developing effective relationships • Manager • Team	✓	✓	✓	✓	✓	✓
Continuing learning and development				✓	✓	✓
Peer support and encouragement	✓	✓	✓			
Inner drive and motivation- personal desire to enhance skills	✓		✓	✓	✓	✓
Continuity of process- Program over time	✓	✓		✓		✓
Feeling valued and I matter	✓	✓	✓	✓	✓	✓
Role clarity and purpose	✓	✓	✓	✓	✓	✓

A number of other processes greatly aided the analysis process and these included:

- Memo writing
- Free writing / mind maps
- Keeping a reflective diary
- Diagramming.

The role that these processes played is considered below.

- **Memo writing**

Throughout the study, the writing of memos and maintaining a reflective diary played a significant part in shaping and creating the emerging theory and supporting the analysis process (Charmaz, 2014). Comparing ideas and connecting data with data resulted in more questions, which prompted periods of self-reflection and rich discussion with my supervisors as my research journey progressed. A memo extract is provided below, as an example. (See Appendix 14 for further memo extracts).

'I strive to remain open to what's emerging and keep asking myself what am I noticing? What am I assuming I will see? What am I not seeing? What else?
I plan to compare focused codes from Phase 1 both Element A and B, with Phase 2 and then Phase 3 and in relation to participants/managers/ peers /direct reports. Constant comparative method supported by my reflexive notes; past participants compared with current participants; managers with participants; managers with managers; managers with peers; managers with direct reports; peers with participants; direct reports with participants; current participants with each other; nurses with AHPs; Registered staff with Non Registered; length of time since participation on DBC LP - is there variation or similarities of focused codes?' (Extract taken from memo 27/08/16)

- ***Free writing***

Regular episodes of 'free writing' and the use of mind mapping techniques also facilitated the development of analytical themes, as these provided the opportunity to constantly compare, challenge, question and add to my thoughts. From the outset of my research journey I used cluster memos, which were spontaneous free writing notes of my thoughts, feelings, comparisons and ideas. I found these incredibly valuable and, at times, therapeutic (Charmaz, 2014). Although similar to the memos described above, which focused more on the complexities of the analysis process and coding, the 'free writing' notes and cluster memos tended to capture impromptu ideas, which I would often incorporate into what I referred to as my 'advanced memos'. Reading back through my 'free writing' notes and mind maps played a vital role in achieving and sustaining progress and focus throughout the inquiry. Combining the use of cluster memos and 'advanced' memos enabled me to '*step off of the dance floor onto the balcony'* (Heifetz, Grashow and Linsky, 2009), in order to gain new insights, clarify questions and guide the analysis.

Visualisations through the use of diagrams, which are described below, of key codes and sub codes from each of the participants' transcripts allowed direct quotes and In Vivo codes to be explored, refined, and synthesised so that the data were reduced and themes became more conceptually dense.

- ***Reflective diary***

Maintaining a reflective diary throughout the research study helped to ensure on-going reflexivity that contributed to the overall quality assurance and robustness of the inquiry (Charmaz, Denzin and Lincoln, 2008; Charmaz, 2006) (see later in this Chapter and also in Chapter seven for a fuller description of reflexivity). Being reflective required me to constantly challenge my assumptions and consider how these might have been influenced by prior professional experience, which as indicated in Chapter one, played a key part in

motivating me to undertake this study (Northway, 2000; Freshwater, 2005; Mills, Bonner and Francis, 2006).

My reflective diary consisted of three key sections:

- One considered methodology
- One considered theoretical/conceptual issues
- One reflected on my role in the whole process and my overall doctoral journey

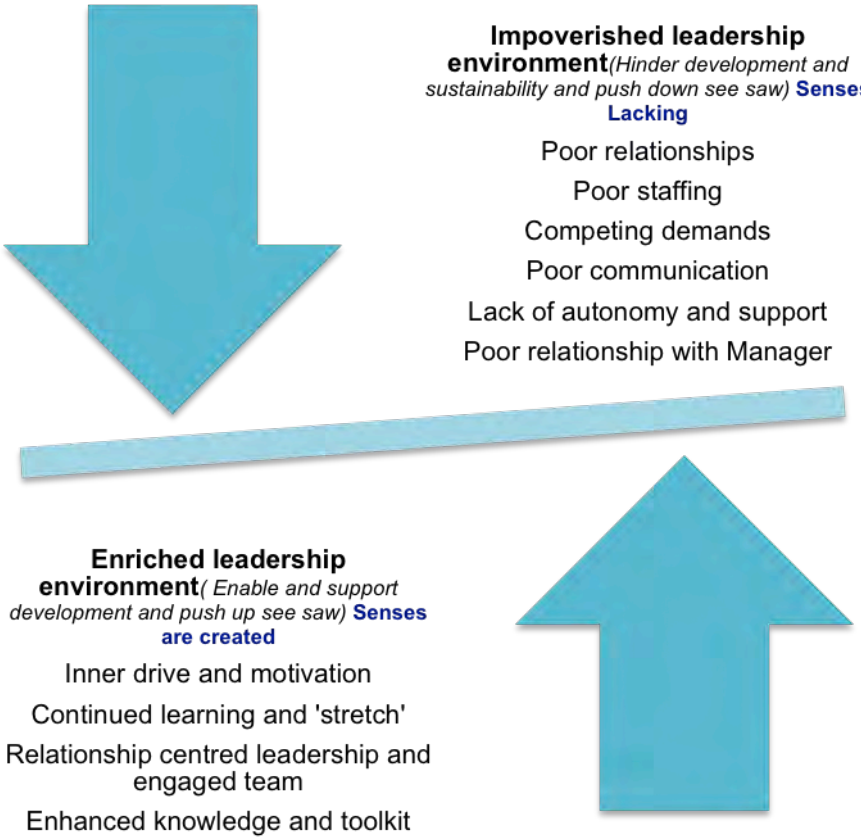
I found this structure to be useful when looking back to reflect on significant insights and learning, particularly when writing subsequent Chapters of this thesis. In addition, reading through reflections and memos, which captured significant moments of learning and discovery, was motivational, encouraging and supported the essential continued commitment to remain focused and conscientious throughout the study. Reflexivity was important in light of my insider - outsider role, to promote transparency, honesty and rigour (Davies and Dodd, 2002). This was a natural and instinctive experience, most likely due to professional accountability and experience as a nurse, coach and consultant.

- ***Diagramming***

The use of diagrams and tables encouraged a shift from description of data, towards more abstract thinking and creativity. Visualising steps taken within a process for example also provided clarity and a deeper understanding of meaning (Charmaz, 2014).

Diagram 4.4, the '**Seesaw**,' which illustrates enabling and hindering factors that have an impact upon the creation of an *enriched environment* (See Chapter Two, *sensitising concepts*), proved to be helpful in affirming my thinking in relation to emerging categories (Corbin and Strauss, 2014).

Diagram 4.4: **The 'Seesaw'**



4.10.2 Theoretical Saturation

Theoretical 'saturation' of categories is said to occur, when no further unique insights emerge from the data collected (Dey, 1999; Charmaz, 2006). Relationships and connections between categories became clear and the emerging theory began to illuminate new insights and understanding, in relation to the original research questions within the study (Morse, 1995; Corbin and Strauss, 2014). By adopting a Constructivist Grounded Theory approach, I remained open to possibilities throughout all iterative stages of the data analysis and tended to avoid the use of the term 'saturation', when considering when I had *sufficient* information and should stop gathering data to focus on

conceptualisation of the data. This positive and proactive approach enabled me to remain focused and therefore insightful patterns emerged and affirmed my thinking as each Phase of the study progressed, which I explored in detail during supervision sessions (Glaser, 1978b; Charmaz, 2014).

4.10.3 Conceptualisation

Using an iterative process, constantly comparing codes and themes, I consistently used a conceptual framework comprising the two *sensitising concepts*; the *Senses Framework* and *enriched learning environments*, throughout my research study. This provided me with a Constructivist-interpretive analytical framework (see Appendix 15) to direct and guide my data analysis (Schwandt, 1998).

Conceptualisation involved the complex process of developing the emerging core categories, which Chapters five and six will describe in detail in the study findings, as well as the co-constructed emerging theory (Charmaz, 2014). **Table 4.10** illustrates an example taken from my reflective diary, of mapping emerging enablers of the developing categories, to the *Senses Framework.*

Table 4.10 Mapping enablers to the *Senses Framework*

Study questions elements	Enablers (developing categories)	Senses created
Reasons and motivations for participating	✓ Supportive manager ✓ Inner drive and positive attitude ✓ Permission and *timing* ✓ Conditions to lead and reflect ✓ Autonomy and responsibility	**Security** **Belonging** **Significance**
Views, hopes and expectations of DBC LP	✓ Enriched learning environment ✓ New tools, continuity of programme ✓ Group and facilitators' Feedback	**Significance** **Security** **Belonging**
Have expectations been met? How has experience been? What has been noticed? Any impact?	✓ Continued learning and development over time ✓ On-going support from manager ✓ Engaged team ✓ Inner drive ✓ Clear purpose (joy and meaning in work)	**Achievement** **Purpose** **Significance** **Continuity**
How to keep going, enabling self and others, learning and improving	✓ Effective relationships ✓ Desire to continue to learn and develop ✓ Enhanced understanding of self and strengths- increased self confidence, self belief, personal resilience and energy (Joy in work/happiness)	**Continuity** **Achievement** **Purpose** **Significance**
What factors enable and hinder impact to be sustained?	✓ Relationships – particularly with Manager ✓ Creation of the Senses-enriched learning and working environments ✓ Support and self compassion-caring for self- building on personal drive and motivation-resilience and energy	**Continuity** **Purpose** **Significance** **Achievement**

The following sub-section will describe the Hermeneutic dialectic process, which was significant throughout this inquiry, as already highlighted in the introductory Chapters.

4.10.4 Hermeneutic Dialectic Process

The hermeneutic dialectic process adopted within this study is an interpretive method, which compares constructions from the data in a way that synergises perspectives and ideas through mutual exploration and engagement by everyone involved in the inquiry, which is fundamental and central to Constructivist inquiry.

This process involved participants; their managers, peers and junior colleagues, to ensure all aspects were considered and co-created through conversation or dialogue using an appreciative approach (Cooperrider and Whitney, 2011). Consensus was negotiated and achieved through openness and transparency and continually comparing ideas as themes emerged. Cross checking of ideas throughout the hermeneutic dialogue, during regular supervision sessions and at De Montfort University Annual and Formal Reviews as part of the RDP, all contributed to gaining a clearer understanding of emerging constructions, thus enhancing credibility of the data (Guba and Lincoln, 1989; Rodwell, 1998).

The hermeneutic process encourages an approach based upon honesty and quality, therefore reduces risks of bias or inaccurate presentation of information (Glaser and Strauss, 1967; Glaser, 1978a; Lincoln and Guba, 1985; Guba and Lincoln, 1989). Therefore, in order that all participants played an active role throughout their participation, as the data emerged, stakeholders in varying roles within healthcare and with differing experiences, responsibilities and lengths of service, assisted in shaping the research data analysis and findings by means of hermeneutic dialogue (Rodwell, 1998). See **Table 4.11**, which summarises the means I engaged in hermeneutic dialogue at each Phase.

Table 4.11: Means of engaging in Hermeneutic dialogue at each Phase of the study

	Face to face at end of Interview	At end of Telephone interview	Via electronic mail	During subsequent DBC LP
Phase 1	✔	✔	✔	
Phase 2	✔	✔	✔	✔
Phase 3	✔	✔	✔	✔

This Co-Constructivist element of the inquiry enabled all those engaged in the process to construct new and enhanced understanding of the situation under investigation and to explore options for change and learning (Rodwell, 1998). This proactive and collaborative process fitted well with the underpinning ethos of DBC LP in promoting coproduction and engaging leadership.

4.10.5 Summary of Data Analysis processes

Adopting a Constructivist inquiry method to generate themes and constructs, data analysis was based on a Grounded Theory approach as described above, which supported an emergent strategy of theoretical sampling (Corbin and Strauss, 2014). Emerging themes in the early analysis of Phase one Element A, informed ensuing interviews and data collection in Phase two to provide on-going comparison (Charmaz, 2011). Each unit of data was compared with each other in a continual systematic process of inquiry. As the themes emerged from the data, constructions were developed, which informed the subsequent interviews (Fontana and Frey, 1994; Savage, 2000). Participants were actively engaged in the data analysis processes continually throughout all Phases of the study through hermeneutic dialogue.

Following Phase three data analysis, a purposive sample of participants was invited to take part in further hermeneutic dialogue beyond their initial interviews, which enabled a deeper exploration of themes and co-construction of the emerging theory 'grounded' within the data (Rodwell, 1998).

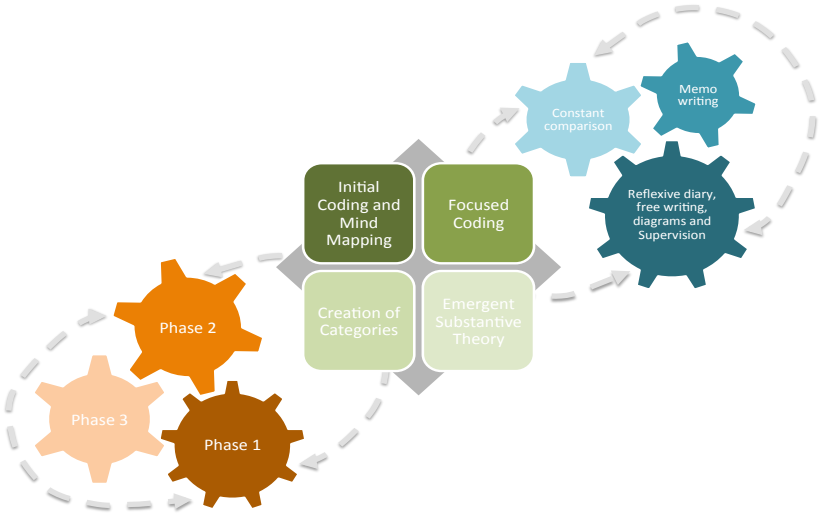
In summary **Table 4.12** and **Diagram 4.5** below illustrate the key stages of the data analysis process adopted throughout the three Phases of the study.

Table 4.12 Summary of Data Analysis process

✓ Immersion in the data	Self transcribed all interviews
✓ Reflective memos captured as on-going practice	Initial reflections noted and episodes of 'free writing' (little and often)
✓ Detailed reading and annotations of transcripts	Descriptive thematic early coding (223 codes generated initially)
✓ Creation of mind map for each participant's interview	Tested out various tools and templates (e.g. 4 quadrants, intrinsic/extrinsic/personal/professional; 6 leadership capabilities tool)
✓ Uploaded transcripts to NVivo	Initial grounded theory coding; word by word coding; line by line coding- e.g. ➢ Continually learning developing and reflecting ➢ Leading by example and engaging others ➢ Communicating effectively ➢ Finding joy in work ➢ Understanding self and others ➢ Planning and prioritising goals ➢ Lacking awareness ➢ Leadership challenges ➢ Work life balance ➢ Continuity and sustaining progress
✓ Adopting coding practices	In Vivo coding; Focused coding; sunburst queries, nodes frequency, work cloud queries, hierarchy charts
✓ Identification of initial core categories (7)	➢ Creating and developing effective relationships with Manager and Team ➢ Continuing learning and development ➢ Peer support and encouragement ➢ Inner drive and motivation- personal desire to enhance skills ➢ Continuity of process- Programme over time ➢ Feeling valued and I matter ➢ Role clarity and purpose
✓ Exploration through the lens of the Senses Framework and enriched environments (*Sensitising concepts)*	Focus on importance of creating enriched learning environments for relationship-centred leadership to develop
✓ Visualisation of analysis using Senses Framework *(Continually linking back to research questions)*	➢ Each Sense visualised as a main tree branch ➢ Enabling and hindering factors visualised as smaller tree branches ➢ Expectations/motivations/experiences /impacts visualised as sub branches of

	the tree
✓ Co-constructing themes with participants at each phase of the study	Hermeneutic dialogue
✓ Created diagram of see-saw	Visualisation of enablers and hindering factors
✓ Emergence of Focused codes	➢ Inner drive and motivation *(Personal and Professional self)* ➢ Continual learning, development and stretch (Creating the conditions) ➢ Relationship-centred leadership (*Relationship with manager and team)* ➢ Enhanced skills, knowledge and toolkit
✓ Using sensitising concepts exploration of individual/team/ Organisational levels	Table created to depict
✓ Creating conditions for relationship-centred leadership	Diagram created
✓ Re-reading transcripts throughout each phase	Constant cross checking and making comparisons; capturing memos of what's emerging, discussions at Supervision
✓ Emergence and development of core categories (5) and substantive theory	Five C's- Context, Chronology, Catalyst, Conditions and Consequences
✓ Visualisation of temporal longitudinal research process	Temporal diagram of creating the conditions
✓ Creating a sense of continuity as researcher/facilitator	Stepping off of the dance floor onto the balcony asking self '*what are participants telling me?'*

Diagram 4.5 Key stages of Data Analysis process



4.11 Ensuring Quality

This section begins to explore the key factors in relation to quality within the research process, however a more detailed discussion is provided within Chapter seven.

Ensuring quality in qualitative research is fundamental, potentially challenging, and begins prior to data collection, through to the completion of the study (Charmaz, 2014). As a researcher working in a healthcare environment where quality is key to ensuring safe, effective, compassionate care, holding quality at the forefront of my mind was imperative throughout my inquiry, as was ensuring meaningful and understandable written outcomes and impact, whilst maintaining honesty and focus during the research process (Emden and Young, 1987; NHS Scotland, 2017b).

In order to evaluate the quality of Constructivist inquiry studies, Guba and Lincoln (1989) developed 'parallel' criteria; *credibility, transferability, dependability and confirmability* (see **Table 4.13**), as the traditional criteria adopted from a positivist stance, specifically *internal validity, external validity,*

reliability and objectivity, did not reflect the principles underpinning Constructivism (1994). Consideration was given to these 'parallel criteria' within my study, a summary of which is captured within **Table 4.13** below.

Table 4.13 Comparing Parallel and Traditional criteria

Positivist Traditional criteria	**Parallel criteria**	**Questions posed**	**Considering Parallel criteria in relation to this study**
Internal Validity	**Credibility**	What is the wider scope and focus of the topic under investigation?	• See Chapters one and two • Clarity and transparency promoted throughout via hermeneutic dialogue/ Analysis processes • Prolonged engagement with participants – longitudinal study
External Validity	**Transferability**	How can the learning be used in other contexts?	• Implications are discussed in Chapter nine • Readers of this thesis can also decide this when considering recommendations in Chapter nine
Reliability	**Dependability**	What data collection and analysis processes are used and how does this fit with constructivist inquiry?	• See sections 4.7- 4.10 for detailed description • Cross checking and supervision discussions supported dependability
Objectivity	**Confirmability**	How are the findings presented linked to the data and research questions?	• See Chapters five and six for thorough description of findings linked to rich quotes/data presented • See examples of memos within detailed data analysis processes undertaken

Attention is now given to the additional criteria proposed by Guba and Lincoln, which formed the basis of the '*authenticity criteria' (*See **Table 4.14),** that further enhanced the parallel criteria, and are more appropriate and applicable to a

Constructivist inquiry, such as this study (Guba and Lincoln, 1989; Rodwell, 1998).

These original '*authenticity criteria'* are listed below:

- Fairness
- Ontological authenticity
- Educative authenticity
- Catalytic authenticity
- Tactical authenticity

However, to provide a more simple, easy to understand, user-friendly model, researchers at Äldre-Väst Sjuhärad (ÄVS) Research Centre in West Sweden, further developed and enhanced the '*authenticity criteria'*, which was referred to as the *ÄVS model matrix* and subsequently became the *EA Matrix* (Hanson et al., 2006; Wilson and Clissett, 2011). The ÄVS Research centre, established in 2001, had the initial goal to create effective partnership working between older people, family carers and staff/health and care professionals.

To enhance the EA Matrix further, and to promote its practical applicability, additional criteria were added to the matrix in relation to three Ps- **P**lanning, **P**rocess and **P**roduct (See **Table 4.14).** This enabled the authenticity of the Constructivist inquiry to be strengthened, by consideration given at each stage of the Matrix to the planning, processes and product phases of the research inquiry (Nolan et al., 2003; Wilson and Clissett, 2011). The ÄVS Research centre developed a reliable and transparent evaluation of quality process, which involved the perspectives of service users, professionals and health and care providers. Their aim was to bridge the gap that often exists between theory and the application to practice, by presenting new information in an understandable way to promote implementation to diverse contexts. Therefore, the original *authenticity criteria* proposed by Guba and Lincoln, formed the basis of the principles of the ÄVS centre's work.

Table 4.14 EA Matrix

EA Matrix	Planning	Process	Product	***Original Authenticity Criteria***
Equal Access				*Fairness*
Enhanced Awareness -Self				*Ontological Authenticity*
Enhanced Awareness -Others				*Educative authenticity*
Encourage Action				*Catalytic authenticity*
Enable Action				*Tactical authenticity*

In 2003, Nolan et al suggested the EA Matrix, with the new easier to understand and more accessible use of language could be used to support wider partnership working and enhance care for older people (Nolan et al., 2003; Nolan, 2003; Hanson et al., 2006). Subsequently in 2009, the evaluation of *Leading into the Future* pilot programme (see Chapter three) was underpinned by the EA Matrix, which Professor Mike Nolan led.

Using the EA Matrix clearly aligned with the participatory nature of DBC LP and with the co-constructive and collaborative approach adopted within my study, therefore it was utilised in relation to evaluating the quality of this study and to reflect upon the extent to which the study had met the initial aims set out at the start of this Constructivist inquiry.

The EA Matrix will also be explored in detail within Chapter seven, where I propose that the EA Matrix could be used for leaders to evaluate programmes, changes in practice and research processes.

To conclude this initial exploration of quality within my study, two additional sets of criteria are highlighted, which are discussed later in Chapter seven.

The first is a set of 'four indicators', which were originally suggested by Glaser and Strauss (1967) to evaluate the quality of Grounded Theory research.
The four indicators- *work, fit, grab, modifiability*, are listed below:

- **Work:** Does the theory *work* in the sense that it provides a better understanding of the issue under study and does it *work* in that it provides insights, which can be applied in the real world?
- **Fit:** Does the theory *fit* with the data that are used to support it?
- **Grab:** Does the theory 'grab' the reader's imagination, so they can see that it applies to the issue under study?
- **Modifiability:** Can the theory be potentially *modified* in the light of new data? (See earlier section 4.6 on moving to a formal theory).

These indicators were used to reflect upon the theory, which emerged from this study and will form part of the discussion in Chapter seven.

The second additional set of criteria, which are also discussed in Chapter seven, were proposed by Charmaz (2006; 2014), and are captured in **Table 4.15**. Charmaz suggests such criteria are required, because "*These criteria address the implicit actions and meanings in the studied phenomenon and help you analyse how it is constructed*" (2014, p. 338), which I hoped would ultimately enable my theory to emerge and develop.

Therefore, when further reflecting upon the quality and rigour of my study, which is discussed in Chapter seven, the questions listed in **Table 4.15** will be addressed, and consideration given to the '*credibility, originality, resonance and usefulness'* of my 'theory', which is introduced in Chapter five.

Table 4.15 Charmaz's Criteria for evaluating Quality of Grounded Theory

Credibility	• Is the researcher familiar with the setting and topic? • Are the data sufficient to merit the claims? Have systematic observations been made between categories? Do the categories cover a wide range of observations? • Are there strong links between the gathered data and the argument and analysis? • Is there enough evidence for the claims to allow the researcher to form an independent assessment and agree with the claims?
Originality	• Are the categories fresh and do they offer new insights? • Does the analysis provide a new conceptual rendering of the data? • What is the social and theoretical significance of this work? • How does the Grounded Theory challenge, extend current ideas and practices?
Resonance	• Do the categories portray the fullness of the study experience? • Have taken for granted meanings been revealed? • Where the data indicate, have links been drawn between institutions and individual lives? • Does analysis offer participants' deeper insights about their lives and worlds and does the theory make sense to them?
Usefulness	• Does analysis offer interpretations people can use in their everyday worlds? • Are there any generic processes within the categories and if so, have they been examined for tacit implications? • Does the analysis spark further research in other substantive areas? • How does the work contribute to knowledge? How does it contribute to making a better world?

(Charmaz, 2014, pp. 337-338)

To conclude, the importance of ensuring quality in Constructivist Grounded Theory research has been introduced above and significant criteria suggested, which will be further described in Chapter seven.

The ethical considerations will now be explored in the following sections.

4.12 Ethical considerations

Ethical approval was gained in August 2015 from De Montfort University, Faculty of Health and Life Sciences, Faculty Research Ethics Committee. Further approval was also obtained from NHS Lothian Research and Development (R & D) Department and Edinburgh Napier University (ENU) R & D Department, as DBC LP is delivered in partnership.

4.12.1 Advantages of my dual role

I am in the privileged position of facilitating the delivery of DBC LP and DLE for AHPs within NHS Lothian; therefore a potential risk of 'insider-outsider' issues required strict confidentiality in relation to engagement with participants during the programme and within the study (Dwyer and Buckle, 2009). Ground rules are agreed on day one of each programme to ensure a safe learning environment is created.

Specific data collected during interviews were not shared with other programme facilitators, programme participants, or managers during the study. However I did share broad themes and ideas that were emerging from the data, with subsequent participants on the programme who were not engaged in my study, during workshop conversations. Often emerging themes from the on-going data analysis resonated with the workshop topic at that time, so I would share these and seek the group's feedback and thoughts on the themes. This often affirmed my thinking and enabled me to share the group's feedback/ thoughts on the themes with study participants through hermeneutic dialogue, where appropriate, and usually at the end of their interviews. The study participants contributed their reflections on the group's feedback, as well as their personal views on the merging themes, thus promoting constant comparison and co-construction.

There was explicit emphasis, clarity and transparency on the expectations and responsibilities of participants and myself, at the outset of the study, with all

programme facilitators and participants involved. As researcher '*occupying this space between the two perspectives, affords a deeper knowledge of the experience' being studied* (Dwyer and Buckle, 2009, p61).

Asselin (2003) argues that the reality of being in a position of insider-outsider requires a real focus to remain objective and open to new learning since there is the potential to be influenced through previous experience and knowledge gained during the study. My aim was to fulfil both the insider and outsider positions effectively, whilst ensuring ethical accountability, consequently enhancing my professional and personal roles through progression of my research journey (Sidebotham, 2003). How I did this, through reflexivity, is described in the section 4.13 and later in Chapter seven section 7.7.

4.12.2 Potential for positional power

A potential issue and limitation identified at the outset, due to my facilitator role within the programme, was that of positional power, which might have had an influence on participants, resulting in bias and:

- A perceived obligation to take part in the study.
- A perceived obligation to be positive about the programme (DBC LP).
- A potential impact on the data provided by the participants.

Therefore I dealt with this potential issue of positional power by sending the information/invitation to participants before commencing the programme to ensure they were fully informed about the research study, hoping to minimise any risk that they would feel obliged to opt into the study, and to enable as robust a consent process as possible. In addition to this I remained mindful of the potential biases and ensured professionalism, integrity and authenticity at all times, as well as ensuring that I engaged in regular supervision, and reflection on my practice as a researcher (McDermid et al., 2014).

4.12.3 Informed consent process

Under the principle of autonomy, participants from the DBC LP 2015-2016 cohort were invited to 'opt in' to my study- my intent being not to coerce or exert pressure due to my 'insider' role within the organisation. An invitation letter and information sheet (see Appendix 5) was sent via electronic mail and hard copies were posted to individual participants via internal mail, prior to them commencing the programme.

Obtaining informed consent and maintaining confidentiality, were of paramount importance at each Phase of the study (Fetterman and Wandersman, 2007). In line with the emergent and dynamic process of qualitative Constructivist inquiry, I followed the principles of process consent, which allowed mutually beneficial engagement in the study and the opportunity to confirm details already provided within the information letter (Munhall and Chenail, 2008). Participants communicated their willingness to opt into the study mainly by electronic mail and occasionally by returning the tear-off slip provided at the end of the invitation letter.

Arrangements and confirmation of interview date, time and venue, was agreed through electronic mail exchange. Interviews were held at a neutral venue, mutually agreed with the participant, such as an education centre room, which was away from their workplace, at a convenient time and date. Privacy, ensuring confidentiality and limiting distractions, were important factors taken into account. Therefore programme workshop days were avoided, so that other participants were not aware of who was taking part in the study. Prior to the interview commencing, participants were thanked for their willingness to attend for interview and reminded of the overarching aims of the research study. They were offered the opportunity to ask any questions or clarify any information. Once affirmation of their wish to proceed was received, the participant was then invited to read through the consent form (see Appendix 6), initial all relevant

sections of the form, confirming they understood and agreed with all points, then sign and date the form.

If a telephone interview was the chosen option for the participant, the process was the same as above and with their permission I signed the consent form on their behalf and wrote on the form *'signed on behalf of…with their permission'.* During Phase one it was possible for me to ask the participant in private, to sign the form, when I saw them next at a programme workshop.

4.12.4 Ensuring confidentiality and safe storage of data

The importance of confidentiality was emphasised prior to the start of the interview and an explanation provided about the safe storage of consent forms, transcripts and digital recorder in a locked filing cabinet only accessible to myself, within a locked office of a hospital education centre.

It was explained that I personally would transcribe all interviews verbatim, that all names or identifying information would be anonymised and that all individual participants, which would include their managers, peers and direct report/junior colleagues at various Phases of the study, would be coded to ensure anonymity. The transcripts, when uploaded to the data management system NVivo, which was described earlier in the Chapter when discussing data analysis, were also stored on a password protected secure laptop, which was also kept in a locked cabinet. Reassurance and affirmation of this was also given in the brief introductory explanation to the participants.

The fact that direct quotes from the transcripts would be used within the Thesis and any future publications was clarified with participants with an emphasis on anonymity and the protection of identity of individuals, specific clinical areas or healthcare sites. All participants were offered the opportunity to receive a copy of their signed consent form, typed transcript and of any reports at any point, however none of the participants made any requests.

It was explained that as part of this Constructivist inquiry, themes from subsequent data analysis would be explored with all participants as the study Phases progressed, on an on-going basis, particularly at the end of each interview. This would enable themes to be co-constructed through dialogue, mutual challenge and exploration. Participants were informed that my supervisors would read transcripts and reports as part of supervision and that ethical accountability would be assured at all times.

4.13 Reflexivity and Constructivist Grounded Theory

The following section begins to describe the pivotal role that reflexivity plays within Constructivist Grounded Theory research, and illuminates its particular importance within my study. This is further considered in Chapter seven, section 8.7.

Gentles et al (2014, p.1) state that reflexivity "*most often refers to the generalised picture in which researchers strive to make their influence on the research explicit."*

Reflexivity in qualitative research involves a continuous process, whereby the researcher reflects upon their personal influence and contributions to the entire research process (Gough, 2003). The role of reflexivity in Grounded theory has become increasingly significant over recent years (Leonard and McAdam, 2001; Gentles et al., 2014; Ramalho et al., 2015). I realised that it was vital at all stages of my study, to be aware of my values and potential assumptions, biases and perceptions, and how these might impact upon my role as researcher and the actual study itself. Therefore I considered my role within the evolution of the DBC LP, is at the centre of this Constructivist Grounded Theory study.

Reflecting on my role over the past decade emphasised the importance of reflexivity as a key factor within my research journey. As the programme had evolved over the past decade, and continued to be supported and promoted by NHS Lothian, a significant amount of intelligence, constructive feedback and

formative evaluation data, had been gathered, which provided background information and understanding for myself as researcher, and also had the potential to inform this inquiry. My supervisors, who were pivotal in the original design and evaluation of the pilot programme (Leading into the Future, see Chapter three), had also observed the impact that the programme had on individuals at a personal and professional level. The quality improvement projects and small tests of change, which participants had undertaken over the years, were successful outcomes, which were presented at annual celebration workshops and clearly impacted positively on care and service delivery. Intellectual grit, a significant level of commitment, and investment in developing leaders, had all influenced the continued delivery of the programme within the organisation.

Following a review of reflexivity, Gentles et al (2014) deduced that despite the acknowledgement of its importance, many researchers failed to explicitly adopt a reflexive approach, which they deemed as essential to promote transparency within the research process as a whole. Therefore, considering the approach suggested by Gentles et al (2014), and later affirmed and added to by Ramalho et al (2015), I reflected upon my own reflexivity, following their questions below (see also Chapter seven for an additional extensive section 7.7 on reflexivity- *my personal reflections and insights*):

- *What influence have I had on the research design and questions, including pre-existing knowledge/concepts and role played by the literature?* These issues have been discussed in detail within Chapters one to three, in particular in relation to my researcher/facilitator roles and within this Chapter when describing my chosen methodology.
- *What was the nature of my interactions with the participants?* Again, this has already been discussed in the earlier Chapters one to three and within the Ethical considerations within this Chapter and included any 'power' that the

participants may have perceived that I had, how I communicated with the participants, the collaborative elements of the study and how I involved them to co-construct the theory.

- *How might I have influenced the way in which the data was collected and analysed?* This has been described explicitly in detail within this Chapter, particularly in relation to underpinning Grounded Theory analysis processes, such as constant comparison, memo writing and maintaining a reflective diary, which Gentles et al (2014) suggest ensure that the researcher implements reflexivity.
- *How might I have influenced the writing and reporting of this study and subsequent thesis? How might the experience of undertaking this study have impacted upon me personally?* This is discussed in depth within Chapter seven, which describes the potential parallel process I have experienced, that of an enriched 'doctoral studies' learning experience, similar to the enriched experiences shared by the DBC LP participants.
- *What role have my supervisors played in influencing my study?* Ramalho et al (2015) suggest this is an important additional aspect, which doctoral students need to be explicit and clear about in their thesis. I have referenced my Supervisors and the role they have played, at several points throughout my thesis, particularly in Chapter one section 1.2 and Chapter seven, section 7.7.

In summary, consistency of facilitation and leadership, as well as personal drive and motivation to support and develop leaders at all levels, has supported and enabled the evolution of DBC LP. Creating a *Sense* of **Continuity**, within my role as Leadership Practitioner has enabled the programme and evolving model

based on participant feedback and evaluation, to remain a priority within the organisation's leadership framework. Reflexivity has played a significant part of my nursing career and has been enhanced and strengthened during this doctoral research experience, which section 7.7 in Chapter seven aims to illuminate.

4.14 Chapter summary

This Chapter has described how a hybrid approach to Constructivist Grounded Theory, with an emphasis on Fourth Generation Evaluation, was selected as the most appropriate methodology for this inquiry. A summary was provided of the key considerations in relation to methodology, methods, quality and ethics, in addition to detailing how the chosen methodology fitted with the study aims/foreshadowed questions, and my personal ontological and epistemological views. The vital role of reflexivity has been introduced and will be elaborated on within Chapter seven.

The following Chapter five, will provide a brief overview of the *'theory'* that was developed from the data, together with biographies of the study participants and their managers, and details of their expectations and motivations for participating on DBC LP.

Chapter Five. Introducing the 'Theory': The Five 'C's'

5.1 Chapter Overview

As described in early Chapters, the study described in this thesis, explored the experiences over time, of participants who embarked on the DBC LP, together with a number of their managers and peers, in an effort to determine if the programme was successful in meetings its original aims, and, if so, to better understand the factors that might either facilitate or inhibit such success. In order to give direction to the study, a number of '*sensitising concepts'* were used to frame a series of '*foreshadowed questions'.* These are reproduced below:

- What are the expectations and motivations of Nurses and Allied Health Professionals (participants), for undertaking the clinical leadership programme? What are the expectations of their managers?
- How do participants experience the programme? Do their expectations change over time and how do they feel that their expectations have been met? What do their managers, peers and junior colleagues notice about the participants after their experience of the programme?
- How have the programme aims been met? How do these aims fully reflect what the programme has achieved?
- What are the potential impacts following participation in the clinical leadership programme and what factors either facilitated or hindered any subsequent changes over time?
- How can the participants' experiences of the programme and/or any subsequent changes be understood using the *Senses Framework* and an *enriched environment*?
- How can any insights that emerge from the study be used to inform the development of similar programmes in differing ***C****ontexts*?

In seeking to address these questions, the study adopted a Constructivist approach informed by the writings of Guba and Lincoln (1989), Rodwell (1998) and Charmaz (2006; 2014), as described in detail in Chapter four. The study

was underpinned conceptually, primarily by the *Senses Framework* and the role that the 'Senses' can play in creating an *enriched environment* (Nolan et al., 2002b; Brown et al., 2008).

As a result of a detailed longitudinal study and in-depth analysis of extensive volumes of data, a *'theory'* was developed, that I believe provides a creditable account of the way the programme was experienced and the impacts that it had. This Chapter begins with a brief overview of the resulting *'theory'* that will be elaborated upon in the following Chapters. In addition, the Chapter provides biographies of the principle participants (DBC LP programme participants and their managers). These biographies seek to bring the participants, and their subsequent experiences, to 'life' by highlighting the factors that encouraged/enabled them to undertake the programme in the first place. This detail provides additional important contextual information that is necessary to fully appreciate the more detailed sections that follow. The concluding sections of this Chapter are based on data collected from participants, their managers, peers and junior colleagues, at the end of the programme, and will begin to consider some of the ***C****onsequences* of participating on the programme. The Chapter ends with a series of reflections on the achievement of the DBC LP aims and how they have been met or not, for participants, linking examples to the *Senses Framework*.

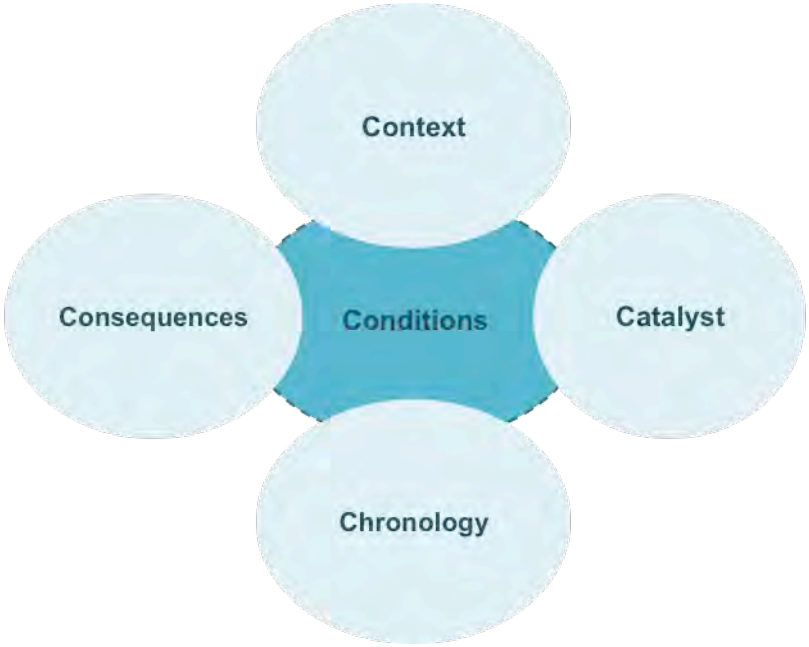
5.2 Theory overview

Two main methodological approaches influenced this study as was described in Chapter four. One was Fourth Generation Evaluation and the other Constructivist Grounded Theory. The product of a classical Fourth Generation Evaluation (Guba and Lincoln, 1989) is typically a 'case report' that ideally provides a consensus of the views of multiple stakeholders, as to the outcome of a particular, usually educational, initiative. In presenting the findings of this study, I could have generated such a 'case report'. Whilst this would no doubt have been useful, and the insights provided may well have been 'transferable'

beyond this particular study, I wanted to move beyond this goal. In order to do so, I sought to compare the experiences of current programme participants, with those who had completed the programme in previous years (Element B, see Chapter four section 4.8 and later Chapter six), and subsequently synthesise these with the findings of earlier evaluations of this and similar programmes (as outlined in Chapter three). The product of my study therefore goes beyond a 'case report' and comprises a form of 'grounded theory'. Unusually two types of grounded theory were developed in this thesis. One might be considered as a substantive theory relating to the particular programme that was the subject of my study. However, as was noted in Chapter two, because this study was informed by, and drew upon, existing theoretical frameworks, more than would typically be the case in a grounded theory study, the findings can also be considered as moving the idea of the *Senses Framework* towards a 'formal' mid-range theory. What follows below is a brief overview of the main categories comprising the substantive '*theory*' relating to the particular programme. These will be elaborated upon later, both in this and subsequent Chapters, with reference to the *Senses Framework* and *enriched environments.*

The substantive '*theory*' emerging from this study is captured by an alliteration of '**Five C's'** as outlined and illustrated in **Diagram 5.1.**

Diagram 5.1 The Five 'C's Theory



For the findings of qualitative studies to be potentially applicable beyond a particular set of circumstances, it is widely acknowledged that a full understanding of the '***C**ontext*' in which the findings were generated, is essential (Bryman, Stephens and a Campo, 1996; Boud and Walker, 1998; Firth-Cozens and Mowbray, 2001; Rycroft-Malone, 2004; Edmonstone, 2011b). ***C**ontext* therefore is the first '**C**' to be considered here.

- ***Context*** for the DBC LP. With respect to this particular study, ***C**ontext* is a multi-layered phenomenon that is best considered as comprising three elements: 'national' 'local' and 'immediate'. It is important to appreciate these varied ***C**ontexts*, as they have each shaped the programme and the findings from this study. The 'national' and the 'local' ***C**ontexts* that resulted in the development of the programme, in the light of widespread concerns about the quality of care delivered for older people, were presented in Chapter three. The 'immediate' ***C**ontext* relates to the

programme itself and those who completed it. Naturally a major influence on the success of the programme was its underlying philosophy, mode of delivery and content. These aspects were considered in detail in Chapter three, which outlined the philosophy underpinning the programme, its essential content and its delivery approach, highlighting its participative and adult learning led style.

Later in this Chapter I will provide biographies of the programme participants and their managers, as these also form an important part of the local ***C**ontext.* From these descriptions two further '**C**'s, that are integral to the theory and reoccur at various points, emerged. One relates to the factors that motivated the participants to apply for a place on the programme and what prompted their managers to nominate and support their application. These can be considered as the '***C**atalyst'* for participants undertaking the programme. The importance of a ***C**atalyst* will appear again at a number of points. The other '**C**' concerns the point in time at which the participants undertook the programme, and whether, for example, it was planned to fit in with a certain stage in their career progression and/or personal life. Another '***C***', the ***C**hronology* of events, captures this. Both ***C**atalyst* and ***C**hronology* often comprised a mixture of both *personal* and *professional* elements as does the next **C**, '***C**onsequences'.*

- ***C**onsequences.* The term ***C**onsequences* is used here to capture the outcomes of the programme at a number of levels and over a period of time. These included both the immediate and longer-term ***C**onsequences* for the: individual participants, both *personally* and *professionally*; for their managers in respect of their initial and subsequent expectations; and for participants' peers and junior colleagues. Given the focus of the programme, many of these ***C**onsequences* related to changes in the leadership style of participants, but as will become apparent, the ***C**onsequences* could extend far beyond this.

The final '**C**' comprising the 'theory' concerns the '***C**onditions'* that appear necessary for the above ***C**onsequences* to be achieved.

- **Conditions.** ***C**onditions* are perhaps the most important consideration of all and refer to what appeared necessary for the ***C**onsequences* of the programme to be as positive as possible. These ***C**onditions* will be explored primarily using the concept of an *enriched environment,* based on the *Senses Framework*, as described in some detail in Chapter two.

Having provided a brief overview of the substantive theory*,* attention is now turned to the first of the '**C'**s': the immediate ***C**ontext.* The nature of the programme itself is naturally a key part of the local ***C**ontext,* and this has already been considered in Chapter three. What follows below are a series of biographies of the participants, with a focus on the *personal* and *professional* factors that shaped their motivations for undertaking the programme and their expectations of it.

5.3 The immediate '*Context'* of the programme: Introducing the 'Element A' Participant's

The following two sections of this Chapter, consider the *personal* and *professional* ***C**ontext* of the study participants, and introduces these individuals using narratives containing anonymised biographical details, which hopefully gives 'life' to the participants and their managers engaged in the research study, and explores their motivations and expectations from both a *personal* and *professional* perspective. These were captured during Phase one of the study, at the start of their DBC LP experience. The accounts provided are illuminated through the use of participants' quotes from interview transcripts.

Often at the start of the programme, participants did not fully know what to expect, despite having prepared for the application process. This involved completing a

supporting statement and a discussion of their development needs with their manager and an informal phone interview lasting approximately twenty minutes.

The application process therefore involved detailed preparation for both facilitators and applicants, as experience over the years had confirmed that this ensured that the right programme was being applied for at the right time, for the right staff. ***C****hronology* was therefore an important consideration from the outset. The fact that over a ten-year period, the vast majority of participants completed the programme, affirmed the importance of the robust application process. This was different to other programmes within the organisation at the time.

Within 'Element A' Phase one of the study, five Nurses and four AHPs opted in to the study. The participants' managers were from the same profession as the participant, except for Emma whose manager Emily was an AHP. The colleagues (peers and junior colleagues) were also from the same profession as the participant. What follows below, is an overview of each of the programme participants, what motivated them to take part and their expectations of the programme, together with similar accounts from their managers.

Table 5.1 provides a summary of the 'Element A' participants, their managers and colleagues, who participated in the study, using pseudonyms to ensure confidentiality. Terms such as 'Banding' and specific role titles are defined within the Glossary at the start of the thesis.

Table 5.1 'Element A' Participants

Code	Pseudonym of Participant	Role and workplace	Manager's Pseudonym	Peer's Pseudonym	Junior Colleague's Pseudonym
EA01	Dave	Deputy Charge Nurse (DCN), Older People's Rehabilitation ward in Acute General Teaching Hospital	Dot		Diane

EA02	Amy	Staff Nurse (SN), Acute Psychiatry ward in General Teaching Hospital	Aria	Ali	Ann
EA03	Billy	Advanced Nurse Practitioner, Major Acute Teaching Hospital (all wards at night)	Babs		
EA04	Fiona	DCN, Older People's Rehabilitation ward in Acute General Teaching Hospital	Frances		
EA05	Cath	Occupational Therapist (OT), Learning Disabilities Services, Health and Social Care Partnership	Carol	Chris	Celia
EA06	Tina	Physiotherapist (Physio) Team Leader, Respiratory Outpatients Services, Rehabilitation Hospital	Trish		
EA07	Jane	Physio Team Leader, Paediatrics Services, Community	Jackie	Jude	June
EA08	Viv	OT, Paediatrics Outpatients services, Acute Paediatrics Teaching Hospital	Vera	Val	Vic
EA09	Emma	Community Support Worker Manager (Nurse), Health and Social Care Partnership	Emily		

5.3.1 Dave

Dave had worked for many years within Older People's services as a Band five Staff Nurse, before taking on an 'acting' position as Deputy Charge Nurse (DCN) for several months. Dave referred to himself as a '*jack the lad'* character who enjoyed work and used fun and humour to motivate his colleagues. After a period as 'acting DCN' he applied for, and was successfully promoted to the substantive post. Work and personal life were busy for Dave and balancing both was at times stressful and challenging. Despite this, Dave thought that he was ready to move on in his career and saw the programme as an opportunity to do so. Up until now he thought that he had been '*meandering in an easy job and I was refusing to go to the next level and now I have gone to the next level, I have really grasped it.'* In terms of the theory, the programme came along at just the right time for Dave (***C****hronology*), and as will be clear below, Dave's manager was of a similar opinion.

Initial expectations and motivations

Dave's expectations of the programme provided an understanding of the ***C****atalyst* that motivated him to apply. He framed these explicitly in terms of his new role and what he thought he needed to succeed in it:

'I think…. because I had taken on the band six role and I thoroughly enjoyed it and I wanted to enhance my role and increase my knowledge of leadership, increase my leadership skills, using new strategies- just to improve the ward, to improve myself. I think it's about making sure everyone feels appreciated at their work. It's about empowering everyone, I want everyone to feel appreciated at work and come to work enjoying their work.' (Dave)

As the quote above suggests, Dave was keen to learn new strategies for influencing his team and in order to do so, he recognised that he needed to become a better 'listener,' because, '*As a Band six you have to be a good*

listener if people are coming to tell you things,' and fine tuning these skills was one of his main aspirations for the programme.

Dave's manager, Dot, had similar expectations and wanted him to enhance his leadership and communication skills and to build upon his recent progress since taking on new responsibilities, especially decision making and looking beyond a clinical role:

'So you could see him making progress in the six month period in the senior role, so it was more to get him thinking about prioritising at work when you have difficult decisions to make. I want him to have more confidence, I mean he comes across as confident but he is not really.' (Dot)

She also confided that she was looking for him to be ready to take on her role when she retired, and this element of longer-term planning added an extra dimension to the ***C**hronology* of events. Dave and Dot appeared to have a supportive working *relationship* based upon mutual respect and this laid the foundations for positive ***C**onditions* from the outset.

5.3.2 Amy

Amy had worked outside the NHS for many years, in a completely different role and organisation outwith healthcare, before applying to undertake her Nursing Degree, which had always been her ambition. She had a young family and wanted them to grow up a little before she felt fully able to commit to a nursing career. Amy absolutely loved her job within acute mental health, and talked about how proud she felt working for the NHS. She was the third member from her team to participate on the programme, as her manager Aria, actively supported staff to engage in DBC LP. Aria was very positive about the programme and had supported two previous participants, as she could see the impact and benefits on the individuals and subsequently the influence on her team. Here one can begin to see an element of **Continuity** (an important

component of the *Senses Framework*) that will resurface at a number of points throughout this thesis.

Aria had recognised Amy's potential for some time, but wanted to wait until she felt that Amy was ready for the programme, both *personally* and *professionally*. Amy had also done her 'homework' and had spoken to a colleague Ann, who had previously completed the programme, before deciding to go ahead and apply. Here ***C**hronology* exerted multiple influences, both in terms of Amy's individual circumstances, and the long history of supporting the programme. This careful planning suggests that positive ***C**onditions,* likely to improve the chances of success, were in place from the outset. The beginnings of an *enriched environment* had been created over time, as the quotes below from both Amy and Aria indicated:

'Aria had said you would really enjoy this, you would absolutely thrive on it and so think about it for next year, so she didn't push it and I went back to her a few months later and speaking to Ann (junior colleague and also a past participant) about what it was all about really. So that's why I wanted to get involved really…' (Amy)

'So a year ago … the timing wasn't right for Amy (but) I think she has great leadership qualities, I think she can get people on board, she is calm in very, very difficult situations and she is open and honest and she challenges me as well which is great.' (Aria)

Initial expectations and motivations

Amy's ***C**atalyst* for undertaking the programme was the hope that it would help her to reflect on her practice by providing protected time away from the busy workplace. She believed that this would enable her to appreciate what the team were already doing well, and also to consider how they could improve on their practice for the benefit of their patients. As she had come to nursing later in life,

she also felt that she had developed numerous 'life skills' that she hoped the programme would help her to apply to her new role, and thereby increase her confidence:

'The opportunity to take a step back from what we are doing on a day to day basis and kind of think what is this all about and what are we doing here, not just doing your shift but really thinking about the impact we are having on the patients we are with. I suppose I'm quite new into nursing but I have a lot of experience working elsewhere, so I've got transferrable skills but I need to develop my own confidence in my nursing role.' (Amy)

Aria also hoped that the programme would enhance Amy's confidence, and in addition would provide her with opportunities to develop greater awareness of the 'bigger picture' beyond her clinical role. These were very similar to the expectations held by Dave's manager Dot, and also as with Dot, Aria was planning ahead and envisaging opportunities for promotion for Amy:

'For Amy I guess sometimes when you are a Band five staff nurse in a very acute clinical area, it's a challenge for you to see beyond what's immediately in front of you. But I think it's also really important that when you are confident and really comfortable in your role to start to put your head above the parapet and see what's around you and maybe start to question. So I would want her to come back with a view that actually I can do that and with a kind of, more of a career development focus in mind.' (Aria)

Developing self-belief and self-confidence in order to delegate and communicate more effectively were therefore expectations shared by both Amy and Aria. Such joint goals suggested positive ***C****onditions* existed, and these were further enhanced for Amy as she also had the support of colleagues within the team who had been past participants of DBC LP.

For both Dave and Amy it seemed that ***C**hronology, **C**atalyst* and ***C**onditions* were closely aligned from the outset and **Continuity** again emerged as an important factor. Moreover both Dave and Amy, together with their respective managers, could see the potential **Significance** of the programme both *personally* and *professionally*. Once again it seemed that the foundations of an *enriched environment* were being laid.

5.3.3 Billy

Billy was an experienced Advanced Nurse Practitioner, who worked for a number of years in the 'Hospital at Night Team' at an acute hospital. Billy recognised that he had a wealth of clinical experience and knowledge and he also enjoyed teaching junior staff and enabling others to learn, so felt that it was time (***C**hronology)* for him to develop more formal leadership skills. Like other participants, such as Dave, Billy was confident clinically; however now recognised that there was more to his role, and hoped that the programme would provide the opportunity to develop his leadership skills. The need for Billy to *'come out of his shell'* provided the ***C**atalyst* for the programme:

'I'm not very good in group situations you know, there's a little bit of me that's actually quite shy even though I can appear otherwise, so I think I need kind of bringing out of myself in that respect I think I need to do that.' (Billy)

Billy also hoped to become more confident in his *personal* life, as well as within his *professional* role. He could see the opportunity to transfer his learning from the programme to both aspects of his life:

'I see the course, it's not really just about work, you can take all the skills and thoughts that you have from these sessions that we do and kind of apply them to your own life generally. It is not just sort of this is for work, you can apply this to everyday life that's what I'm hoping it will achieve.' (Billy)

Billy's manager Babs, who was a past participant of the programme, saw the potential for Billy to develop his leadership skills, particularly in relation to emotional intelligence. As did Billy, she also anticipated that it would benefit him both *personally* and *professionally.* ***C****hronology* was therefore right for both Billy and Babs, and Bab's prior experience of the programme reinforced this for her:

'I speak to a lot of the team about it (programme) and my experience. He said he would like to take part in something to develop his management skills and I did say this was about leadership skills and being a leader and that's why I recommended and supported him going on it. I would want him to be more self-aware about himself and I know he can develop into a far more rounded practitioner and person by going on the leadership programme and add value for him and then the whole team.' (Babs)

Consequently, she had actively encouraged him to apply, confirming she would fully support him throughout the programme. Billy seemed to trust Bab's advice and opinion of the programme, and was willing to challenge himself:

'I think initially it was my manager Babs who said about the programme and was singing its praises; I've not got a huge amount of managerial experience. Babs felt this course would open doors or make me think about things differently, em so essentially that's why I came on the course to expand my horizons as it were.' (Billy)

From the three biographies presented so far, the important role of the manager and the *relationship* between the participant and their manager emerged as central to setting the ***C****ontext* for participation in the programme, both in terms of agreeing that it was the right time to apply (***C****hronology*), agreeing why the programme was relevant (***C****atalyst*), and in creating positive ***C****onditions* from the outset. The latter in particular seemed to auger well for future support both during the programme and subsequently. Babs recognised the importance of

creating supportive ***C**onditions* based on her own experience, as she described below:

'Support him by encouraging him, I ask him every week and constantly ask him how it is going. I've told him he needs to trust the process and you only get out of it what you put into it. I want to support him to do that and work out a way to enable him, keep stretching him gently nudging him. I'm lucky I've been on the programme, I know what's involved, I want to give him the time, support him.' (Babs)

This promise of active support provided the participants, some of whom were a little anxious about stepping outside their comfort zone, with a much needed Sense of **Security**, that further contributed to the burgeoning *enriched environment*.

5.3.4 Fiona

Fiona was an experienced DCN with many years *'under her belt'* working in Older People's rehabilitation services. She loved the practical aspects of her role and had focused on '*hands on'* care for most of her career, whilst also prioritising her family. She now felt the time *(**C**hronology)* was right to expand her horizons, as the quote below captured:

'Because I haven't really done much for me- it's always for other people so… so now the kids are a bit older I've got to do something for me, when you've been nursing for a long time you need to keep learning and wake yourself up again.' (Fiona)

With encouragement from her manager, Frances, Fiona now felt ready to do something to develop her leadership role. As with a number of the other managers Frances had been a prior participant on the programme and so ***C**hronology* and **Continuity** both played an active role yet again. Moreover, the

overt support provided by Frances created a Sense of **Security** for Fiona, who was keen to embrace the challenges ahead, despite not being; '*100% sure what I'm going to achieve.' (Fiona)*

Initial expectations and motivations

Fiona hoped that by developing herself as a leader she would be able to influence and support the development of her junior colleagues, who she described as being *'disengaged and task orientated at times'*. Fiona was passionate about nursing, and believed she was conscientious, but perhaps lacking in confidence. Both she and her manager hoped that the programme would enhance her self-confidence and so make her better able to effectively lead change. However, despite her experience and passion, Fiona tended to '*hide her light under a bushel'* and found it difficult to articulate her *personal* strengths as a leader, although she knew she was doing her job well. Frances recognised this and was aware of how her own confidence had been increased by taking part in the programme. This experience had helped Frances to recognise the central part played by inter-personal *relationships* in leadership.

Consequently, Frances hoped that the programme would provide an opportunity for Fiona to shift from a purely clinical focus, and in so doing, to enhance her communication skills, especially in relation to giving and receiving feedback:

'Something about gaining confidence, it's about developing her skills in feedback and change management. So giving her the opportunity to start leading some of that work herself.' (Frances)

Fiona therefore had embraced the opportunity to develop as a leader, with her manager Frances' support and permission. The importance of *timing (**C**hronology)* and readiness to learn, as well as having a supportive *relationship*

with the manager, were once again highlighted as key elements of creating an *enriched environment.*

5.3.5 Emma

Emma was a District Nurse by background, who had been promoted to a post in which she now managed a team of Support Workers within an integrated service across health and social care in the community. Along with two colleagues with the same role and job title, they had set up the new team. She described this time as a *'steep learning curve'* as she needed to meet the challenges of working part-time in a new and demanding role, whilst balancing this with her family life. The *timing* (***C****hronology)* of the programme now felt right for Emma, as she was now ready to reflect on her learning and develop both *personally* and *professionally:*

'I started as a Band six manager with a brand new team, starting up a whole new team from scratch and it was em, you know something I had never done before and also I was a Band five before so I had a little bit of leadership but was never in charge of a team for any length of time, so as well as becoming a new kind of manager, my role, my title is 'Community Support Worker (CSW) manager' em it was also setting up the new team as well, so it was all brand new and it was also a huge steep learning curve.' (Emma)

Initial Expectations and motivations

Emma was aware that her leadership style was different to her peers in that she was a quiet person, who wanted to maintain harmony in the workplace, whereas her peers were more vocal and direct in their communication styles. She wanted to develop to do the best in her role, in often challenging circumstances, working with differing personalities. Emma's ***C****atalyst* was her desire to build her self-confidence and enhance her leadership skills by developing her self-awareness and self-belief:

'I think confidence is the main thing, I did want to be able to be confident in the way I deal with the CSWs, em, I'm quite a quiet person as well so I just wanted to be able to, you know, have the confidence to go forward, speak out in meetings you know em just I think that was the main thing.' (Emma)

Emma's manager, Emily, was confident that she would further develop and enhance her leadership qualities, because she embraced new situations and opportunities with a positive mind-set and she was intrinsically motivated:

'I think just her general and positive attitude and the kind of resilience she has developed over the last year, I think that will really come through and I think it will be evident in whatever she is working with. I think she will be an asset to where ever she is because she is able to you know, yeh rise above the situation.' (Emily)

Emily clearly saw the potential for Emma to develop as a leader and wanted to be as supportive as possible, so that Emma could flourish. Given Emma's rather quiet personality, this again helped to create an important Sense of **Security** for her.

5.3.6 Cath

Cath was an OT working in a community based Learning Disability (LD) service. Cath loved her work, and her wider family life with her husband and young children were also very important. She described herself as being '*very much part of the local community'.* Achieving a good work/life balance was therefore important for Cath and she hoped that amongst other things the programme would assist her to develop her time management skills, providing an important ***C****atalyst* for the programme.

Initial expectations and motivations

As with several of the other participants, Cath's manager, Carol, had seen the leadership potential in Cath and actively encouraged her to apply. Despite this, Cath was initially reluctant to do so, not really seeing herself as a *'leader'*:

'In the initial stage it was my manager who suggested it, saying this was an opportunity – I was initially put off by the leadership part as I'm not, I didn't see myself in any leadership role and didn't want people thinking that I am bringing myself up to the ranks and going to be taking that position.'(Cath)

Consequently, Cath avoided using the term *'leadership'* when talking to her colleagues about the programme and simply referred to it as the '*Delivering Better Care Programme'*. Whilst she was aware that there might be leadership opportunities in the future, Cath's main goal in undertaking the programme was to enhance her time management skills in order to better prioritise her workload and become more efficient:

'I think part of it is being able to prioritise and part of it is being able to say no and being able to work with distractions and limit- you know sometimes I work on something and make it bigger than it needs to be so I'd like to become more efficient in the things I do and finish things.'(Cath)

Carol was aware of Cath's goals and actively tried to help her apply what she had learned in practice, to develop ways of working. Carol also had a longer-term vision in which she saw Cath taking on a more overt development role, when she felt ready to do so. An element to the extended ***C****hronology* of events was evident. For Carol those aspects of the programme that encouraged practical application of learning were a key part of its success:

'*We are looking at pathway development in various aspects of the service as we move into the health and social care Integration agenda. Em and there are*

certainly roles for Cath within that and I wanted to feel confident that she had support. I can see how it's affecting her thinking in a positive way and I'm really pleased about it. I am finding her very enthusiastic about the course and I do find she is going away and thinking about what's happened and how she can fit it into practice straight away (that) actually helps you embed those things, yeh.' (Carol)

Cath was also aware of, and much appreciated, the support she had both from her manager and the wider team of which she was part:

'The team here are very supportive, everyone has the same level of busyness so we all understand, our manager is very supportive, she is always there kind of if you want her and she is not kind of on your back as well so she gives you the freedom to get on with things.' (Cath)

For Cath, these supportive *relationships* with her manager and the team as a whole were key factors in making her feel more secure about undertaking the programme. This coupled with seeing the programme as possibly helping her to achieve significant goals, worked to create an *enriched environment*.

5.3.7 Tina

Tina worked as a Senior Physiotherapist within Respiratory Services and had many years' experience at a senior level. She was keen to support and develop her team and service, as well as build upon her *personal* leadership skills. Recent events had seen the amalgamation of a number of teams, and this had presented numerous leadership challenges, and for Tina reinforced the need for her to develop further. The *timing* (***C**hronology*) was therefore right and there was an obvious ***C**atalyst* for undertaking the programme now, as her quote illustrates:

'I had been involved in combining three services into one and I was absolutely petrified of being responsible for managing a much larger group of people than I had previously, (especially) people who had already been in the service (for some time) who weren't terribly keen on being managed differently. That potential for confrontation or disagreement were the sorts of things I was quite anxious about and I felt that coming on the course I might have more strategies at my disposal or more confidence about taking on some of those issues'. (Tina)

Despite being an experienced clinician, Tina still lacked the confidence she felt she needed to deal with her expanded, and potentially more challenging role. The fact that she had a supportive manager, who she felt able to turn to for help and advice, was a comfort for her, as was the support of a small number of colleagues that she trusted. These factors enabled her to fully commit to the programme and to feel, in her own words feel '*secure'.*

Initial expectations and motivations

Tina's manager, Trish, could clearly see the potential Tina had to develop others within the team, whilst fine-tuning her existing leadership skills, particularly in relation to self-management and communication with external colleagues. She saw these developments as being of benefit to both Tina herself and the wider service, especially external *relationships*, as this was an area in which Tina's enthusiasm sometimes needed to be 'reined in':

'Tina (has) the motivation, skills, enthusiasm to push on and has identified herself as that sort of leader within that team- the role model, the innovator, the ideas, the do-er of the actions, bringing her team along with her. I think her key areas (to develop) are her communication… not within her team; it's more with external agencies as it were. I wouldn't say her communication is a problem emm, it's hard to describe that I think it's because she is so passionate about it

at times then she vents her feelings in a way that, it's not that it's unprofessional it's just she needs to target it a bit more appropriately.' (Trish)

As with so many of the other participant's stories so far, it is their *relationship* with their manager that emerges as a critical factor in helping to create an *enriched environment* from the outset. This was something that Tina's manager was well aware of, as she recognised the importance of supporting and communicating with Tina to enable her to get the most from her experience:

'So I think she will need to be a priority and that's important for me to have that conversation with her about where does she feel it (the programme) is in her priorities and if I think it's maybe less than it maybe should, we can maybe have some conversation about that. Because it is like anything you get what you put in.' (Trish)

Tina saw the programme as providing a much needed opportunity to '*step*' back from the seemingly relentless day-to-day pressures of work, and to reflect on issues within a supportive environment, that enabled her to get off the '*treadmill and have the opportunity to take a breather and have a look at things.'*

Therefore Tina and Trish appeared to have similar expectations of the programme and saw the opportunity as a means of stepping back, reflecting and fine-tuning existing skills. The ***C**atalyst* was therefore in place, the ***C**hronology* was right and the ***C**onditions* had laid the foundations for an e*nriched environment* creating a Sense of **Continuity**, with Tina's career plans, a Sense of **Significance** for what the programme potentially provided, and a Sense of **Security** and **Belonging** with a small group of peers.

5.3.8 Jane

Jane was an experienced Physiotherapist, working with children in the community. Two years before applying for the leadership programme, Jane had taken on additional leadership and management responsibilities within the team

following the retirement of her longstanding manager. This had proved to be challenging for Jane, who described herself as self-motivated and conscientious and wanting to do her best for herself, her patients, and her team. Jane felt that developing her leadership strengths would enable her to have a clearer sense of direction within her leadership role, as although she felt confident clinically, she was less so with respect to her leadership abilities. This provided the ***C****atalyst* she needed:

'I now lead a team of over thirty staff and I am feeling unconfident about what my leadership strengths are, and I felt it (the programme) would help clarify that and help give me some direction; where do I need to be leading and helping to take this diverse group of staff who I haven't led before and a group of staff who I have led before and a group of staff who rotate in to us.' (Jane)

Jane realised that to achieve her goals, she would require considerable support and encouragement both from Jackie her manager, and colleagues, as well as her fellow participants on the programme. Unfortunately, her manager Jackie chose not to opt into the study at 'Phase one' (Jackie did opt in during Phase two however), and therefore it is not possible to include her initial expectations of the programme. Jane had tacitly alluded to the fact that there might be communication issues between her manager and herself, despite valuing her manager's support. This would suggest that some of the important elements of an e*nriched environment* were missing for Jane. This is something that will be explored in more detail later. Therefore for Jane although the *timing* (***C****hronology*) of the programme was right, and there was a ***C****atalyst* for enrolling on the programme, compared to the other participants, the ***C****onditions* were perhaps not as favourable.

5.3.9 Viv

Viv was a senior OT working in children's outpatient services. She had additional teaching responsibilities with a local University and was passionate

about supporting and enabling others, as well as influencing things at a more strategic level. Like others in the study, Viv described herself as clinically confident, and now felt that the time (***C**hronology)* was right for her to develop her leadership skills and contribute to making a difference to the wider OT profession:

'I am nearly at the end of my career and I feel I lead at the moment with a lot of the clinical stuff that I do, but I wanted to make more of an impact with the profession, taking things forward more strategically and I need the language and the influence to do so.' (Viv)

The *timing* (***C**hronology)* and the ***C**atalyst* were clearly in place for Viv.

Initial expectations and motivations

As well as wanting to increase her circle of influence, Viv was keen to enhance her self-confidence, despite her years of experience. In order to do so Viv was hoping to develop her communication skills and become more confident in articulating her ideas to others:

'I think increased confidence for me, I think success will be that I will be able to articulate what I want to do and my thoughts about how to progress things in the most em concise but professional way.' (Viv)

Viv's manager, Vera, actively supported Viv's engagement with the programme, acknowledging Viv's enthusiasm, intrinsic motivation and drive, plus her commitment to continually learn and develop her leadership strengths:

'I guess for somebody at Viv's stage of her career to still be so fresh and still be so keen to undertake new learning I think is a real, a real strength if I'm honest, Viv has been in the organisation a long time and yet she still manages to sustain that freshness and is still keen to be learning right up to whatever stage

she decides to retire, she has got that kind of mission on her certainly, which I think is a real strength.' (Vera)

It was evident that Viv and Vera's *relationship* was based upon mutual respect, and that they shared similar goals for the programme. Vera appreciated and acknowledged Viv's determination to continue to learn, and was supportive and encouraging. Unusually, Vera's expectation that Viv would develop her understanding of the wider organisation was different from that of the majority of managers, who tended to focus on the individual and the subsequent impact on the team. Vera described this below:

'The whole point is of it (programme) is having an impact on the organisation and the way we deliver services, it could be the fact you are thinking differently, you have a different perspective and that brings a new dimension.' (Vera)

Fortunately this aspiration was congruent with Viv's enthusiasm and motivation to continue to develop, and thus influence both the wider team and the organisation as a whole. Viv seemed to have the desire to do so.

5.4 Summarising the Five 'C's' Theory so far

This Chapter so far, has sought to introduce the programme participants and their managers, prior to the start of the programme and to outline their initial motivations for enrolling on the programme, and what their initial expectations of it were. In trying to understand these factors, the substantive **Five 'C's' Theory** was used, and efforts were made to begin to locate this theory with reference to the *Senses Framework* and an *enriched environment.*

The brief biographies of the participants completed the local ***C**ontext* for the programme, and described how the *timing* of the participants' applications seemed to fit in both their *professional*, and sometimes *personal*, goals and future aspirations. This highlighted how the ***C**hronology* of the programme was an important consideration. ***C**hronology* was often closely linked to those factors

that acted as a ***C**atalyst*, encouraging participants to apply for the programme. Interestingly these could also be organised using an alliteration of **C's**. Therefore, the participants were typically at a stage in their ***c**areer* (often due to promotion or taking on new responsibilities), where they were ready to move beyond a primarily *clinical* role to take on a greater leadership function. However, they often lacked the *confidence* to do so, particularly in respect of their *communication* skills.

In order to encourage participants to apply for, and subsequently enrol on, the programme, the **role of the manager** was crucial. With one exception, managers worked hard to create positive ***C**onditions* for the participants that were akin to those captured by the concept of an *enriched environment,* as created by the *Senses Framework.* Therefore the **Significance** of the programme, in terms of the participants' career stage and goals, was highlighted, and consequently they could see the **Purpose** of undertaking the programme. Furthermore, many of the managers had either previously completed the programme themselves and/or supported other staff to do so, providing an element of **Continuity**. As a result, the managers were well aware of the demands of the programme and made clear to the participants that they would give them all the support that they needed. This added an important Sense of **Security**.

On the basis of the above, it seems that at this early stage crucial aspects of the participants' experiences could be understood using the **Five C's*,*** and that for most participants an *enriched environment* was evident from the outset. The next section recounts participants' experiences of the actual programme and begins to explore the early ***C**onsequences* of it.

5.5 Participants' views at the completion of the Programme

5.5.1 Introduction

The previous sections within this Chapter have provided an introduction to, and overview of, both the programme participants and their managers and the substantive theory that emerged from the data. The latter suggested that an understanding of the 'success' or otherwise of the programme, could be gained by considering **Five C's**, these being: ***C**ontext*; ***C**atalyst*; ***C**hronology*; ***C**onditions* and ***C**onsequences*. The main focus in the previous sections was on providing a better understanding of the local ***C**ontext* for the programme, mainly in the form of biographies of the participants, together with what had provided the ***C**atalyst* for their application to the programme and how the *timing* of this (***C**hronology)* was consistent with their *personal* and *professional* situation. An early attempt was made to describe how these factors helped to create positive ***C**onditions* from the outset, using the *Senses Framework* and the concept of an e*nriched environment*. For both participants and their managers (except one participant's manager, who did not take part in Phase one of the study), the programme had come along at the right *time*, as most participants had either recently taken on greater leadership responsibilities or were thought to have the potential to do so in the future. Both participants and their managers recognised the need for participants to widen their focus beyond their clinical role, and that they needed to develop the confidence and enhanced communication skills to do so. These formed their initial expectations of the programme.

The following section is based on data collected from participants, their managers and in some instances participants' peers and junior colleagues, at the end of the programme and will begin to consider some of the ***C**onsequences* of participating on the programme, as described by these groups of healthcare staff. As the programme ran over a ten-month period, and included work-based projects, a number of changes had already occurred by this point. As will become apparent, the initial expectations of both participants and their managers were exceeded in the vast majority of cases, and changes were already evident both within

participants themselves and their *relationships* with others. In this section these changes will be explored in the ***C**ontext* of participants' experiences of the programme and explained, where appropriate, using the *Senses Framework* and the concept of an e*nriched environment.*

5.5.2 How did things go?

As noted above, participants and their managers had expectations that taking part on the programme would enable participants to look beyond their clinical role, and develop the confidence and communication skills necessary to become more effective leaders. From their impressions at the end of the programme, this certainly seemed to have been the case, with many participants feeling that they had developed their communication skills, and that the programme had provided them with a new set of 'tools' to enhance their leadership qualities. This is considered below.

Emma wasn't quite sure what to expect at the start, however her insights evolved over time, something she put down to the way in which the programme was structured:

'I think the course exceeded my expectations; I didn't really know what to expect. It was almost like it was, it was a slow, growing process (laughs), I felt that you didn't necessarily get it straight away, but as the days, each month went on, and as a whole em it really does make sense, yeh.' (Emma)

Similarly Jane stressed that the new insights she had gained and, as with Emma, attributed these in large to the way in which the programme was organised and delivered:

'Em I think they (my expectations) have been met, I wanted to have a bit more in my tool box about, you know, about different aspects of leadership em to make sure I was kind of up-to-date with leadership thinking. Em and just to

have some time to reflect on my leadership style and to yes to learn a lot more about myself which has really helped so there were some light bulb moments. And also spending time with very skilled facilitators and also a peer group em and having that ability to discuss with them.' (Jane)

Many participants described the programme experience as 'different' to other courses and programmes that they had encountered, in that it was less formal and didactic, and more open, encouraging, thought provoking and inspiring, which they had appreciated:

'I really appreciated how it's (the programme) kind of not strict in a way, not like in the NHS when you need to do this this and this… it's open and em thought provoking and it eh makes you think in a different way and kind of inspires you to be open to things. In that sense it's a bit different to any other courses I have been on, you know, it's good, good.' (Emma)

This did not happen by chance, and the facilitators worked hard to forge individual *relationships* with participants early on within the workshop settings, which enabled a Sense of **Belonging** and **Significance** to be created. Consistency in the approach to facilitation was underpinned by the *Senses Framework,* which also helped to create a Sense of **Continuity.** In addition, the programme was deliberately structured to provide the time and space to allow participants to step back, reflect and try out new approaches with a diverse group of like-minded and motivated leaders from across the organisation. This seemed to add to their Sense of **Security** and **Belonging,** as both Tina and Pat described below:

'It's a nice mixed group as well, it's people doing very different jobs too that's been helpful to build a support network. Spending time together, doing a project together, it will strengthen links and support too. So pause and think about things.' (Tina)

'I really liked the fact it was a diverse group, lots of different specialities, lots of different hospitals, lots of different grades, Bands 3-7, everybody has a part to play. I remember again you saying leadership isn't about what level you are at and I really took that on board. I loved the difficult conversation work we did and also the Emotional Touchpoints. I liked them because they worked for me and eh, and they are things I can use relatively easily. I really enjoyed when we had break out groups, everyone had different opinions and there is an impact and that can sometimes be hard but it felt really safe and nobody was judged.'(Pat)

Once again this was a carefully planned part of the programme, allowing a safe space for participant's voices to be heard, and facilitators role modelling how to create a Sense of **Security** and **Belonging** from the outset, enabled participants to forge close *relationships* quickly. These relationships developed and evolved over time so that as Jane noted, '*It's absolutely an enriched learning environment...'*

As a ***C****onsequence* most participants felt safe and valued within the programme, and were subsequently able to develop and support others within the group; skills that they were able to take back to the workplace, as will be demonstrated later. Creating the right ***C****onditions* not only enhanced participants' enjoyment of the programme but also was evidently conducive to learning, as Dave recalled:

'I just always remember that period of being one of the happiest periods I have done in nursing. Because it was such a positive environment and people just, they just light up, they just suddenly you know, everything is so interesting you know and when you start to go through all the dynamics etc em you learn new skills, you think about new skills'. (Dave)

The experience of reflecting on existing leadership skills and tools, whilst considering areas for development and new learning opportunities, contributed to the participants' growing self-confidence, further enhancing a Sense of

Purpose and **Achievement.** The pride that participants felt is well illustrated by Tina and Amy:

'When I look at where I am now and compared to twelve months ago I do think I have had quite a big sea change in terms of confidence and self-belief and when I look back I think yes I can do a much better job now, yeh'. (Tina)

'Just accepting these are things I am really good at and that's a definite shift. I was maybe reluctant to do that but now I am proud of it actually and I feel like I have done really well and I am chuffed to bits!' (Amy)

As with several of the participants, Viv found that participating on the programme enabled her to affirm what she already knew and she was subsequently better able to reflect upon how she could use her skills to enable and develop others. This added to her confidence:

*'I think that has been absolutely fascinating both in terms of learning from others and actually appreciating how much I do know and how much I can support and help others as well. Being able to understand what I've got inside me and what I can give to other people. Probably I'm definitely more confident in **how** I am em approaching things but also **how** I am articulating, you know, what I am doing, how I am doing it.' (Viv)*

Cath also seemed to embrace the development opportunities the programme provided, and this too helped her to recognise her strengths as a leader and see the potential to enable others. Again this was a boost to her confidence:

'*Realising that I am a really good leader and I feel like I am, and I feel I can see that in other people and I really want to just kinda help other people identify that in themselves.' (Cath)*

Viv reiterated the points made earlier in the Chapter, that being given the *time* and permission to develop and subsequently implement their learning, enabled the participants to feel valued and **Significant.** The opportunities for networking and learning from each other's stories seemed to be well received and impactful:

'It was actually being given that time because we were very lucky em you know, we were afforded that time, so it I suppose felt like we were being invested in and since we have come back as well you know we have been given things to do and we have been doing more within the department as well in terms of some of the leadership and more senior level eh em activities as well. I think it was also that time to actually meet people outwith your department as well, listen to other's lives as it were and we all know in NHS Lothian that you know, individual stories are very, very powerful that's how we learn.' (Viv)

The flexible application of learning to practice and the opportunity to implement small changes within the workplace in between the workshops reinforced learning and helped participants to practice their burgeoning skills and confidence within a relatively safe space. Participants also valued this incremental approach, as Dave described below:

'So we have done a lot of 'right let's try this out and see how it goes' and again that's something that stuck in my head as well and that's been good because I wouldn't have known how to organise that before. I would have steam rollered in 'right let's just bang it out' rather than thinking, no let's take a wee bit at the moment, let's not jump in too fast, eh so that's helped you know, definitely.' (Dave)

Of course this level of flexibility would not have been possible without supportive managers. So far, I have considered how the programme was purposely organised; aiming to create an e*nriched* learning *environment* for participants, and the data would suggest that these ***C****onditions* were highly

important. However, this would have been of little avail if the clinical environment and leadership culture were not receptive. It is here that the managers' role became evident. As with the participants, most managers felt that their expectations of the programme had been met.

Managers' expectations generally were similar to those of the participants themselves. Several managers had been a past participant of the programme or had acted as mentors for other participants, and so had a good understanding of the demands the programme made. This of course influenced their expectations and alerted them to the type of support that they could provide. Despite this familiarity, all the managers, except for one, felt that their expectations had not just been met, but exceeded. Most were delighted and in many cases proud of the participant's achievements. They described how participants had become more proactive and were better able to see the wider organisational picture. They noticed that this was often a gradual development over the duration of the programme:

'I think a gradual kind of em awareness of kind of bigger picture stuff, so I think before she went on she was focused on her job and her team and doing that to the best of her ability, but gradually as the months went on…em much more like putting herself up for stuff, and again she is much more proactive in that way.' (Emily)

Enhanced personal qualities and communicating effectively with others were observed as significant developments, something that the participants had themselves recognised. Managers who encouraged flexibility in the application of learning to practice and created opportunities for participants to influence, helped participants to further develop their potential:

'I think it's important that actually, that for those that I am encouraging to go on other cohorts or the team leads that they really get them to understand that so, em that actually at the end of this it's not like you've just got a new skill, it's

about how you use all the things that you have learnt and flexibly put them into different little small bits or big bits of your work streams em and set them up for it at the beginning.' (Trish)

The ability to manage challenging situations within their team was also perceived as a successful achievement, by both participants and their managers, as Emily described of Emma below:

'Em, she is definitely more confident in herself and in her abilities and Emma has a particularly tricky work colleague and I think prior to the course she found it really difficult to manage this individual, whereas now she is really able to separate out em kind of fact from opinion and she knows what she is good at and she knows what areas to develop but she has a much stronger sense of identity and really it gave her a kind of gave her a confidence boost so yeh yeh. I definitely say she is much more self-assured.'(Emily)

Presenting their project work at the final celebration workshop was a pivotal moment for many participants, as it served to affirm their newly enhanced self-confidence, self-belief and self-esteem, and added greatly to their Sense of **Achievement** and **Significance**, despite initial anxieties at the start of the programme. Most of the managers described how valuable and important it had been to attend and support the participants at the celebration workshop, especially when for many participants this was their first time ever, public presentation. Seeing how their nominee had developed, reinforced how successful the programme had been for many managers, and also the importance of providing participants with their support, as well as highlighting the support participants gave to each other:

'I think in terms of attending the celebration events where they present their projects, I've attended two of these and supported both of the staff and not only in terms of great projects, it gave me a real sense of what they have delivered

on and I think it was really important for the staff to see me there and taking a real interest.' (Trish)

*'So I've been at a couple of the days at the end, (*the celebration days*) and there is a sense of when you walk into that room, I think there is a bit of love for each other, do you know, you have that sense for them all that, especially when they are doing their you know their presentations, everybody is completely rooting for them so I think that's a really nurturing environment you know. So there is something about, right ok well I'm, I'm being invested in, there's an investment in me here so does that mean that I'm valued.' (Aria)*

Data gathered from a sample of the participants' junior colleagues and peers, reiterated and affirmed what has been described in the sections above. Ann, a junior colleague of Amy, had herself been on the programme and had recognised Amy's development as a leader:

'Em, well she obviously progressing onto her new role, her leadership continues to grow, her leadership skills, em, she is really encouraging, em you know she is kind… so supportive em, and yeh really em caring and compassionate!' (Ann)

Similarly, Jane's junior colleague June, had noticed something different in Jane's leadership style and communication, however she was unsure as to the reasons why. Jane had not informed June about her participation on the programme until she invited her to participate in this research study. On reflection, June began to realise that her participation on the programme could possibly explain Jane's recently changed approach:

'It was just a subtle change I saw, it was probably in her you know just her body language, her whole persona really, and then when I found out she was doing this I thought of my goodness, you are becoming a, don't want to say a better manager but more for managing people.' (June)

In addition, the programme can be seen to have been successful because it was consistent with the participants' *professional* (and to some extent personal) circumstances at the *time* ('***C**hronology'*). Managers again played a key role in this, by encouraging and supporting participants to attend at the appropriate *time* and recognising that they were ready to develop and enhance their effectiveness as leaders. The programme was often referred to as a 'platform or a springboard', which came along at the right *time* both for the individual and the organisation, such as a promotion, or new teams merging together and colleagues being open to change and willing to engage with new ideas and learning. This suggested both *personal* and *professional* elements to *timing*, which subsequently enabled continued development, particularly of *personal* leadership qualities such as self-confidence and self-belief, and on-going learning, which was beneficial during role transition within a promotion.

Consideration was required by participants in collaboration with their managers, in relation to when and at what point in the individual's career would be most appropriate *timing* to participate on this particular programme, to enable them to fully commit and engage in all programme activities. This was discussed at the phone interview and applicants were asked specifically '*what makes this programme the right one for you at this time*?'

Getting the *timing* right enabled participants to reflect and develop a clearer Sense of **Purpose** and direction within their role. Some managers clearly had given this thought prior to supporting the participant's application, as Babs and Aria illustrated below:

'So the programme comes at a pivotal time for him and I think it will be one of the few factors which will see him emerge as a butterfly- and I think nobody is perfect and I don't want Billy to be perfect that would be odd, but I think success would mean he was a bit more considered, able to contribute more to the team, open to more suggestions, modify his language.' (Babs)

'I wanted her here in my ward and then I just felt the time was right for her because she has been in acute psychiatry now and when you come into acute psychiatry it takes you a wee bit of time, cos it's busy, it's busy busy so takes time to adjust. So the year prior to that, I sent somebody on it, the timing wasn't right for Amy so, come back to why did I support, what did I see in her? I think she has great leadership qualities.' (Aria)

Another aspect of *timing,* which emerged as important, was the longitudinal element of the programme. The DBC LP was delivered over a significant period of *time*, ten months, which created a Sense of **Continuity** for participants, through having the workshop experience on a regular basis, and allowed the supportive *relationships* amongst the group and facilitation team to develop over *time*. This longitudinal feature of the programme also enabled a flexible delivery and facilitation approach, which was tailored to the needs of the group. Participants seemed to appreciate having the consistent protected space and *time* to reflect on their experiences of applying the tools to practice and stepping away from the busy workplace in order to learn as part of a group of like-minded leaders.

The length of the programme was an important factor within the initial design of DBC LP and on-going evaluation provided evidence to support the continued ten-month timeline, as the question was often raised in the organisation about shorter and more frequent programmes being an alternative option. Participants and their managers recognised and committed to the development opportunity over *time,* which they described as enabling and embedding the application of learning to practice.

Feeling valued and that the organisation had invested in them by supporting their participation in a ten-month programme, were also enabling factors to participants fully committing and engaging in the programme and beyond. For many participants and managers they expressed their realisation that taking

time to reflect and develop over *time*, would potentially sustain any impact and development they achieved, as Emily shared below:

'I think you need that time and the time in between just to reflect and especially someone like Emma she really does reflect and she uses that time well em and so I think if you tried to put the same amount of content into three months I just don't think it would work the same way. I mean it would work a bit but I don't think it would have the same, em that same impact because it's kind of reinforcing themes, so you go back every month and go oh yeh so I think the timeframe is key.' (Emily).

Participants accepted that although they aimed to test out the tools within the workplace, they were also required to undertake some of the self-reflection and self-directed activities within their own *time*. They were their own gatekeepers on this and self-managed according to their priorities and flexibility:

'A fair amount of that in your own time, and I managed to squeeze a little bit in my work time but it was mostly done in my own time. So again it was that extra pressure and management, but I think I very much feel the benefits outweigh any negatives and I have said to a few people this is really good and you get out of it almost what you need. It's not, you know there is no prescription with it it's like, the course will be flexible depending on the needs of the group, but actually it's just a really, really good positive thing to do, so, and it's local so you don't need to get funding for it or overnight stays if you are going somewhere else, it's local and because it's spread over the year I think it is manageable with your work.' (Jane)

5.6 Summary of how the Five C's Theory has illuminated the participants' experiences

To conclude, data collected at the end of the programme (Phase two) would suggest that initial expectations of the programme had been met and in most cases exceeded, for both participants and their managers. Self-belief and self-

confidence had grown, and both participants/managers felt that they (participants) had developed in their leadership skills and abilities. The ***C**onsequences* at this stage were therefore very promising, and this can be understood largely in terms of the ***C**onditions* that had surrounded the programme. The structure of the programme and its mode of delivery had worked to create an e*nriched* learning e*nvironment*, in which participants felt a Sense of **Security** and **Belonging** from the outset. This was enhanced by a Sense of **Continuity** provided by skilful and consistent facilitation. As the participants got to know one another over the course of the programme, their close *relationships* further e*nriched* the learning e*nvironment.* The practical elements of the programme created a **S**ense of **Purpose** and **Achievement**, that allowed participants to practice, and reinforced their developing skills, building their confidence further. The presence of a supportive manager was also an essential consideration, creating an e*nriched* clinical e*nvironment* within the work setting. Importantly participants of the programme seem to have been purposively selected because it was the right *time* for them (***C**hronology*).

So, it is becoming clear that a number of factors needed to be in place for the programme to be of optimum benefit, and that these can be largely understood using the **Five C's.** In this section of the Chapter the main focus has been on the importance of ***C**hronology* and in creating the necessary ***C**onditions*. If these factors are in place, then the early ***C**onsequences* appear to be very positive. Whether these can be maintained over time is the focus of the next Chapter.
Before moving on to these latter ***C**onsequences,* it is interesting to reflect upon whether the data would suggest that the initial aims of the programme have been met. These are considered in **Table 5.2**:

Table 5.2 Reflections on the Achievement of DBC LP Aims

Programme Aims	**Has this aim been met by all participants?**	**How the aim has been met / what factors supported this? (*Personally* and *Professionally*) What *Conditions* have been created to enable this to happen (or not)?**

Develop their personal qualities and skills as transformational compassionate leaders	**Yes**- all participants shared examples of developing *personally* and *professionally*, which was affirmed by their manager and often their peer or colleague	• Development of personal qualities such as self- awareness, self- confidence through self reflective tools and discussion within workshops *(Sense of **Significance, Purpose** and **Achievement**)* • Through the development of effective *relationships* with manager and teams (*Sense of **Belonging** and **Achievement***) • Through supportive conversations with manager *(Sense of **Security** and **Significance**)* • Through right *timing* for engagement and participation in programme activities (*Sense of **Purpose**)*
Work with others on the programme to exchange ideas, build upon expertise in the group and develop collective leadership and practice	**Yes**- evidenced by feedback from participants following work based activities and projects	• Through participation in a range of interactive workshop activities and projects (*Sense of **Achievement** and **Purpose**)* • Engagement with current and past participants, through shared learning experiences *(Sense of **Belonging** and **Continuity**)*
Develop an increased understanding of compassionate, safe, person-centred and *relationship-centred care* and actively use these concepts within	**Yes**- participants shared examples of applying tools within their roles and through engagement with teams to gather feedback/stories from	• Through personal reflection on practice, through feedback from manager and peers (*Sense of **Achievement** and **Continuity**)* • Through application of tools to practice and within project (*Sense of **Purpose** and*

their role	patients and service users	***Significance**)*
Develop skills of using an appreciative inquiry approach to quality improvement	**Yes**- observed when sharing learning at celebration workshop and when giving feedback to each other following work based activities	• Through participation in work based activities and project *(Sense of **Purpose**, **Continuity** and **Achievement**)* • Through shared learning experiences within the workshops and with Quality Improvement (QI) teams (*Sense of **Belonging** and **Achievement**)*
Develop skills in engaging members of their team and leading a small test of change	**Yes**- participants demonstrated engagement with teams when sharing stories and presenting project at celebration workshop	• Through undertaking work based project and engaging teams *(Sense of **Belonging** and **Achievement**)* • Through self reflection in leadership role as role model and enabling others in caring conversations (*Sense of **Security** and **Significance**)* • Through presenting project at celebration workshop (*Sense of **Significance** and **Achievement**)*
Develop a working understanding of policy that relates to quality in health and social care	**Yes**- illustrated in project work and conversations about their role within the wider organisation	• Through understanding and seeing the bigger picture and how that relates to their role (*Sense of **Purpose** and **Significance**)* • *Personal* and *professional* development in approach to contributing to the organisation's objectives- through enhanced

		awareness of proactive approach, understanding and knowledge *(Sense of **Achievement** and **Significance**)*
Share their learning and development and celebrate success	**Yes**- All participants shared how impactful they had experienced the presentation of project and their learning	• Through successful presentation of project and learning to peer group and managers *(Sense of **Belonging**, **Achievement** and **Significance**)* • Through feedback at each workshop and sharing of stories in relation to applying tools and learning to practice *(Sense of **Significance** and **Achievement** and **Continuity**)*

In conclusion, the data from this study does suggest that the aims of the DBC LP had indeed been met. The following Chapter explores whether or not the early ***C**onsequences*, which have been highlighted so far, are in fact sustained over time or not, and if so, what are the enabling and hindering factors.

Chapter Six. Findings: *Consequences* over time, *Conditions* created and a *Catalyst* for change

6.1 Chapter overview

The preceding Chapter provided an overview of the substantive theory that lies at the heart of this thesis. This theory comprises **Five C's** that together provide a better understanding of participants' experiences of the DBC LP by exploring the: ***C**ontext* for the programme; the ***C**atalyst* that encouraged participants to apply for the programme; the extent to which the programme *timing* was consistent with key points in the participants' *professional* and/or *personal* lives (***C**hronology*); the ***C**onditions* that surrounded the participants' application and; what the ***C**onsequences* of the programme might be. This overview was followed by brief biographies of the participants and their managers, which completed the local ***C**ontext* for the programme, by considering their reasons for applying for the programme (***C**atalyst*) and what their initial motivations and expectations of the programme were. It was also suggested that the **Five C's** could be understood using the *Senses Framework* and the concept of an *enriched environment.* Subsequently, the participants' experiences of the programme at its completion were explored and the early ***C**onsequences* described.

The data suggested that the programme *timing* was important and often coincided with key recent events such as a promotion or reorganisation of services. The participants themselves often felt that they were 'ready' to move on in their careers and to consider taking on a greater leadership role. These factors provided the main ***C**atalyst* for the participants. Their managers usually agreed and actively supported their application, fully aware of the on-going support that the participants would need, in order to get maximum benefit. A number of the managers had either been on the programme previously and/or supported other colleagues to do so. This served to create a relatively *enriched environment* from the outset. Both participants and managers had similar

expectations relating to the need for participants to move beyond a clinical focus and develop their leadership skills. In order to do so there was a need for them to increase their confidence and to improve their communication skills.

The participants, their managers and other colleagues were interviewed at the completion of the programme (Phase two of the study), to tease out their experiences, and to explore if their initial expectations had been met. There were clear indications that the participants had enjoyed the programme, and the participants and their managers reported considerable gains, in both their confidence and communication skills. These were the ***C**onsequences* that both groups had wanted. The facilitators had worked hard to create an *enriched environment* in which participants experienced a Sense of **Security** and **Belonging,** early in the programme. This was reinforced by their managers, who in the main provided the support that the participants needed. The ***C**onditions* were therefore very positive and this enabled participants to achieve maximum benefit.

These early data suggested that the programme was successful in meeting its aims, as described in Chapter three, and that the **Five C's** theory provided a useful explanatory framework, especially when interpreted using the '*Senses'*, to consider how an *enriched environment* could be created. However, I wanted to go beyond this and to consider if any initial gains could be maintained and built upon, and if so, what factors helped to promote positive ***C**onsequences* in the longer-term. That is the purpose of this Chapter, which considers the data from Phase three of the study, in which participants, managers and a range of colleagues were interviewed one year after the programme had been completed. These data help to tease out the longer-term ***C**onsequences* of the programme, for the participants themselves, the teams with whom they worked, and in some instances for the wider organisation. In addition, the ***C**onditions* that appeared necessary for positive outcomes to be maintained are considered, again drawing on the *Senses Framework* and the part it played in helping to create an *enriched environment*.

In order to provide further depth, this Chapter also draws upon data collected from the 'Phase one Element B' participants, whom had completed the programme up to eight years previously. Particular attention is given to their experiences of the longer-term ***C****onsequences* of the programme and ***C****onditions* they considered necessary in order to promote these. The next section of this Chapter begins with an overview of the main ***C****onsequences* of the programme for participants, twelve months following its completion.

6.2 Longer term *Consequences* of the programme.

6.2.1 Improved self-confidence

One of the main ***C****atalysts* for both participants and managers of enrolling on the programme was recognition that participants needed to improve their self-confidence and communication skills if they were to become more effective leaders. Data collected at the end of the programme suggested that early, but significant gains had been made in these areas and the interviews conducted twelve months later indicated that these gains had not only been maintained but also actively built upon.

Improved self-confidence and its subsequent impact on participants' leadership skills were described by all the participants and reinforced by the views of their managers and colleagues. Much of this was due to improved communication and the participants' new found abilities to be both more proactive and reflective. By reflecting on their leadership styles and strengths, participants were better able to address difficult situations in the workplace that they previously would have avoided, such as dealing with challenging colleagues and conflict situations within the team in a more assertive and less threatening way. Tina captured a flavour of this:

'So I feel much more equipped to em sort of face up to challenges and not get quite so em nervous and worked up about how its gonna go… I think I am

better at being em able to say what I want to say in a way that doesn't sound as if I am either so nervous I can't even get to the point or I am so annoyed that I just sound like Mrs Angry. I would say that's probably been my biggest learning over the last twelve months.' (Tina)

Such an approach often resulted in improved *relationships* within the team, as Jane described:

'I would say the things that I have really changed in is that confidence and that those interpersonal skills and that knowledge that I need to build relationships and you know have those effective conversations day to day…I've got two or three (colleagues) that are particularly difficult and whatever I say it's a negative something back from them and I am just learning to not take that personally and I am trying to find ways to turn it around.' (Jane)

The importance of building good *relationships* based on being confident to 'be yourself' was similarly recognised by Emma:

'I just em I think most notably it's just allowed me to realise that I can be myself and be the way that I am and that's ok and em have the confidence em to deal with people in situations. I can make new relationships with new people, I can easily give ideas or opinions on things.'(Emma)

Emma's manager, Emily, who had also been a participant on the programme in the past, recognised how they had both grown, stated that *'I see Emma and I both really benefitting from it and I think it's great… yeh!'* This suggested longer-term benefits for past participants too, something that will be explored later.

Many of the participants noticed a change in how they addressed potentially difficult situations and became more proactive in dealing with these before they escalated. To do so they often used some of the 'tools' that the programme had introduced them to, as captured by Cath:

'I would normally have shied away from difficult conversations and conflict with colleagues and (now I'm) thinking, no we'll just, we'll deal with this and it was pulling on some of the tools and it was very much the transactional analysis and knowing the place that this person comes from and dealing with it rather than taking it in a very personal way.'(Cath)

Enhanced confidence and a greater awareness of what made each practitioner 'tick' as a leader were other valued and developed skills, as Viv highlighted:

'As a leader (knowing) what makes me tick you know, what kind of leader I am, but also (what) my triggers (are) as well because being more aware of them is you know (helpful), you are more prepared eh for being in a situation you know…' (Viv)

Viv's manager Vera, affirmed this enhanced self-confidence and had also noticed that Viv was more aware of the bigger picture and had developed her ability to self-reflect, which had influenced how she engaged and enabled others in the team:

'I have seen her being more reflective, knowing who she is herself and how that then influences others… that kind of wider awareness of not just your own landscape but kind of landscape around you in terms of you know, policy, political and all of that side of things.' (Vera)

The programme also seemed to have helped move participants towards a greater realisation and acceptance of a leadership role. It will be remembered that Cath had initially avoided referring to DBC LP as a 'leadership' programme as she did not see herself as a leader. However as she developed her self-confidence, Cath felt more able to embrace leadership opportunities, and was more aware of what she had to offer, which was also confirmed by her manager Carol:

'I'm kind of leading on a lot of things, I feel more confident about stepping up to take a bigger lead on a piece of project work or something. I'm bringing my own level of expertise that you know they don't have and recognising that and thinking actually the stuff that I'm bringing they're not bringing to it.' (Cath)

'Well I get accurate feedback and I get her opinion of what she thinks has happened or direction of travel and because I think she is more confident in herself that comes over well and I feel I can rely on her skills in that area.' (Carol)

Billy, who had wanted the programme to challenge his thinking, also reported his expectations as still being met a year later, with positive consequences:

'I think what I'd been lacking is confidence and this course has kind of sparked me back and it challenges you (and your) perspectives and makes you expand on things.' (Billy)

Improved self-confidence also helped participants to become more organised as well as enabling them to see the 'bigger picture' beyond a clinical role. Their managers, for whom this had been an important expectation from the outset, appreciated this, as Carol illustrated:

'I think what I see is she is more organised and more in control of her day to day and her planning. She is very good at deputising for me now, (and is) beginning to consider the more strategic level. She offers more confidence and I have more confidence in her having a bigger view, more of an overall view.' (Carol)

As suggested in the quote above the programme had also helped participants to develop greater self-awareness and this was widely recognised as an important ***C****onsequence* twelve months after completion of the programme.

One of the important lessons that participants had learned was a greater acceptance of their limitations, and the realisation that they could not be 'perfect' all the time. Setting realistic expectations, was seen as a significant **Achievement** by many participants, as Jane reflected:

'*You can't do everything, em and you can't do everything to exactly perfect standards all of the time so sometimes good enough will do and that we need to not beat ourselves up when, it's good enough, because actually most people are happy enough with good enough em and actually good enough is still really, really good.' (Jane)*

Jane went on further to reflect that because she was now happier within herself, she was better able to appreciate what was realistic for others and that this impacted significantly on how she interacted with the rest of her team:

'So I guess it's about taking the knowledge that you have about yourself but actually applying it, em and probably being a bit gentler with people, em which I guess is that bit about building relationships and interpersonal skills em… I don't mean to be and it's not really me but I (can) come across as being quite harsh, and I (sometimes) don't give people a chance to think. So I have learned to kind of give myself that time to reflect and then think about how do and I say in my response.' (Jane)

This ability to be more self-reflective and think about the impact of your response to the reaction of others, was a major ***C**onsequence* of the programme, and its influence on the ways in which participants were more skilled at enabling others, will be considered shortly. Before that attention is turned to some of the longer-term *personal **C**onsequences* of the programme for participants.

6.2.2 Longer-term Personal Consequences

So far, the positive ***C**onsequences* of the programme at a *professional* level have been quite clear. In addition however, for some participants the programme had a beneficial impact on a *personal* level. Some of these impacts were on their careers, in terms of promotion, whilst for a small number, their improved self-confidence and self-awareness influenced their personal lives outside of work.

With regard to her *personal* career development, Viv described how in a recent interview she had actively drawn upon her learning from the programme:

'But I tell you a lot of well what I took from my leadership course (informed) how I managed myself at interview based on I suppose, a lot of what I'd actually picked up and you know used and have been using since we spoke last. ' (Viv)

Viv was not alone, four other participants from Element A had gained promotion and one had taken on a new role since they completed the programme. For one participant in particular, Billy, the programme had also helped him to deal with a difficult period in his *personal* life and to move on both in work and in his home life, as he described:

'I think it (the programme) has had a big impact on me personally – certainly when I started the course my life was an absolute horror show you know, I was still living with an ex-partner and that was a really bitter breakup, selling a house, a lot of trauma going on there and also my depression going on there as well so a lot, like I was really struggling and the course really helped me with that. So the course helped me, em like certainly improve things if that makes sense and I felt it was certainly quite supportive in certain aspects of my life, I think it impacted more on my personal life than my professional life but you know and that's much more difficult to quantify, my personal life is much more complex, I found it a really useful and supportive course.' (Billy)

None of the other participants described anything quite like this, however Billy's experience of finding that the programme had positive ***C**onsequences* beyond work was not unique, as will become apparent later when the previous (Element B) programme participants are introduced.

Having so far focussed primarily on the positive ***C**onsequences* of the programme on the participants' self-confidence, attention is now turned to the effects of this on their ability to enable others within their team; a key leadership skill.

6.2.3 *C**onsequences*** - Enabling others

One of the positive longer-term ***C**onsequences* of the programme, the effect it had on participants' self-awareness and the way that they interacted with others, has already been noted. This section expands upon this and considers how participants subsequently worked to create an *enriched environment* for their team and how this in turn enabled the team to grow and develop. This empowered participants to delegate more effectively, and thus allowed more opportunities for their colleagues to grow. This was noticed by managers such as Jackie, who saw a shift in the ability and willingness of participants like Jane, to delegate more effectively and work collaboratively with the team. Jane herself had affirmed this with a particular focus on developing good interpersonal *relationships*:

'One thing I think that maybe has come out of it is, is the sort of recognition that she (Jane) can't do everything herself em, so there is perhaps a bit more trying to include the Band sevens, all the senior staff and task them with things, I think that's a thing that perhaps has improved in that I think previously she thought 'well I am now the leader of this team therefore I have to do everything', em, so that's better.' (Jackie)

'I think I am probably more reflective with them (team) em and I think I've been more vocal about sharing that with my colleagues, you know, I've tried to do more joint working with people because I think it's probably a really good way of sharing my skills and knowledge clinically you know, but also, it's that kind of personal bit…the inter-personal skill bit that's really important you know.' (Jane)

Jane's junior colleague June, had also noticed changes in her, especially her '*human approach':*

*'Yeh because I had just noticed and it had been in my thoughts a few months before that, thinking she is really doing well with… managing the team and I just noticed a, just a change in her, you know, just her communication skills em just really across the board if that makes sense. I think she is a bit more calm and I don't mean it to sound bad but she was… she is just more tolerant and I think she i**s** easier to approach, she has maybe got more of that human approach.'(June)*

A number of managers had noted changes in the participants' leadership approach, such as Trish, who thought that Tina was now more considered, confident and proactive when interacting with others in the team:

'Well I would say maybe em subtlety of approach, you know a couple of years ago em Tina would maybe kind of em kind of throw herself full on into em into a response of a situation that might have some constructive criticism attached to it and would be slightly defensive in her approach, whereas I think her way now is much more subtle in you know 'think about this, you know actually you know' rather than being as defensive or as outspoken.' (Trish)

Many of the participants who had recognised the importance of a supportive manager in creating an *enriched environment* for them, now began to realise that they needed to do the same for their team. Viv captured this below:

'The other thing I am pretty interested in at the moment which is important, is the more sort of mentorship supervision side of things because people will be a little bit more dispersed, within the team as well, making sure that eh everybody is feeling part of that team, they are feeling valued and what have you so really it was very much about team-working, teambuilding, you know these are skills that I have used this past year and see as something that I will be developing further as well within the team.' (Viv)

As participants began to reflect more actively on their role, they realised the importance of helping the team to develop greater self-awareness and that as leaders they needed to model calmness, engage more effectively with others and build *relationships* within their teams. Emma for example, talked about feeling more comfortable at engaging with others and Jane too felt more able to provide leadership and to recognise the need for and to motivate others to change:

'I am (more) capable of making people feel at ease em eh and I think that's quite useful, I'm calm. It's different to what, how I was doing before I was on the course.' (Emma)

'So I feel much more confident trying to help lead and guide people, I've got lots of sort of mini and bigger projects going on throughout the whole of the service and I think there are probably still some areas that we are missing em that we could improve on.' (Jane)

Participants clearly enjoyed investing time in developing their team and this created a Sense of **Achievement** for them:

'I feel it's taken this long to get the team working altogether and I want to enjoy that feeling and that enthusiasm, people coming with ideas and things and em being able to support them to take things on yeh.' (Tina)

Colleagues of the participants also appreciated this, and found the positive leadership they were now experiencing, energised and motivated them, as June and Val described below:

'If you have got someone who is leading you, you are motivated and you know they are really good at their job and everything, and I think that should have an effect on a team you know and it can only lead to more positive…happy working experience as well, really when you are, when you are all kind of, it makes you pull together more I think.' (June)

'She just, she never fails me in how she has a really creative idea of doing something so I think her flair in creativity and engaging people and it was a great meeting and everyone came away buzzing.' (Val)

As is clear from the above, junior colleagues and peers also recognised how the programme had brought about positive ***C****onsequences*, as Ann described of Amy, who was recently promoted:

'I think that is like I say a lot of her qualities are… amazing qualities and I think a lot of them are engrained, but the programme will have definitely em helped her develop, because it's different when you are on the leadership programme and you know you can adapt your leadership skills to the work environment you are working in and when your role then moves into a more em formal leadership role, em. I think the tools that she (Amy) will have used throughout the programme will definitely help her along the way.' (Ann)

In order to lead the team effectively, the participants often had to 'multi-task,' juggling several balls at once. This was another skill that the programme had developed, and was described by Tina as being akin to a *'puppet master'*:

'I feel like I am the puppet master, you know I have lots of strings dangling and lots of people jumping up and down in different places and it's actually em sort

of overseeing it in a way because I couldn't do all these projects and I couldn't do anything with the ideas if I was having to do all the grass roots work myself, but what I can do is offer support to those people.' (Tina)

For Dave the programme had reinforced for him that he was quite a skilled communicator and able to motivate his team, something that he thought that they appreciated:

'I think, well I think I have learned I'm a, I'm a pretty good communicator and I think I can definitely motivate, I think I motivate quite well, I do go in in the morning and I walk in with a smile and I really get them going for the full day and I think they appreciate it.' (Dave)

Fortunately his junior colleague, Diane, agreed:

'To be honest I think he is always quite positive, em I have never really known him to be negative in the mornings or like when we are doing handover or like if there is an issue he will address it and not be getting at us. Just saying that look that's what we need to be concentrating on, and he knows and appreciates that we are all working hard and he does tell us that.' (Diane)

Managers could see how applying the tools that participants had been exposed to on the programme, particularly the *Senses Framework*, had played a major role in the positive ***C****onsequences* that had ensued. Here, Emily described how Emma aspired to create an *enriched* working *environment* by implementing the *Senses Framework*:

'So, she really liked the Senses Framework em, and that's what she ended up doing her presentation on. I think within the team and again probably due to personalities and that sort of thing, em I think Emma really wanted to create an environment where people are really happy to come to work and wants to get the best out of people when they are at work em and so she yeh really liked that

and obviously applied it to the presentation. And she has applied it to her own kind of style and if she is doing supervision with people she really does bare those principles in mind.' (Emily)

As the section above suggests, once participants had acknowledged their personal strengths as leaders, they became better able to motivate to enable others to develop their own potential, by role modelling and empowering colleagues within their teams. However, there were also positive ***C****onsequences* for the wider organisation, and it is to here that attention is now turned.

6.2.4 ***C****onsequences* for the service and wider organisation

To recap, within this Chapter so far, the ***C****onsequences* on a *personal* and *professional* level have been described and have focused upon the participants' development of self-awareness and self-confidence, which subsequently impacted positively upon how they led and enabled others within the team.

The following section explores the wider ***C****onsequences,* as many of the participants began to understand and see the bigger picture. Instead of focusing on their specific area of expertise, they saw the potential to influence the wider organisation. The notion of growing a community of practice by having a number of participants from the programme with the underpinning values, working across the system, using their learning to engage with others, was seen by Emma, as an opportunity to have a positive influence on the culture of the organisation:

'If you've got all the people that are going on this course and the only thing they take away from it are these baseline ethics, that are you know really good, quality understanding of how you should interact with people, and what you know in a really positive engaging way, then you have got all these people going out into the workplace that are doing that and feel like they have got the support and background and the knowledge to do that. They can go back and

look at those tools whenever they need to. If we have got people who have the ethics of good practice and that's well, that's what's important.' (Emma)

Managers and participants affirmed that the programme had been a valuable investment. It had provided the space and opportunity for participants to reflect on leadership skills and to begin to work together, to develop a shared understanding of their role within the wider organisation, which Carol, a manager, and Viv, a participant, considered below:

'I think she (Cath) has been really pleased to have done it and has got a lot from it so, I think the service has gained from its investment of time.' (Carol)

'I really am a great advocate of people to signing up to the programme as well because I think it gave me such a sort of a wider view, a wider understanding of em of NHS Lothian of you know, the department, of you know… of working, of OT as well, I think it's given me a much broader understanding of you know what is possible and how really we can be the best we can be.' (Viv)

As already noted, expectations of the programme had been exceeded for many participants and managers, as the positive ***C****onsequences* went beyond the individual, and percolated into the wider organisation, as Vera acknowledged below:

'If I am truthful with you, I think the programme was better than I anticipated or expected and em I think it has surpassed expectations probably last time round and I think now I really like the way of it moving forward with a kind of QI focus a bit more.' (Vera)

Cath described how she felt more able to contribute to wider discussions within her service and how she could exert influence and implement her learning from various aspects of the programme:

'So there's lots happening throughout my work rather than one big massive thing and realising actually you are pulling on lots of bits of the delivering better care course. I think if other opportunities came up now I'd feel a lot more confident. Like I'm finding myself in more challenging and more senior kinda meetings and feeling more confident about my place in those meetings, thinking actually there's things I can draw on and feeling like actually I have as valid a point as much as anyone else in this meeting and feeling actually I can speak up in these meetings.' (Cath)

Such wider ***C****onsequences* were all the more valued, as they had not initially been expected. So, the above sections have illustrated how after twelve months the initial positive ***C****onsequences* as a result of the programme had been built upon and consolidated. If such benefits are to be realised by other programmes, it is important to understand the ***C****onditions* necessary for this to happen. It is to this area that attention is now turned.

6.3 Creating and Sustaining the *Conditions* to ensure positive *Consequences*- the enabling factors

As was suggested in Chapter five, the early positive ***C****onsequences* of the programme, could be attributed in part, to the *enriched environment* that had been created both before and during the programme itself. In terms of the theory, the ***C****onditions* and the *timing* (***C****hronology*) were right. Much of this was influenced by the *relationships* between the participants and their managers, and the support that the participants received from their managers and their colleagues. Therefore, based on the data from current participants, managers and colleagues, the same factors can explain why the positive early ***C****onsequences* of the programme, were maintained twelve months later. These factors, which are based upon *relationships*, will be elaborated on below, and again emphasise the importance of creating an *enriched environment*.

6.3.1 *Relationship* with and support from the Manager

The participants' *relationship* with their manager emerged as being fundamentally important to the creation of an *enriched environment*, and hence positive ***C**onsequences*, both before and during the programme and this remained the case twelve months later. Those participants who had developed and sustained an effective *relationship* with their manager that was based on mutual trust and respect, were able to apply their learning to practice and continue to utilise the tools within their roles.

Often the manager had seen potential in the participant and had suggested they apply for a place on the programme, based upon their previous knowledge or personal experience of the programme and its subsequent impact. This is eloquently expressed by Vera who described how she saw the '*spark*' in Viv, and knew that the *'time'* was right for her to engage in the programme:

'There are people that stand out as being at that stage that need that next step and you need to give them that kind of boost and that confidence and see the capability in them, the spark is in them too, and you're igniting it a bit more and you know will get something good out of it, and that's really important, how you select somebody. You see the potential in them, you see the drive and interest, it's where it's coming from, the spark is coming from them in the first place.' (Vera)

This significant investment and commitment, enabled managers to succession plan and develop talent within their teams, by encouraging and enabling them to participate, and by explicitly giving them permission to lead and develop. As the above quote suggests, the participants in turn were motivated to achieve and engaged with their teams prior to, and immediately after the programme, and created an *enriched environment* for their colleagues. The importance of creating the right ***C**onditions* in order to ensure that these early, positive ***C**onsequences* were maintained was reaffirmed twelve months later.

Pat, (participant from Element B, introduced later in section 6.5) described how important her *relationship* with her manager Pam was to her, and how Pam, who was genuinely interested in her development and experience, had encouraged and supported her:

'What you need is a good relationship with your manager in order to allow you to shine and you want to show what you are doing, you want people to be proud of what you are doing and Pam used to say to me, 'Show me what you have done'! It's a very basic need for someone to say, show me it, tell me about it, that's really interesting, you know? And then I can go away thinking great, it's really important to have someone who can go, that's really good, well done.' (Pat)

Amy affirmed Pat's views and had experienced a similar authentic interest and support from her manager Aria:

'Oh without a doubt, it's more than interest, it's not just a 'How was your course'? It's a meaningful 'how is your course, tell me about what you are you thinking', you know it's a real passionate inquisitiveness and genuine support.' (Amy)

Where the *relationships* between managers and participants were effective, the manager, as well as being consistently supportive, was also approachable, reliable and provided opportunities for the participants to engage in new developments within their service areas. Tina captured this:

'I think the other thing that's important is the support you get above you as well and I think I have been really fortunate in having Trish as my line manager because she is very approachable. Em she doesn't, if I ask her something, I have never felt that anything, any question was too stupid to ask and em I think she has also been really supportive when we have wanted to try things out.' (Tina)

This didn't happen by chance and Trish recognised her role in enabling and empowering Tina, by giving her permission to take forward service developments:

'So I think my role in all that was making sure she could dot all her 'i's and cross all her 't's in order to fulfil her idea and it did work and we have actually got it as something that we use as part of our service so it was allowing her the opportunity to develop an idea and giving her support and guidance where there were areas that she didn't quite know where to go with it.' (Trish)

Cath and Carol had discussed opportunities for Cath to apply her learning to practice using her new tools and learning, during Personal Development Planning (PDP) reviews. Carol had also offered feedback on what she had observed, which was supportive and encouraging for Cath:

'She (Carol) has been really good in the sense of when we are doing my PDP reviews she has given quite positive feedback on ideas that we'll kind of put together as a team and she would attribute some of that to the Delivering Better Care course em and she thinks that it has come from that, it's given a broader framework for some of the work.' (Cath)

Collaborative working, mutual respect and continual dialogue between managers and participants, contributed to creating the necessary ***C****onditions* to enable participants to apply their learning to practice. Vera described below how her supportive role involved both a coaching and mentoring approach with Viv, which she felt worked well and enabled Viv to reflect on and explore opportunities to implement her learning and build on her strengths:

'Viv and I have always maintained a relationship around mentoring … looking at setting objectives and what she can do in relation to that, so I suppose my role is em, partly in helping her to reflect on where she is at, and so it's partly a coaching type role there about looking at her strengths and what she wants to

develop, and what she can contribute, partly about giving her the opportunity to use the skills and try things out.'(Vera)

Experiencing autonomy and being trusted to lead the team were also key factors. Where the manager created a Sense of **Security** within the working *relationship* with the participant, this was clearly valued by the participants, who found it to be empowering.

Emma described how valuable the *relationships* with her managers were to her personally. Her situation differed to the other participants in that within her role she reported to three part-time managers. At the time of interview, twelve months after the programme, Emma had started a completely new role as Advice and Complaints Officer within the Health and Social Care Partnership, and reflecting back on her prior experience she was mindful of the importance of developing and building *relationships* with her new managers going forward:

'Yeh I mean my managers were incredibly important to me eh so much so part of the reason why I needed to do something different…you know to have that kind of support and structure and em, to be able to… it's autonomy that's really important to me and em being able to be left to do what I think is right but at the same time have guidance, that's really important.' (Emma)

Managers, in turn, were well aware of the importance of their role and of communicating their support to participants, as Carol said: *'I think it is about creating opportunities and then supporting people into them.'*

Creating a Sense of **Security** and developing trust within the *relationship* between manager and participant, allowed a flexible approach to the application of learning and continued growth, as Trish described when talking about her relationship with Tina:

'I'll trust her to be able to actually run that team ….I would say my role has probably em giving her that autonomy, eh, giving her the permission to use (her skills), to be sort of flexible in her approach and to allow her to grow as a leader and to develop her style herself, as opposed to what I feel is appropriate em so I think that's my role with all my team leads.' (Trish)

Trish and Tina met regularly and this seemed to enhance her leadership and sustain her enthusiasm for her role:

'We meet once a month on a one to one basis but then we will be in regular email or phone contact as things arise and that's appropriate for Tina, she wouldn't want more and she wouldn't want less, so I think we have found that to be right. She is getting that positive reinforcement and because of all that I think she will em she will keep herself fully motivated.' (Trish)

Clearly therefore the participant's *relationship* with their manager and the provision of support, guidance and permission to lead, were crucial to creating an *enriched environment,* that actively enabled the positive ***C****onsequences* of the programme to be maintained twelve months later. However, it was not just *relationships* with their manager that were important, participants needed support from their team also. It is to this area that I now turn.

6.3.2 *Relationships* with and support from the team.

When asked who had supported and enabled participants to develop, managers acknowledged their role, however they were fully aware of the important contribution made by team members, as Carol highlighted below:

'Well the team, her multidisciplinary team around her will have (supported her) as well. She works in a well-established multidisciplinary team and I think that is supportive and they have been able to give her a bit more time to take forward things on behalf of the team.' (Carol)

Celia, Cath's junior colleague, was aware of this:

'Cath is quite senior within the team as well because she has been around a long time so she does sort of command a lot of respect from different team members. Yeh so they certainly have got a good relationship and I think that is pretty apparent when it comes to enthusiasm as well.'(Celia)

Dave described the importance of building on his *relationship* with his team and networks of colleagues and actively sought to cultivate these:

'I think I am very fortunate that I have a good rapport with my sevens and sixes (Bands) all around me and good rapport with managers and I think it's, if I am ever, well if I am ever frustrated in any way or whatever, they tend to know about it and you know you do it in a kind of jovial way and we try and kinda sort things out if there is anything that's concerning or what not so I, I think the good communication thing really does help in the team work. The teamwork is a massive thing, we are asking for suggestions 'what do you think?' 'What could we do better?' (Dave)

Supportive *relationships* within the team seemed to have had a positive influence on how participants experienced their work. Tina highlighted the importance of such *relationships*:

'I think in work, having a line manager who is supportive and approachable, having some colleagues and it doesn't need to be many, it can be two or three who are also supportive and em it's mutually supportive, I think that is the biggest thing. I do enjoy coming to work because I do like the people I work with and I enjoy working with them and I think that makes a big difference.' (Tina)

As Tina's quote above suggests, building *relationships* was not a 'one-way street' and Vic, Viv's junior colleague reflected on this below:

'I find her very open and supportive no matter what the kind of situation, she is very honest as well, and em you know being able to go to her with any kind of an issue and know that it's going to be dealt with kind of rationally, em yeh.'(Vic)

Ann, who was a junior colleague of Amy and also had been a past participant of the programme, talked about how much Amy invested in building *relationships* with her colleagues at all levels, as well as her patients. This had a positive impact on her personally as she felt supported by Amy and consequently held her in high regard:

'I know she is like this with the wider team as well, em trying to eh, find out what people want for their own development needs and trying to drive forward with that, em supportive, so supportive em, and yeh really em caring and compassionate! Em, she works with everybody knowing that everybody's got strengths and weaknesses within the team, em, and pulls together with everybody.' (Ann)

Managers and participants saw the benefits of engaging with a wider network of colleagues as a means of sustaining the positive ***C****onsequences* of the programme. Trish believed that Tina did this very well, and had done both during and after the programme:

'I think maybe the breadth of the network and the different number of people that she engaged with in terms of the project and em going back to those individuals and actually realising the value of working with other people to get to a common goal, so I think she does that very well now.' (Trish)

For Vera one of Viv's strengths as a leader, and something she had cultivated since being on the programme, was the way in which she provided 'light touch' supervision and peer support for her colleagues:

'I think there's peer support, I think there's leadership support em she's em there's mentoring there's all of those things that I think support, there's mentoring both within em the service and outwith with others em I think that helps too, a bit of practising em and trying things out with people that she supervises as well I think that kind of em, I use the word supervision in the broadest sense really but em so people that she has an impact on so I think that, is apparent too, if that makes sense?' (Vera)

At this point Viv had recently been promoted and attributed this, at least in part, to the way in which she interacted with her colleagues:

'Yeh yes and networking and you know also having professional respect for other people as well and I think you know being very inquisitive and enquiring which I think is…you know obviously one of the leadership em attributes that I suppose probably helped me get the upgrade.' (Viv)

In essence, developing and sustaining an *enriched environment,* in which everyone felt secure and significant, was central to building upon the initial positive ***C****onsequences* of the programme, and maintaining these over time. Not surprisingly, poor *relationships* had the opposite effect and even in the best of circumstances, lack of resources and excessive workload could compromise things, by creating a relatively *impoverished environment*. These factors are considered below.

6.4 The negative effects of an Impoverished environment

Given the importance of the manager, it is not surprising that a poor *relationship* had a negative effect. Fortunately, virtually all the participants had very positive relationships with their manager, however the *relationship* between Jane and Jackie was not as positive as it might have been. This may in part have been due to their differing personalities, as Jane described below:

'My manager is quite closed so she, she is probably more introverted and I'm probably more extrovert, she gives me permission to do anything…but she doesn't guide me and say have you tried this have you tried that you…I find that quite difficult because I am probably a bit better with a bit of guidance or a bit of a push into a certain direction.' (Jane)

Jackie, on the other hand, thought that part of the problem lay with Jane's motivation for completing the programme and that possibly she hadn't really been ready for it:

'I maybe just kinda got the impression that this was something that had to be done and got out of the way then that's that ticked, box ticked if you like, you know, 'I've done my leadership course', therefore, you know, I am now a leader. It just wasn't the right thing at the right time for Jane or em hindsight's a wonderful thing isn't it, maybe I should have insisted we sat down and discussed it (going on the programme) more… I am not saying it was all a complete waste of time, perhaps go back and revisit it and maybe have more of a discussion about you know, what did she learn, you know what does she feel she has gained from it…' (Jackie)

A lack of communication and engagement between Jackie and Jane throughout the programme seemed to have impacted negatively on Jackie's understanding of what the programme entailed. Jane did not really feel that she had the kind of support that she needed and therefore her confidence as a leader upon completing the programme was not as great:

'It is strange because I am confident with my families and I am confident clinically but I am not with the team… and I guess it's about…(hesitant) I guess it's about having that reassurance and doing that right thing rather than just it's a negative, you've done the wrong thing but you know, I guess it's about getting that reassurance that I am doing the right thing and I guess that's one of the things that maybe came across in the course. I still need that now.' (Jane)

It seems that an *enriched environment* had not been evident from the start and that this served to reduce the benefit that Jane got from the programme. Interestingly in the interview twelve months after the programme, Jackie seemed to be more aware of the importance of supportive *relationships* and realised that she had a key part to play in enabling this to develop:

'Some of it has to come from me and I would agree it is very important that our relationship is good because I think if you don't get the support to be proactive and show initiative and bring ideas then it could easily just fall by the wayside.' (Jackie)

Even when there were positive *relationships* all around, the positive ***C**onsequences* of the programme could be negatively impacted by excessive demands in the workplace and these are considered next.

6.4.1 Workload demands

Workload and increasing time pressures were seen as factors that worked against participants' efforts to create an *enriched environment*, as Fiona shared below:

'We used to be busy but not in this way so time is just the biggest problem. It's great when you are away on a course and you do feel invigorated and you think oh god I'm alert again and awakened and I love it, then you come back here and within half an hour back in the hospital you are sucked of inspiration because all the other pressures you're under.'(Fiona)

Kate and her manager Karen (also a past participant of the programme) talked about the low morale within their ward due to workload pressures and staffing issues, and how this had impacted negatively on team working and resulted in a loss of momentum in implementing the learning from the programme:

'I think also there was probably a general low morale on the ward with regards staffing issues em, you know we were working generally on the bare minimum and I suppose, and I can see it, I was asking staff to do extra and think out the box and where maybe a lot of them are just coming in and just doing their basic job… just come in do their job and get out you know?'(Karen)

When asked what might re-engage and reenergise the team, Kate suggested having external facilitation from the programme would be a great asset, however, sadly she considered this unrealistic:

'To have someone that's like yourself (laughs), the reason I am laughing is because I know that wouldn't happen, but someone with the right experience and attitude to em have regular meetings with the staff to look at stuff like that and what was the real light bulb was "not what you can't do but what you can do" and not focusing on the negative.' (Kate)

It therefore seemed that even when people worked hard to create an *enriched environment,* the pressures that staff felt in their day-to-day work could, if not destroy, at least in part, negate the best of intentions. Despite this, the overall ***C****onsequences* of the programme (as per previous sections; increased self-confidence, self belief and self-awareness, enabling others, seeing the bigger picture, personal and professional impact), seemed to be largely positive and sustained over twelve months, as least in the eyes of this group of participants, their managers and colleagues.

An exploration of whether there was any evidence beyond this, will follow in the next section.

6.5 Lessons from past participants: How to sustain *Consequences* over time

As already described in Chapter four, those interviewed in Phase one (Element B), were past participants of the DBC LP, who had engaged in the programme

over the past decade, including one participant from the initial pilot programme. All five participants, their managers and colleagues in Element B, were nurses. The thoughts of this group were deliberately sought to explore the longer-term ***C**onsequences* of the programme, over a more extended period of time.

Element B of the study explored the ***C**onditions* that might support positive ***C**onsequences* of the programme, using case studies of five past participants, who had attended the programme between two and eight years previously; including data from their managers and colleagues. This section draws primarily on data that the participants provided about their experiences since completing the programme, however to set this in the appropriate ***C**ontext,* I will provide a brief overview of each participant's 'story'. Prior to this **Table 6.1** provides details of the participants, managers and peers who take part in this phase, again using pseudonyms to ensure confidentiality.

Table 6.1 Element B Participants

Code	Pseudonym of participant	Role and workplace	Manager's Pseudonym	Peer's Pseudonym	Junior Colleague's Pseudonym
EB01	Ria	Staff Nurse, Learning Disabilities Services, Community	Ross	Ruth	
EB02	Pat	Clinical Nurse Manager, Major Acute Teaching Hospital	Pam		
EB03	Mary	Nurse Director, Older Peoples Services/ Long term care Hospitals/ Residential Care			

EB04	Gill	Care Lead Nurse, Care Home	Gail		Gina
EB05	Kate	Staff Nurse, Older People's Care ward, General Hospital	Karen		Kevin

6.5.1 Ria

Ria was a Registered Nurse, working in the community with people with a Learning Disability (LD). At the time of her participation on the programme she was seconded to focus on a specific project within the LD service regionally. She had completed the programme only eight months prior to interview and was the most recent past participant; therefore it was hoped that she would bring a more recent reflection on her past experience, to compare with others over varying times. Ria was unclear initially as to her expectations of the programme yet she had felt that the *timing* was right for her, and that engaging with others from differing specialities would give her a broader perspective. Like many of the participants of the current programme, Ria appreciated the practical application of learning and found learning together with a group of multidisciplinary staff very helpful.

Ross, her manager, was impressed by her enthusiasm as she actively approached him about applying for the programme. He fully supported Ria throughout and saw it as an ideal *time* for her to engage in new learning, which was consistent with Ria's thinking.

Ria's account of her experience of the programme affirmed many of the key factors, which had emerged from the Element A participants. The *timing* **(*C**hronology*)** had been right for Ria and her good *relationship* with Ross, her manager, gave her confidence to apply for the programme and embrace the challenge of being the first participant from her service area on DBC LP.

6.5.2 Pat

Pat had been on the programme a year before Ria, so twenty months prior to the study commencing, and was at the time a Clinical Nurse Manager for an out of hours/hospital at night service within acute hospitals. She had been recently promoted and so the *timing* of the programme had been ideal.

Pat and her manager Pam had hoped that the programme would enable her to develop her *personal* leadership qualities and resilience, as her role had changed and she had increasing responsibilities. Pam spoke highly of Pat and was complimentary about her interpersonal skills and engaging leadership style. She acknowledged Pat's positive attitude and intrinsic motivation. The foundations of an *enriched environment* were evident.

The programme enabled Pat to see the 'bigger picture', and to reflect on her learning in order to continue to develop. Pam acknowledged the importance of the supportive relationships that she enjoyed both with her manager and within her team. The *Senses Framework* had exerted considerable influence on Pat, and she actively applied it within her new role and aspired to create an *enriched environment* for her colleagues.

The longitudinal nature of the programme, which provided a regular space to think and reflect, was particularly valued by Pat, who believed that a shorter more concentrated delivery would not have worked for her. Pat and her manager Pam had developed and sustained a robust and supportive *relationship*, which Pat very much valued. Pam had noticed a vast improvement in Pat's interpersonal skills and personal qualities, particularly in relation to self-confidence, which had continued well beyond completion of the programme.

6.5.3 Mary

Mary' story is an important one, because unlike the other participants, she had completed the programme in Limerick, Eire, and whilst the programme had

followed a similar philosophy, there were also important differences (see Chapter Three). At the time, Mary was a Clinical Nurse Specialist in Older People's care, with an additional practice development remit. Unlike the participants on the programme in NHS Lothian, who had been carefully selected through a robust application process, Mary had been 'sent' on the programme, along with two other colleagues from her clinical area. Mary, who was in a senior role to her colleagues, not only wanted to complete the programme, but also support her colleagues to do so. The initial situation was therefore far from being *enriched*. Despite this Mary described herself as motivated and saw the programme as an opportunity rather than a threat.

Mary had been aware of the *Senses Framework* prior to the programme and fully grasped the opportunity to build on her understanding, and to use the framework to support her colleagues and to enable them to develop as leaders. Mary was also open to new ideas and keen to share her learning with others from various Older Peoples' Care Services in the local area.

At time of interview four years later, she had gained promotion, after realising she had been in her 'comfort zone' and she was now thoroughly enjoying the challenges of a Director of Nursing role. She had also continued to learn and develop beyond the programme, and had successfully gained further academic qualifications.

Mary described the positive impact that the programme experience had had on her, at both a *personal* and *professional* level. In addition, due to Mary's guidance and support, her colleagues, despite initially being hostile to the programme, had eventually enjoyed it and gained considerable benefit themselves. All the participants on this programme had initially been quite hostile however, despite this there had been a complete turnaround, and Mary attributed this primarily to the efforts of the facilitation team who worked to create an *enriched environment* for the participants. Four years later, Mary, her

two colleagues, and the service as a whole, continued to benefit from participating on the programme.

Mary's story highlights the major role played by creating positive *relationships.* In this case, in addition to the part played by the facilitation team, Mary herself had been pivotal in supporting her colleagues on the programme. Her story can be seen to provide a 'negative case' example, in that despite the initially impoverished position in which she and her colleagues joined the programme, the ***C****onsequences* had been overwhelmingly positive.

6.5.4 Kate

Kate was a Staff Nurse who worked night shifts on a long stay ward for older people, which at the time she completed the programme, had undergone significant changes in staffing and leadership, as well as a move to a new ward environment. Kate had participated on the programme five years previously. Despite benefiting personally from the programme, Kate had found it very challenging to engage with the wider team when back in the workplace due to differences in essential beliefs about the purpose of the unit, exacerbated by poor team dynamics.

These circumstances created an *impoverished environment* and there had been relatively little improvement in the intervening period. Not surprisingly, Kate had been unable to sustain the initial enthusiasm she felt when she completed the programme, and her initial sense of 'hope' diminished. However she now had a new manager, Karen, who had been a participant on the original programme. At the time of interview, the opportunity to revisit their learning and consider how it might be applied was emerging. Karen was keen to reignite Kate's initial enthusiasm and explore ways of supporting her to develop. This clearly reaffirms the importance of the *relationship* with the manager, even five years after the programme.

Kate's experience of feeling energised and engaged, whilst having the support from the facilitation team and the programme participants, reinforced the importance of *relationships* and support. However, the subsequent lack of support and engagement with her team meant that she was unable to sustain any changes beyond the timeline of the programme.

6.5.5 Gill

Gill was a Senior Charge Nurse in a Care Home for older people with visual impairments, run by a Charity, when she participated in the pilot programme *Leading for the Future* eight years prior to the research interview. Initially Gill had not wanted to participate on the programme and had few explicit expectations. However, after taking part in a few of the workshops, her views changed and she began to fully engage with the programme. This is consistent with the views of many of the participants in Element A, who found that it often took three or four workshops before the 'penny dropped' and they began to see where the programme was going.

Once she started to engage with the programme, the 'Fish Philosophy' and the *Senses Framework*, as described in Chapter three, section 3.4, had a particular impact on Gill. However, it was the final celebration workshop presentation that marked a significant turning point for Gill, in terms of enhancing her self-belief and self-confidence.

In the intervening eight years, Gill had been instrumental in transforming the culture of her workplace and in encouraging a number of other staff to complete the programme. She talked with great pride about how the care provided by staff within the care home for residents and their families was *relationship-centred* and was underpinned by the *Senses Framework*. This was a commitment that all staff had sustained for almost a decade. Collaborative working within the Care Home was focused on establishing *relationship-centred care* with residents, their relatives and all levels of staff within the team,

and Gill extolled the benefits for everyone of creating an *enriched environment* of care.

Despite Gill's initially rather ambivalent feelings about the programme, her story provided a telling example of how things can change if the right ***C**onditions* are created.

The remainder of this Chapter builds on the above stories and uses them to reinforce and build upon many of the ***C**onditions*, previously described, that appear necessary to sustain and build the positive ***C**onsequences* that may arise from participation in the programme, beginning with the importance of *relationships*.

6.6 Building, developing and sustaining *relationships*

Building, developing and sustaining *relationships* with the manager was endorsed as pivotal to how the participants influenced, consolidated and sustained any changes or impact (***C**onsequences)* on themselves as leaders, or within the team or wider organisation. This required the development of trust, mutual respect and being open to regular two-way conversation from both parties, as Gill highlighted:

'Yeh I think it works both ways, I know I was very enthusiastic about things and was able to get across what I wanted or hoped for, and because they (Gail, the manager) saw a different side of me they were more prepared to go with it, it's a kind of win-win thing. (Gill)

When the *relationship* was built upon a foundation of clarity and understanding of the role of the manager, a Sense of **Purpose** within the *relationship* provided support, direction and permission to lead.

Pat seemed to require gentle encouragement to 'stretch' to Pam's expectations of her leadership role, which with support and permission, she embraced, resulting in her enhancing her leadership qualities:

'I suppose it has been a supportive kind of… an open dialogue with her around, and she has always been receptive to, what can I do better, what do we think, you know, there has been times as well when I have had to say, you can do this just go and do it… I think a lot of it was support and little nudges in the right direction because I think she was certainly developing very quickly in all the skills and qualities and values you would expect from somebody in a leadership role.' (Pam)

As already highlighted in the 'stories' from both Element A and B participants, the ***C**onditions* created during the programme, involved a Sense of **Security** and **Belonging** being developed within the group, which enabled the building of trust and respect amongst the participants themselves, who at the outset of the programme may have experienced conflict and negativity, such as was described above in Mary's story. Trusting the process, within the ***C**onditions* created on the programme over time, allowed the *relationships* between participants to develop and flourish as Mary shared:

'By the end of the programme I really understood them and they totally understood me - our relationship came full circle and our relationship now is still good even although I am in a different role now you know.' (Mary)

Developing and sustaining *relationships* with the facilitators of the programme was also important to participants, who valued observing the *Senses Framework* being used as a facilitation and delivery mechanism, and appreciated the authentic role modelling, which aligned with the programme ethos, as Pat articulated with honesty:

'Also very importantly you are washed over every time on the days by the facilitators, because they are practising what they preach, so that's really important for me, it's genuine, it means something…you are not just standing there and preaching about something that you are not doing yourself. I could see in action, I could see how it made me feel and how valued it made me feel as part of a group.' (Pat)

A Sense of **Belonging** was created through working together on a project and further developing *relationships*, which contributed to a greater Sense of **Purpose** and direction for participants as well as creating a Sense of **Significance** and **Achievement** within their individual roles and workplace. Mary described the subsequent impact she had observed in her colleagues, which illustrated both *personal* and *professional* impact upon *relationships*:

'*You know if you're doing things on your own sometimes, you're going a bit solo, whereas in a group there was a bit of power... and they felt respected I think, you know the impact was positive within the unit because one who developed more confidence, became the link nurse for the pharmacy…she kind of took it in her stride and the other girl, just became far more positive in her approach to people in general.'(Mary)*

Having considered **how** the participants were enabled to build, develop and sustain *relationships* through creating the 'Senses', the following sub-section will now consider how connecting with past participants of the programme also supported the development of *relationships* and thus created a Sense of **Continuity.**

6.6.1 Connecting and maintaining *relationships*

Connecting with past participants and engaging in conversations about the programme experience enabled participants to remain proactive and motivated to continue to implement their learning and 'keep it live', which resulted in them sustaining their enthusiasm and impact. Ideas emerged during the reflective

conversations, which participants considered as ways to engage others and build new *relationships*, especially when working in a new role or organisation. There were participants who maintained in contact beyond the programme and sustained their *relationships*. Ria illustrated how maintaining contact sustained her focus:

'Yeh, you just have to touch base and remember what's important and things and try to focus a bit more.' (Ria)

Ria had supported other participants on the programme and had also spoken at workshops about her experience, which she felt helped her sustain her learning and enthusiasm. For Ria, meeting people face to face and having the interpersonal contact, was important as she described below:

***'**I have been involved with helping others being a past participant and I have been involved in having conversations with you in workshops, so I genuinely think I would have kept hold of things, but actually for me you want to feel that 'rrrrr' in the room again, you want to have that connection, that physical connection.' (Ria)*

Ria saw connecting with others and implementing her learning as a way of maintaining her motivation and momentum for continually developing as a leader and saw the potential for developing new networks and opportunities:

'Keeping it live yup and using that stuff, you know within my team or maybe using it with the wider network team or maybe even using it within a kind of integrated team, but you know maybe it's about using some of the skills and building relationships with my council colleagues.' (Ria)

Maintaining regular contact with each other and creating a Sense of **Belonging** within the group, allowed the participants to translate this into their practice. They recognised the importance of reflection, which enabled them to focus on

their priorities in life and work, something that was not always possible in busy reactive work settings. Dave talked about how he had valued the networking and keeping connected with others from the programme:

'Funny I bump into Billy quite a lot; he's a good guy, he is always good to see and see how he is eh, you know and again that goes down to networking again doesn't it? I wouldn't have known these people had I not been on that course you know?'(Dave)

Participants such as Amy, who had colleagues within their team who had also been past participants, often had expectations in relation to developing personal leadership qualities based on their observations and experiences of working with them. Amy had observed a significant improvement in her colleague Ann from when she had participated on the programme and she seemed proud to have supported her and recognised the importance of maintaining their supportive *relationship*:

'For Ann this programme was a lot about confidence and getting a sense of her role in the ward. Immediately she would say I'm only a band two I'm only this I'm only that. Watching Ann's journey through this was phenomenal, it really was for her confidence actually and when she realised people were listening to her and wanted her feedback and were happy to support her a lot of that really shone through towards the end, in her confidence.'(Amy)

As previously described, the *relationship* with the manager was of significant importance to all participants. An additional factor, which created the ***C****onditions* for an *enriched environment*, was the *relationships* within the workplace. When the participant had colleagues within their team or within their networks that were also participating on the programme or who had previously been a participant, therefore had an understanding of what was involved, they could provide support to the participant and collaborate on change ideas, creating a Sense of **Continuity**. This was evident in many cases, particularly with

managers who had experienced the programme in the past. Where there were no past participants or fellow colleagues in an area or team, this was often more challenging to implement change and share ideas, as Emma had experienced. Emma would recommend to others to consider applying with a colleague so that they could participate on the programme together and support each other:

'I would see that part of my problem is that nobody else from my work has been on the programme at the same time. I would say to anybody who was going to go say next year to go with somebody else because just to have that other person to bounce ideas off would have been em much better.' (Emma)

The suggestion of creating a network for past participants to reconnect and engage in refresher workshops was made by Emily, who could see the potential for the organisation to support and enable this to happen:

'So I don't know whether there is an opportunity even for the people who are in one cohort even to get together every six months or whether that's possible just to kind of em keep an enthusiasm and a sense of… but I think the organisation has to support what's been happening and it's great to do all this leadership development stuff but if workplaces don't give you the opportunity to use it then… yeh.' (Emily)

This idea will be explored later within the discussion Chapter eight.

Therefore, networking with other past participants, supporting colleagues on the programme, taking opportunities to speak to new groups of participants about their experience and maintaining connections with the facilitator team, were seen as enabling factors to sustaining effective *relationships*, thus creating the ***C**onditions* to sustain the ***C**onsequences* from the programme experience.

In summary, the importance of *relationships* was affirmed within this section, not only with the manager, which was pivotal, but also within the team. In addition,

relationships with the facilitators and past participants emerged as fundamental and impactful on the participants' longer-term experience. Once the *relationships* were developed, this contributed to creating the ***C**onditions*, which enabled the ***C**onsequences* to be enhanced and sustained over time.

The following section explores another long-term factor, continuity of learning, which enabled the creation of enriched ***C**onditions* that are necessary to sustain and build upon the ***C**onsequences* over time.

6.7 Continuity of learning, reflection and 'stretch'

The experiences of the Element B participants confirmed that continuing to learn and develop beyond the timeline of the programme experience was an enabling factor to sustaining subsequent ***C**onsequences*. This on-going learning, and development of personal qualities, such as self-confidence, had enabled four of the Element B participants to gain promotion or move into a new role, illustrating the importance of continually learning and feeling 'stretched', as Mary and Pat described:

'So, I went and did my studies, and did well and I would be a learner anyway all my life, but em my aim was maybe to do my Masters and maybe a PhD. But having said that I came to the realisation that wouldn't be practical at this moment, so I took another opportunity and here I am and this opportunity has led me to be much happier in my work, I love nursing, I'm very passionate about nursing but I needed to move you know. '(Mary)

'I am now doing a Masters module in leadership, which really nicely just followed on so feels really fluid and still feels very current, so emm, the one thing that sticks with me is the Senses Framework and in every conversation and every interaction… for me they are just embedded…it's been a light bulb moment.' (Pat)

Those participants who had fully engaged in all aspects of the programme including the work based activities, self directed activities and project work, seemed to thrive on the energy generated from the new learning and from sharing experiences and challenges with each other at the subsequent workshop. This provided a platform, to enable them to sustain their motivation and 'drive' to continue learning beyond the programme timeline. Having the confidence to continue with further learning, development and 'stretch' beyond their area of expertise by applying for new roles, was appreciated by managers, who could see the opportunity for the participant to utilise transferrable skills and apply their learning to practice. Pam could visibly see the difference in Pat, in how she was able to lead with confidence:

'I think what I have noticed is that she has gone for promotion and within that I see she has actually developed skills that are transferrable, as she has taken on new services - in the last three months she has taken on two different services that she has never had exposure to before. What I do see is skills she has developed through the course – she has the confidence to transfer those skills into two different areas and deliver on that. We did a walk round recently with the Board in one of the areas and just her, articulation and confidence was quite different to what it was 18 months ago. It was really nice to see actually.'(Pam)

Experiencing an *enriched environment*, enabled continued learning over time, which had an uplifting and energising effect on participants. In addition to their increased self-confidence and self-belief, a shift in mind-set often contributed to participants continuing to learn, and embracing new opportunities to think differently, as Ria described below:

'It's all about changing your thinking and I think you can only do that by being part of it and learning, it's experiential. It's like an epiphany or something and I thought, if you start believing in yourself and this course was really good at that, it was really good at making you realise everybody has potential.'(Ria)

Reflecting on self and developing an understanding of their personal leadership approaches, enabled participants to set out clearer expectations for self and others, creating a greater Sense of **Purpose** and **Significance,** for all those involved.

In summary, creating a Sense of **Continuity** of learning and development beyond the programme timeline helped participants to consolidate an *enriched environment*. This was central to remaining engaged and motivated over time.

6.7.1 Embedding learning in practice and sustaining positive *Consequences*

The richness of the data shared by Element B participants began to further illuminate not only the ***C**onsequences* of the programme, but also more importantly, how these might be sustained over time. An exploration of the ***C**onditions* necessary to embed their learning and sustain any impact mirrored the ***C**onditions* already highlighted by Element A participants.

In particular the *Senses Framework*, had made a significant impact on the majority of participants, both *professionally* and *personally*, as Karen illustrated below:

'It was the best course I ever did! The Senses Framework was the most helpful tool I ever learned about and I still use it all the time, every day and with every student. I ask them to reflect on what will create a Sense of Purpose, Achievement, how will they feel Secure, that they Belong… I use it in all aspects of life.' (Karen, Manager to Kate and also past participant on the pilot programme.)

Participants highlighted how their whole team was still using the *Senses Framework* in their practice, as Gill described below:

'I would like to think it's (the programme experience*) had a very big impact because I did a lot of changes in here. I changed the care plans, the way that they were done, involving other people, again, there is another thing- before the programme I might have just done it myself but with all the stuff I learned, people, the staff were very much involved in the process of changing care plans. And the whole care plan system is based on and still is based on the Senses Framework.' (Gill)*

Gill also reflected on how she had enabled her team to build upon her own experiences by creating an enabling culture:

'There is allowing, stopping the place being a hierarchical place and involving staff more, em, and involving the families as much as possible, which all the relationship-centred care bit - that has continued as it's a massive part of our participation programme now and everyone is very happy and confident to ask families to contribute to the care plans, it's all underpinned by the Senses Framework, yes I think it is embedded although we are eight years on.' (Gill)

Having experienced an *enriched learning environment*, subsequently enabled participants to embed their learning into practice, as Ria described:

'I think it's because the facilitators have got an awareness of the Senses Framework you are making people feel like they belong, are comfortable, eh have a Sense of Security and everything. And I think it goes a long way, so I think that's the difference, whereas I have been to say other courses where, you go in and you don't know if you are in the right place, you are scared to maybe talk out in case you say the wrong things and stuff. Whereas you created this environment that was safe and quite nurturing and things so people did engage in it a lot better and I think you allowed that to happen, which I think helps me still apply my learning in my role now.' (Ria)

On their return to the clinical environment, ***C**onditions* had been created by the manager, team and organisation, which had supported the participants to apply what they had learned to their practice. This often had a profound effect on the participants personally, allowing them to achieve an effective balance in both their *personal* and *professiona*l lives and created an enhanced Sense of **Purpose** in work which reenergised participants. Mary had noticed this both in relation to herself but especially her colleagues who had initially been highly sceptical about the programme in Limerick:

'She got insight into herself, she really flourished, she blossomed, she definitely gained from it, her family life gained from it you know and the other girl she just em continued to flourish at a different level and continued to have confidence and was happy where she was at you know. One girl got particularly good insight into herself and I'd say you did a huge amount to help her going forward and I would say she changed a lot of things in her life, and that reenergised her.'(Mary)

One of the most significant insights to emerge from the study was how participants sustained and embedded their learning by creating the ***C**onditions* for an *enriched environment* using the *Senses Framework*, as an underpinning mechanism. This will be explored further in Chapter eight. Attention is now turned to the means by which participants sought to overcome the barriers to creating and sustaining an *enriched environment*.

6.8 Overcoming the barriers to creating the *Conditions* necessary for an *enriched environment*

Many participants faced similar challenges to enacting their new leadership role and most experienced periods of self-doubt. To help overcome these they harnessed the power of sharing experiences, which enabled them to realise that they were '*all in the same boat'*. This sharing enabled the participants to maintain their self-confidence and self-belief by working with other, as Gill described below:

'I think I had lost a lot of confidence in myself so yeh… going on the programme, I remember everyone on one of the days, everyone realising that we all thought that everyone else knew an awful lot more than we did and were all better than we were. But because we had got to know each other and listened to each other's experiences we all suddenly realised everyone was the same as us and we were all floundering a bit. Em so I think that was quite an eye opener and knowing that other people were at the same stage made me feel more confident in myself.' (Gill)

Being aware of potential hindering factors such as excessive workload, enabled participants to be more proactive and to sustain their enthusiasm. Some participants, despite initial reservations, therefore took the chance to '*step out of their comfort zone'*, when the opportunity arose. This served to further enhance their Sense of **Achievement**. Gill captured both the anxieties and rewards that she experienced when she decided to present at a conference:

'Not long after the programme had finished we got the emails from Gail…looking for people to speak at conferences and I decided that we would go for it and put forward an abstract about caring for older people… and it was all about the Senses Framework… and we were actually picked to do a session…and we stood up and you know there was only maybe 50 people in the room but at the time, yeh I was a bit nervous about it and it was a total turn around and when it got to it and I stood up in front of people, I actively enjoyed it, I loved doing it. And then, I think just having the confidence to progress to make myself better at work, getting the deputy manager's job here and I do training for all of the staff every month, talking on the subsequent courses emm…having the confidence to give people news that they are not necessarily going to like, giving feedback to people in a more confident way.' (Gill)

To conclude, the data gained from participants engaged in Element B of the study provided further insights into how they had built and developed effective

relationships with managers, teams and facilitators. These *relationships* helped them to create the ***C**onditions* that stimulated continual learning and enabled them to embrace new opportunities and sustain the initial positive ***C**onsequences* often over many years.

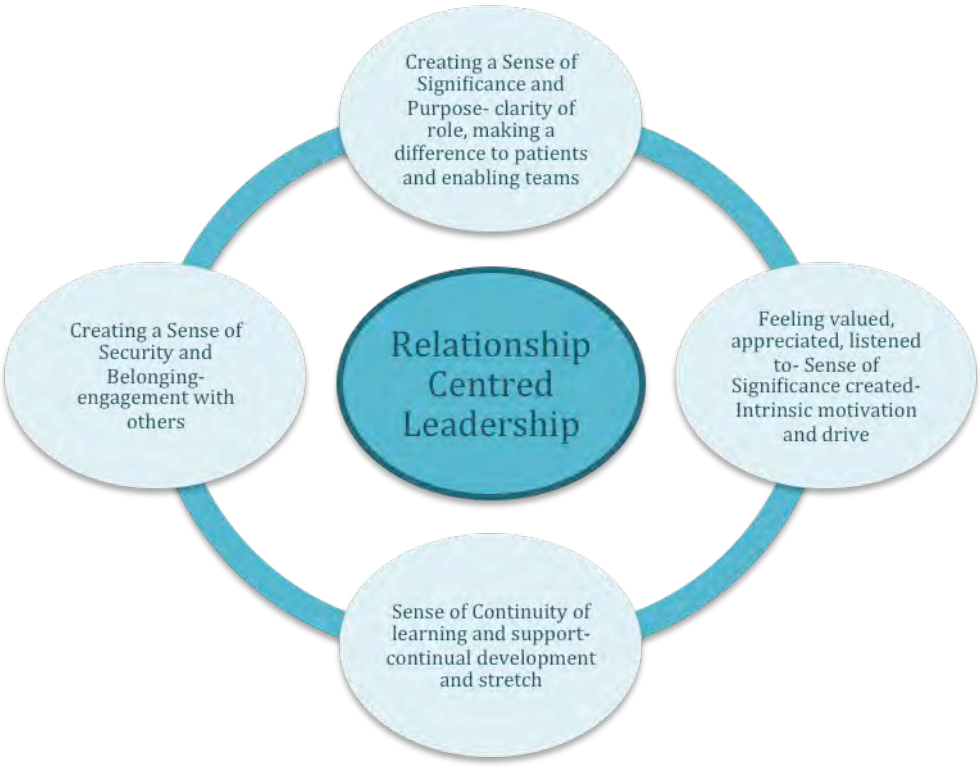
6.9 Chapter summary

In summary, this Chapter has demonstrated how the substantive theory, the **Five C's**, which was developed from this study, when linked to the Senses, provides an explanatory framework that helps to illuminate how the initial positive ***C**onsequences* of the DBC LP can not only be sustained but also extended over time.

Consequently, building on the experiences of past participants of the programme, their managers and peers (Element B), has provided a rich and in-depth affirmation of the ***C**onditions* that appear to be necessary, to create and sustain positive ***C**onsequences.* The importance of fostering positive *relationships,* particularly with their manager and teams appears crucial.

Based on the data from all Phases of the study, a better understanding of the ***C**onditions*, necessary to creating and sustaining an *enriched* learning *environment*, has emerged, and these are summarised in **Diagram 6.1** and can be seen as being crucial to what can be termed *'**Relationship-Centred Leadership'.***

Diagram 6.1 The *Conditions* necessary to achieve *Relationship-Centred Leadership*

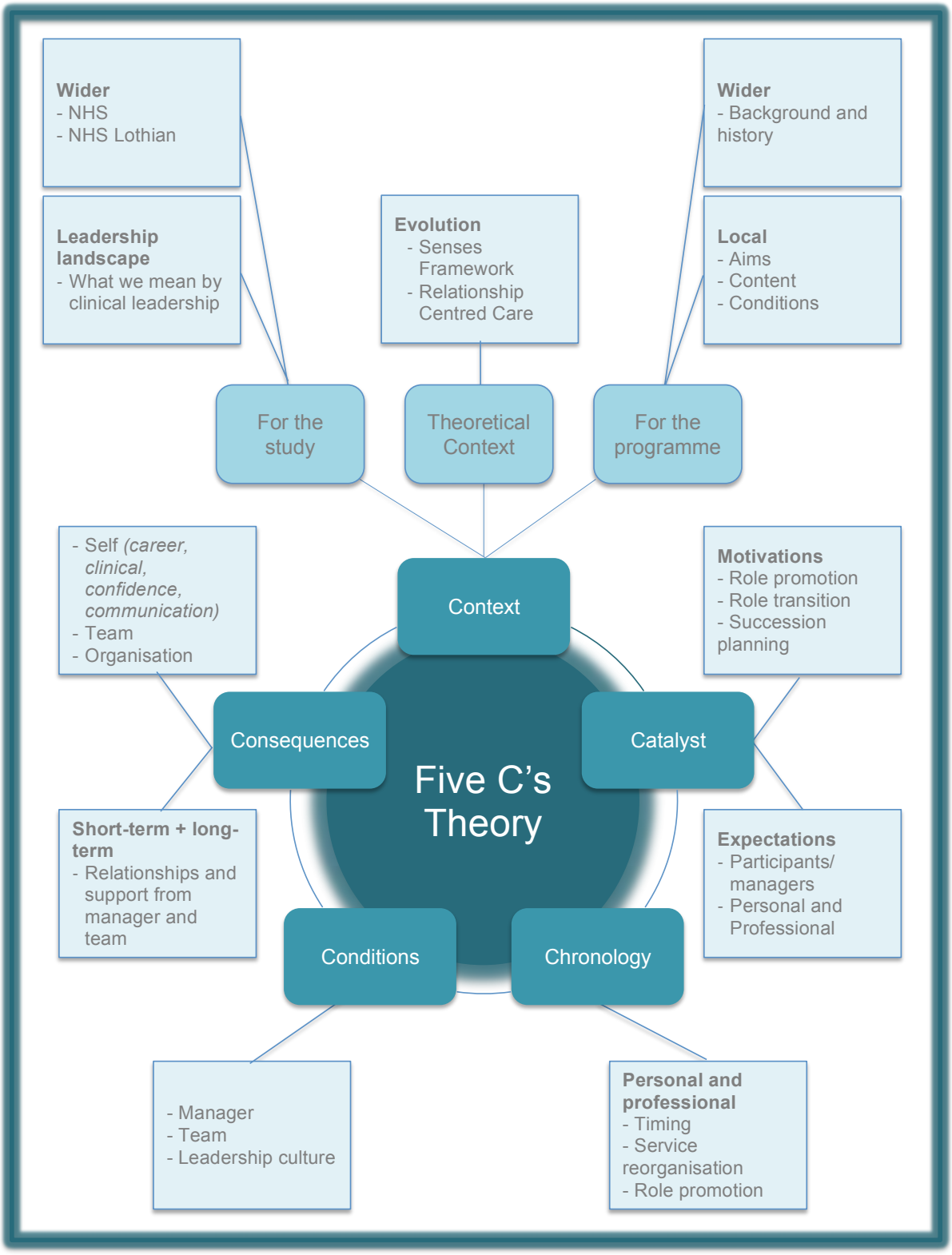


Throughout each Phase of the study it became apparent that the *Senses Framework* had made a significant impact on many of the participants, who found they constantly used it to shape their daily interactions with others. Interestingly the Element B participants in particular, had, in many instances, embedded the *Senses Framework* within their practice over several years and this had had an impact both *personally* and *professionally.* In this respect my study can be said to add yet further evidence of the utility of the 'Senses' in a wide range of settings, moving it further along the road to becoming a 'formal' theory.

However, the study has also resulted in the development of a substantive theory that sheds important new light on how a particular programme might increase its chances of meeting its aims. This requires attention to the multiple factors captured by the **Five C's** theory, highlighting the importance of

understanding and attending to: the ***C**ontext(s)* within which a programme operates; the ***C**atalyst(s)* that motivate participants to apply/be nominated; the *timing* of the programme (***C**hronology)* in relation to the *professional* and *personal* lives of participants: and the subsequent ***C**onsequences* that might be expected. These latter factors subsequently influence the extent to which the ***C**onditions* necessary to create an *enriched environment* can be created and sustained. **Diagram 6.2** seeks to illustrate how the key elements of the **Five C's** theory interact:

Diagram 6.2 The Five C's Theory



The wider relevance and potential implications of the findings described in Chapters five and six, will be considered in the following Chapters. Prior to this, Chapter seven will further reflect upon both the quality of the proposed new substantive Five C's theory, and the research process itself. Lessons learned and limitations of the study are also discussed. Chapter eight will draw out the Significance of the Senses Framework and enriched environments in relation to the findings from this study and discuss how this links to current literature and what this means for leadership in healthcare. The concept of '*relationship centred leadership'* - will be explored and how the **Five C's** theory might be applied will be considered.

Chapter Seven. Reflections on the 'Quality' of the study and its findings

7.1 Chapter overview

Having provided a detailed account of the ***C****ontext* for my study (Chapters 1-3); justified and described my methodological approach (Chapter 4); and provided an overview of the **Five C's** theory that emerged from the data (Chapters 5-6), this Chapter focuses predominantly on the 'quality' of both the research process and the resultant theory.

As described in Chapter four, Constructivism was the primary influence on my study, and I employed a *'hybrid'* approach comprising Constructivist Grounded Theory informed by elements of Fourth Generation Evaluation. Therefore it is important to consider the 'quality' of my work using the relevant criteria. However, as was noted in Chapter four, there is no clear consensus as to how to judge the 'quality' of qualitative studies in general, and Constructivist work in particular. Here I will use the EA Matrix (Nolan et al., 2003), to consider the quality of the research process, and apply the criteria suggested by both Glaser and Strauss (1967), and Charmaz (2006), to consider the quality of the theory that was developed (see Chapter four for my rationale). However I will also argue for the need to expand the EA Matrix by adding two further dimensions that I term ***E****valuate* ***A****ction* and ***E****mbed* ***A****ction*. I believe that this modification to the EA Matrix will further methodological debate as well as enhance the usefulness of the Matrix for both researchers and practitioners. Consequently, in addition to the theory that emerged from my work I feel that my suggestion of an extended EA Matrix can be seen as another potentially important contribution of my work.

Following a consideration of the 'quality' of my work, attention will be turned to the limitations and strengths of the study. Furthermore, given the central role

that I played in both the design and delivery of the DBC LP and the research described in this thesis, a reflexive section concludes this Chapter.
However, prior to this I will briefly consider whether the *foreshadowed questions* that informed the study have been adequately addressed.

7.2 To what extent have the *foreshadowed questions* been addressed?

At the end of Chapter one, in which I provided the background to my study, I outlined the initial '*foreshadowed questions'* that prompted me to undertake a doctoral study. Following a detailed consideration of the differing forms of '*knowledge'* that subsequently informed my study (See Chapters two and three), these initial questions were expanded as captured in **Table 7.1** below.

Table 7.1 Expanded study Aims/*Foreshadowed questions*

Expanded study Aims/*Foreshadowed questions*
• What are the expectations and motivations of Nurses and Allied Health Professionals (participants), for undertaking the clinical leadership programme? What are the expectations of their managers?
• How do participants experience the programme? Do their expectations change over time and how do they feel that their expectations have been met? What do their managers, peers and junior colleagues notice about the participants after their experience of the programme?
• How have the programme aims been met? How do these aims fully reflect what the programme has achieved?
• What are the potential impacts following participation in the clinical leadership programme and what factors either facilitated or hindered any subsequent changes over time?
• How can the participants' experiences of the programme and/or any subsequent changes be understood using the *Senses Framework a*nd an *enriched environment?*
• How can any insights that emerge from the study be used to inform the development of similar programmes in differing ***C****ontexts*?

In seeking to address these questions, a theory comprising **Five C's** was developed, which suggested that it was important to consider: the ***C****ontext* underlying participants' engagement with the programme; the ***C****atalyst* that motivated them to apply (and their managers to nominate/support them); the *timing* of their participation on the programme (***C****hronology),* taking into account both personal and professional factors; the ***C****onsequences* of having undertaken the programme, both at completion and in the longer term (once again both personal and professional ***C****onsequences* were evident); and crucially the ***C****onditions* that appeared necessary to ensure that participants gained maximum benefit from the programme, and that they were able to initiate and sustain change.

The concept of an *enriched environment* in which the participants experienced the Senses themselves (both throughout the programme and subsequently during their daily working environment), and were able to create the Senses for others (colleagues and patients/carers), was a crucial consideration, with 'success' turning largely on the quality of '*relationships*'. On this basis, the idea of promoting *relationship-centred leadership* was suggested as a way forward. This will be considered more fully in the next Chapter eight.

I therefore feel that the *foreshadowed questions* have indeed been addressed and that the insights that have emerged, have considerable potential to inform developments, not only in the immediate ***C****ontext* (that is, possible future changes to the programme itself), but also wider initiatives in the local (NHS Lothian) and national (NHS as a whole) ***C****ontexts.* These will be discussed in detail in the following two Chapters.

However, if the findings of the study are to genuinely inform future developments it is important to have confidence in the quality of these findings and the processes that were used to generate them. It is to this issue that attention is now turned.

7.3 How can we have confidence in the quality of the research process and the subsequent findings?

As outlined above and described in greater detail in Chapter four, I will now use the EA Matrix (Nolan et al., 2003) to consider the quality of the research process, and the criteria suggested by Glaser and Strauss (1967) and Charmaz (2006) to consider the quality of the **Five C's** theory.
I will begin with the research process.

7.3.1 Applying the Äldre-Väst Sjuhärad (ÄVS)/ EA Matrix to the study

Chapter four described the emergence of Fourth Generation Evaluation and Guba and Lincoln's (1989) development of the 'Authenticity Criteria', as a new approach to gauging the extent to which a study had been conducted in a manner consistent with Constructivist principles. Nolan et al (2003) subsequently modified this approach, and in doing so, they sought to promote the same ideals, however, using a language that was more accessible to a non-academic audience. This development, initially termed the ÄVS Matrix, now referred to as the EA Matrix, will be used to reflect on the quality of the research process at the three stages suggested by Nolan et al (2003), that is during the **planning** of the study, during the research **process** itself and also the resultant **product(s). Table 7.2** below provides some examples of how I sought to meet the criteria at differing stages of the study and the following text elaborates upon these.

Table 7.2 EA Matrix - examples of how I used the 3P's and EAs to evaluate the quality of my study

EA Matrix	Planning	Process	Product	*Original Authenticity Criteria*
Equal Access	Robust protocols agreed and ethical approval gained to try	Values of honesty and trustworthiness applied throughout the research	Efforts to ensure that all participants' voices were heard in co-creating the emerging constructions, how	*Fairness*

	and ensure potential access to all participants who wished to take part. All potential participants invited to opt in. Information sheets provided to all in hard copies and electronically, in easy to understand language.	process. Wider access sought to engage with a sample of managers and peers	they related to practice and their relevance to leadership in healthcare. All participants' views considered. Longitudinal study over 3 Phases to capture changes over time Copies of their transcript offered to all participants after interview.	
Enhanced Awareness -Self	Semi-structured interviews over 3 Phases using open questions provided safe reflective space for participants	Hermeneutic dialogue over the longitudinal timeline. Sharing examples of emerging themes in the data, so participants could contribute to their development	Co-creation of emerging themes and constructs. Self-reflection affirmed key learning and achievements- *personal* and *professional* self-awareness enhanced.	*Ontological authenticity*
Enhanced Awareness -Others	Involvement of a range of managers and colleagues to provide wider perceptions on experiences and impact.	Participants actively encouraged to reflect on impact on peers and managers.	Data comparisons from a range of perspectives. Reflection over time allowed participants time to 'mature' and develop whilst implementing learning to practice and engage with others.	*Educative authenticity*

Encourage Action	Exploration of current and future potential actions was planned into the research process. Active reflection on these issues encouraged.	Interviews provided space to reflect on actions and encourage future actions. Inviting participants to make suggestions and give their views.	Participants gained further insights into on-going leadership role and potential actions to take, through engaging in the research study. Involving participants in discussion of emerging substantive theory and moving the *Senses Framework* towards a 'formal' mid-range theory.	*Catalytic authenticity*
Enable Action	This was not a planned activity at the outset but because of enhanced self-awareness and understanding of their leadership strengths most participants were better able to act.	Due to both taking part in the programme and the study participants felt empowered and enabled to create an enriched environment for self and others to act.	The 5c's theory was presented in a way that was readily understood by participants and this allowed them to appreciate how it might be applied in action	*Tactical authenticity*

The following sub-sections will now describe each element of the EA Matrix in turn, highlighting the synergy and connection between them.

7.3.1.1 Equal Access

In this Constructivist inquiry all participants of the 2015-2016 DBC LP group were invited to opt in to the study, in an effort to ensure as wide a range of participant's voices as possible were heard. In the end only a relatively small number (n=9) chose to do so. Most of those who did not opt in were concerned about the further work that this might entail, in addition to that required by the programme. For those who did decide to take part there was a need to balance

a range of both *personal* and *professional* factors. Therefore, making the decision to participate was not taken lightly and required careful consideration, planning and a desire to engage in the research process. Theoretical sampling as discussed earlier in Chapter four, within Phases two and three of the study, widened access by inviting a range of managers (who also participated in Phase one), peers and junior colleagues of the participants to take part. Consequently, whilst all people had the chance to 'opt in' only some did. This is inevitable in research of this type. It has therefore to be considered if only certain types of people chose to participate and whether this can be considered as a limitation of my study? This will be addressed in a later section, however as far as facilitating the opportunity to join the study, I feel that in planning the study I made every effort to promote ***Equal Access***. Everyone was fully informed of what the study was about and therefore made an informed choice on that basis.

Once the research process itself was underway the many ways in which I sought to ensure that all participants' voices were heard and that they had an equal opportunity to contribute to the development of the emerging theory, were described in detail in Chapters five and six. Similarly participants were encouraged to comment on the emerging theory, so that the product of the study, (the substantive theory), was agreed by all participants. Based on this experience it seems that Methods, as well as the Methodology, play an important part in promoting ***Equal Access***. Moreover as this was a longitudinal study, creating a Sense of **Continuity** throughout the hermeneutic dialogue within each Phase, also promoted ***Equal Access.***

In summary, promoting ***Equal Access*** involved seeking views from all participants who chose to be involved in the study, ensuring all their 'constructions' were represented and their voices were heard. My efforts to ensure ***Equal Access*** required establishing mutual respect between the participants and myself, in order to promote the open and on-going interactions necessary to reach consensus (Rodwell, 1998). Practical considerations such

as arranging a convenient date, time and venue prior to the interview were also important factors. Furthermore, all participants were offered a copy of the transcript of their interview, however everyone chose to verbally discuss the emerging themes rather than read paper copies of transcripts. All participants expressed an interest in reading the final thesis and ***Equal Access*** to this will be provided.

On the other hand it must be remembered that ***Equal Access*** was obviously restricted to staff within one particular programme within one NHS Board in Scotland, namely NHS Lothian, although a small number of staff from NHS Borders were offered the opportunity each year. This will be considered again when the limitations of the study are addressed.

7.3.1.2 Promoting Enhanced Awareness

Enhanced Awareness refers to whether participants gained a richer awareness of both self and/or others by participating in the study. In classical Fourth Generation Evaluation this is often achieved via the hermeneutic dialogue and the sharing of emerging themes at each Phase of the study. However, in my work the situation was more complex, in that it was a fundamental objective of the programme itself that all participants became more aware of their leadership style, and the programme actively sought to enhance this. Consequently, whilst Chapters five and six provided numerous examples of how participants became more aware of themselves and others, it is not possible to say with certainty whether this was due to taking part in the programme or was as a result of taking part in the study, or was a combination of the two. However, I believe that there are indications that at least some of this ***Enhanced Awareness*** was as a result of taking part in the study, especially the interview process.

All participants seemed to gain an ***Enhanced Awareness*** of their own leadership journey, including greater insights into their leadership qualities, strengths and the role that reflection had played. A number of the participants

shared that having the interview conversation had been really helpful and that talking about their experiences and exploring the emerging themes, enhanced their awareness of their progress and of any impact to date. Moreover, many managers of participants, some who had also been past participants, shared their personal insights and seemed to develop an '***Enhanced'*** understanding, through developing '***Awareness'*** of others' perspectives and experiences. This included appreciating the challenges and complex environments current leaders faced and an acknowledgement of the role they played in creating the ***C****onditions* for participants and teams to flourish.

For me therefore, an interesting and unexpected finding from the study was the value that was placed upon the experience of the actual interview process itself and its subsequent impact. Often at the end of the interview, participants noted how beneficial and valuable the process had been and that the provision of a safe and confidential space to reflect on their experience had been significant and beneficial at both a personal and professional level. Focusing on what had been achieved and the progress they had made, added further motivation and a greater Sense of **Achievement,** as is captured in the quotes by Ria and Jane below:

*'Absolutely, yeh I've **really** valued it (the interview), like every time I speak to you I leave thinking oh I feel very enthused and inspired myself, so yeh that's definitely something.' (Ria)*

'That's (the interview) been really good, it's always really good to talk through with somebody as well it's like reflective practice, I've found it very helpful as well thank you.' (Jane)

The interview process itself therefore, over and above the programme, appeared to further ***Enhance Awareness*** as participants reflected on initial expectations and considered the impact of taking part in the programme. Having the space and time to reflect during the interview seemed to enhance

the ***C**onditions* that enabled participants to realise what they had achieved and what its impact might be, as Viv and Pat illustrated below:

'That point of reflection when you think 'oh my god I have really done an awful lot and I have moved myself forward eh a lot, as well' and I think that sometimes we don't kind of sit down and think about it and chart it.' (Viv)

'(Taking part in) this research affirms what you are doing and why you are doing it and the impact it has and how it sustains people and why organisations need to invest, you know, it's not just about the clinical skills, you know, it links in with your happy healthy working life, and how we treat each other.' (Pat)

The opportunity for periods of reflection over time, which this longitudinal study provided, was appreciated and possibly enabled the participants to continue to implement their learning. It might therefore have contributed to encouraging and enabling action, as will be considered below.

In summary, throughout the study, participants, managers and their colleagues had the opportunity to engage in hermeneutic dialogue and contribute to the on-going data analysis, which seemed to '***Enhance'*** their '***Awareness'*** of emerging themes. The interview process itself provided a reflective platform to further '***Enhance'*** personal '***Awareness'*** and insights into their leadership experience. The substantive theory, which has evolved, the **Five C's**, has provided an ***Enhanced Awareness*** of the participants' experiences, subsequent impacts and enabling ***C**onditions* to creating *enriched environments.* This may well have been a major factor in encouraging and enabling action.

As for the products of the study, that is, this thesis, the theory it contains, and my suggestions for extending the EA Matrix (see later), it is hoped that they will be able to further ***Enhance Awareness*** and both ***Encourage*** and ***Enable Action.*** Their potential to do so will be considered in the next Chapter.

7.3.1.3 Encouraging and Enabling Action

As a consequence of ***Enhanced Awareness,*** Constructivist inquiry aims to alert participants to new opportunities for action (Rodwell, 1998; Nolan et al., 2003). Once again however, with respect to my study, disentangling the effects of taking part in the programme from those due to taking part in the study is not straightforward. In Chapters five and six, participants provided numerous examples of how they had been ***Encouraged*** and ***Enabled*** to act, both during and after the programme. The Five C's theory shed light on the ***C****onditions* that appeared necessary for positive ***C****onsequences* to be initiated and sustained. However, it was important to explore whether these were due to the programme, taking part in the research or, more likely, a combination of both.

Once again I feel that there is evidence that taking part in the research did play a role in further ***Encouraging*** and ***Enabling Action***. The importance of building and sustaining *relationships* between participants, their managers and the wider team was a core ***C****ondition* central to both ***Encouraging*** and ***Enabling Action***. This was confirmed by the narratives and lessons learned from Element B participants, which also highlighted the key enabling factors to ***Encourage Action***, which resulted in creating and sustaining the ***C****onditions* for positive ***C****onsequences* to be embedded into practice. There is little doubt that the *enriched conditions* created within DBC LP, had ***Encouraged Action*** within the group of participants, which consequently enabled continued learning and stretch through providing an additional ***C****atalyst* to ***Encourage*** and ***Enable Action.***

The data collection process also played a part in ***Encouraging Action*** and ***Enabling Action***. As noted above with respect to ***Enhanced Awareness,*** taking part in the interview process over time had a positive effect on the participants' awareness of self and others, and there is also little doubt that the sharing of ideas between participants and their managers contributed to their growing *relationship* and is likely to have had an important, albeit impossible to

quantify, effect on the extent to which subsequent ***Action*** was ***Encouraged*** and ***Enabled***. In addition, it was clear that the longitudinal nature of the study over three Phases ***Enabled*** participants to reflect over time and possibly to plan for further action on a proactive basis.

Having considered the extent to which the study might be said to have met the EA criteria, below I turn attention to how this EA Matrix might be extended.

7.3.2 Extending the EA Matrix: Evaluating and Embedding Action

When the 'Authenticity Criteria' were originally suggested, (Guba and Lincoln, 1989), and subsequently modified (Nolan et al., 2003), their intention was to provide a means of gauging the extent to which a study engaged participants in a way that was consistent with Constructivist principles. However, since using them in this longitudinal study, which explored a programme, which was designed to bring about changes in behaviour of the participants, it seemed to me, that the EA Matrix might be usefully extended to consider impact in the longer term.

My study suggested that both the programme and participation in the study had indeed ***Enhanced Awareness*** of self and others, and subsequently ***Encouraged*** and ***Enabled Action*** by stimulating the ***C****onditions* necessary to create and sustain an *enriched environment*. However, whilst these changes seemed to be beneficial, the EA Matrix did not suggest a formal means of demonstrating this. I would therefore argue that it would be very useful to ***'Evaluate'*** any ***Action*** that occurred. Furthermore if the ***Action*** proved to be beneficial, then it would make sense to explore ways in which the ***Action*** could be '***Embedded'*** in day-to-day practice. If, on the other hand, the ***Action*** did not prove to be beneficial, then '***Embedding'*** it would be counterproductive and an ***Enhanced Awareness*** of this would be useful in order to ***Encourage*** further ***Action*** to improve the situation. In this way the EA Matrix could be used as a tool for reflection on the quality of qualitative research studies, and in addition,

initiatives such as leadership programmes. It would also potentially be useful as a practice tool in clinical and related healthcare settings. This would add a level of greater flexibility, which aligns with current approaches to reflective practice that are based on a collaborative approach (Wilson and Clissett, 2011).

I suggest that the introduction of the two new elements: ***Evaluate Action*** and ***Embed Action,*** contributes to the overall value of the EA Matrix and provides a means of promoting a structured approach to reflection that is practical, 'flexible', 'fit for application' and 'understandable' (Lomborg and Kirkevold, 2003; Glaser and Strauss, 1967).

In this way the EA Matrix would no longer be a 'Matrix' but rather a cyclical process that would potentially by very useful both in a research ***C****ontext* and for practitioners when considering quality improvement changes to their work environment. It would continue to be useful in gauging the quality of Constructivist work and also have wider application with regard to differing, yet similarly related methodologies, such as Action Research. This is captured in **Diagram 7.1,** referred to as the EA Matrix 'Cycle'.

Diagram 7.1 The EA Matrix 'Cycle'

Having considered in some detail the extent to which the study can be said to have met the EA Matrix criteria, and suggested an extension to this, attention is now turned to the quality of the **Five C's** theory itself.

7.4 Reflecting on the Quality of the substantive theory- the Five C's

As was noted in Chapter four, there is no clear consensus on how to judge the quality of a grounded theory. Here I use the criteria suggested by both Glaser and Strauss (1967) and Charmaz (2006; 2014), to support my reflective judgments (see Chapter four for rationale). Although the criteria proposed by Glaser and Strauss (1967) clearly preceded those of Charmaz (2006; 2014), as my study was influenced more by the writings of Charmaz (2006; 2014), I will consider her criteria first. A summary of Charmaz's criteria and how I feel that I met these is provided in **Table 7.3.** I elaborate upon these in the subsequent text under credibility/resonance and originality/usefulness, as these seem logically related at a conceptual level.

Table 7.3 Summary of Charmaz's Criteria for evaluating Quality of Constructivist Grounded Theory

Charmaz's Criteria	Points to consider when evaluating quality in Constructivist Grounded Theory	Summary of points and signposting to relevant Chapters
Credibility	• Is the researcher familiar with the setting and topic?	• Yes –vast experience as leadership facilitator and Organisational Development see Chapter one
	• Are the data sufficient to merit the claims? Have systematic observations been made between categories? Do the categories cover a wide range of observations?	• Yes -robust description of Data Analysis processes in Chapter 4 section 4.10
	• Are there strong links between the gathered data and the argument and analysis?	• Yes – **Five C's** Theory provides credible account of data (participants' experiences and subsequent impacts), which links to wider discussion –See findings Chapters 5/6 and discussion

		Chapter 8
	• Is there enough evidence for the claims to allow the researcher to form an independent assessment and agree with the claims?	• Yes – Robust use of quotes from participants' narratives. See Chapters 5/6 and Chapter 8
Originality	• Are the categories fresh and do they offer new insights?	• Yes- based upon the *sensitising concepts*, which is new in leadership literature
	• Does the analysis provide a new conceptual rendering of the data?	• Yes- *relationship-centred leadership* is a new concept for consideration. The **Five C's** is a new theory.
	• What is the social and theoretical significance of this work?	• **Significance** to proposing *relationship-centred leadership* and the value of the **Five C's** theory. See Chapters 8 and 9
	• How does the Grounded Theory challenge, extend current ideas and practices?	• Advances the use of the *Senses Framework* and *enriched environments.* **Five C's** theory offers unique opportunities for application. See Chapters 8 and 9
Resonance	• Do the categories portray the fullness of the study experience?	• Yes- Extends beyond professional to include personal impacts and includes past participants over time. See findings Chapters 5 and 6
	• Have taken for granted meanings been revealed?	• Yes- See Reflexivity accounts in Chapters 4 and 7
	• Where the data indicate, have links been drawn between institutions and individual lives?	• Yes *Professional* and *Personal* impacts explored in findings Chapters 5-6
	• Does analysis offer participants' deeper insights about their lives and worlds and does the theory make sense to them?	• Hermeneutic dialogue with participants throughout the study ensured co-construction of emergent theory
Usefulness	• Does analysis offer interpretations people can use in their everyday worlds?	• Yes - practical, understandable and applicable, see Chapters 8 and 9

	• Are there any generic processes within the categories and if so, have they been examined for tacit implications?	• See robust reflexivity throughout processes and evaluation of quality- Chapters 4 and 7
	• Does the analysis spark further research in other substantive areas?	• See potential for further research in recommendations Chapter 9
	• How does the work contribute to knowledge? How does it contribute to making a better world?	• See Implications and recommendations in Chapter 9

(Charmaz, 2014, p. 337-338)

7.4.1 Credibility and Resonance

Several processes were enacted to ensure optimum credibility and resonance of the theory that emerged from my study. Reflexivity and supervision played an important part and helped me to explore and challenge any assumptions, preconceived ideas or biases that I might have held, and ensured that I avoided 'forcing' the data to codes. Constructive challenge during supervision was pivotal in relation to ensuring the robustness of data analysis in ensuring that my findings were grounded in the data. This helped to ensure that honesty, integrity and professionalism, which are values I have held throughout my career, were sustained during the research process. I feel this supported my ***credibility*** as a researcher and practitioner.

The hermeneutic dialectic process with participants during the Constructivist inquiry, which was explored earlier in Chapter four, provided further opportunities for transparency and sharing of my decision-making and rationale within my data analysis, which I tried to ensure was clear, concise and explicit (Charmaz, 2006; Houghton et al., 2013; Charmaz, 2014). This also added to ***resonance*** – by checking that emerging themes and codes resonated with the participants at each Phase.

Prolonged engagement with participants over the two-year period of this longitudinal study enabled the formation of effective *relationships* that were based on mutual trust. Engagement with participants of Element B (past participants over the last eight years) was over a shorter period, however communication via telephone or email allowed hermeneutic dialogue and clarification of emerging constructs (Rodwell, 1998). All participants were incredibly committed and willing to be contacted as and when the study required, which was much appreciated.

Ensuring confirmability in this study involved diligence in all processes, maintaining professionalism and honesty in note keeping, writing transcripts and decision-making in terms of analysis. I hope that this will enable anyone reading my work to follow the processes and make sense of the steps taken from initial data collection through to findings and discussion (Rodwell, 1998).

7.4.2 Originality and Usefulness

The ***usefulness*** of my research findings for the leadership 'landscape' going forward was a continual personal driver and key motivating factor throughout my study. No previous studies have used the *Senses Framework* both as an underpinning theory, and facilitation and delivery mechanism, in order to explore factors that enable and hinder the sustainability of impact following leadership development, which suggests ***originality*** of my research that I hope will provide a contribution to knowledge. This will be discussed in Chapter nine. Further debate as to the potential ***usefulness*** of my work will follow in the next Chapter.

An additional set of criteria for considering the 'quality' of a grounded theory are those of: *work; fit; grab* and *modifiability* proposed by Glaser and Strauss (1967). Although these were not designed for use in a Constructivist study, they do have a focus on the practical utility of a theory and I therefore considered it important that my study also met these criteria, given that one of my goals was

to produce a piece of work that could be applied to improve future leadership development.

Consideration is given to each of these criteria in relation to my substantive **Five C's** theory, as is illustrated in **Table 7.4**.

Table 7.4 Work, Fit, Grab and Modifiability Indicators -The Five C's Theory

Indicator	Questions to consider	Summary of evidence
Work	Does the theory *work* in the sense that it provides a better understanding of the issue under study and does it *work* in that it provides insights, which can be applied in the real world?	Using an alliteration of C's – ***C**ontext, **C**atalyst, **C**hronology, **C**onditions* and ***C**onsequences,* Chapters five and six illuminated the experiences of all participants and provided insights for application elsewhere.
Fit	Does the theory *fit* with the data that are used to support it?	**Five C's** emerged and were developed from the data, which support and advance the *Senses Framework* and *enriched environments*
Grab	Does the theory 'grab' the reader's imagination, so they can see that it applies to the issue under study?	Simple understandable use of language, using alliteration of '**C**'s' to enable reader to readily see how each '**C**' connects and interlinks, whilst also relating to the Senses
Modifiability	Can the theory be potentially *modified* in the light of new data?	Flexible for various situations and applications, adjustable, potential to be an evolving theory, which could be tested out following recommendations in

		Chapter 9. **Five C's** has moved the idea of the *Senses Framework* towards a formal mid-range theory; therefore it has scope and potential for further modifications.

In conclusion, the **Five C's** theory does appear to meet both sets of quality criteria as proposed by Charmaz (2014) and Glaser and Strauss (1967).

Having considered the 'quality' of the study from a number of perspectives, the next section turns attention to the limitations and strengths of my work.

7.5 Limitations and Strengths of the study

The following section will discuss the potential limitations and strengths of the study. I do not reflect here on my role in the process, as this is considered in separate sections 4.12 and 7.6, however I do acknowledge the possibility of my dual role as researcher and facilitator being a potential limitation of the study.

Inevitably in a small-scale study undertaken as part of a doctoral programme with limited resources of time and money, there are numerous potential limitations. However, in considering these, it is important to be reasonable about what can be expected and at the same time, it is necessary for the researcher not to over inflate claims about their work.

Therefore, it must be acknowledged that this study was centred on one particular programme, within one NHS Board in Scotland, with its own culture and ***C**ontext.* Consequently, it is essential not to assume that the theory developed and the lessons learned, are necessarily transferable to other ***C**ontexts* and settings. However, I hope that I have provided sufficient detail about the ***C**ontext* so that potential application to other settings is enhanced.

The extent to which this might be achieved is considered in the next two Chapters.

Another potential limitation is that of sample size. However, as I have discussed earlier, this is not a major consideration in a qualitative study of this type, and every effort was made to ensure that all those who wished to participate had the opportunity to do so. Since my study took place, the DBC LP has been made available to a far wider group of staff including support services, administration and clerical staff. This more diverse group could potentially have produced quite different findings, but the widespread application of the Senses in other studies would suggest that this is not necessarily the case.

On the positive side, this longitudinal study was conducted over an extended period of time and, as was hopefully demonstrated above, remained true to Constructivist principles. I feel that the substantive **Five C's** theory, which emerged, has the potential for far wider application, and this will be explored further in the next Chapters. Moreover, the embedding of the study within the *Senses Framework* also suggests the potential for the findings to have wider transferability, and this is also considered in Chapters eight and nine.

7.6 My personal reflections and insights

The final issue to be considered in relation to the quality of my study is that of reflexivity. As has been noted at several points, due to the central role I played in both the programme itself and this study, it is important to consider any impact that this might have had.

In Chapter four I described how reflexivity in grounded theory studies has been given relatively little attention until recently. However, following a review of the literature of the topic, Gentles et al (2014) outlined a framework that identified what they considered to be the main areas that should be considered. I chose to adopt this, and extended it by adding the work of

Ramalho et al (2015). I also described how I felt that I had addressed these dimensions of reflexivity up to the point of starting the study (See Chapter 4 section 4.13). I build upon this here in the following sub-sections, with the addition of further insights that emerged as the study progressed, and using the *Senses Framework,* to consider the extent to which I feel that I both created and experienced an *enriched environment*:

- ***What influence have I had on the research design and questions, including pre-existing knowledge/concepts and role played by the literature?*** These issues were discussed in detail in Chapters one to three. Here I noted that I did not undertake a traditional review of the literature but rather drew on a range of differing forms of knowledge to inform my *foreshadowed questions.*
- ***What was the nature of my interactions with the participants?*** Again, this was discussed in some detail in Chapters one to three and within the Ethical Considerations in Chapter four, where I discussed any 'power' that the participants may have perceived that I had, how I communicated with the participants, the collaborative elements of the study and how I involved them in co-constructing the theory.
- ***How might I have influenced the way in which the data was collected and analysed?*** This was described in detail in Chapter Four, particularly in relation to the approach I employed when conducting my Grounded Theory analysis, with a focus on constant comparison, memo writing and maintaining a reflective diary, which Gentles et al (2014) suggest helps to ensure that the researcher implements reflexivity. Below I expand further on my part in data analysis. Charmaz (2014, p. 32), states that: '*The quality of your study starts with the data, as does its credibility'.* The

extract in **Table 7.5** is from a memo I had written when reflecting on the quality of my data collection, and highlights the questions I asked myself whilst striving to ensure the quality and credibility of my data.

Table 7.5 Memo reflecting on ensuring Quality (16/11/17)

'Having heard Deborah Rowland (*writer, inspirational speaker, change coach, author and teacher, in the field of leadership and change)* speak at a conference, her work resonated with me and I became curious as to how I could think about this in the ***C**ontext* of my study. 'Still moving' is about 'mindful' change… has given me ideas to consider reflecting on the quality of my research process and the actual data itself. How can I ensure it is credible and how will I know if I have sufficient depth and scope of data?'

Rowland (2017) talks about creating moments of stillness as a leader and the programme, which is the focus of my study provides this opportunity for participants to 'pause', stay still and reflect on who they are and be clear about what is their purpose and focus as a leader. I am now mindful of the importance of creating moments of stillness during the actual data collection process and how it may impact upon the quality of the data I collect. Taking moments of stillness before and after each interview is one way I have been doing this implicitly. What else should I be considering and could discuss at supervision to ensure the highest quality of my data and equally as important, how I collect the data?

Reflective practice enables me to focus on the quality of the research process and the data. Questions I keep asking myself:

How can I ensure I have sufficient background context data about my participants?

How much detail do my questions glean in relation to participant's views and motivations?

What is **not** being said? How can I seek to understand then be understood in my questioning techniques?

How can I ensure enough comparisons in the data I gather from Element A and Element B and the participants' managers /peers?

My initial thoughts:

One of the benefits of insider role is that I glean intelligence and insights over 10-month programme as I develop and build relationships with the participants.

The longitudinal study over 3 Phases provides me with 3 opportunities to interview participants, creating a Sense of **Continuity** and reconnecting- potential to enhance relationships.
Continuity of participants and managers engaged in the study contributes to the richness of data opportunities.
Transcripts are lengthy and through transcribing them myself I am immersed in the data- the challenge might be reducing data - enabling succinct quotes within findings.
Emerging themes/connections across transcripts allows an exploration of what might be beneath the surface and not being said by participant.
Comparisons are made between Element A and B participant's data.
Time is spent at the start of each interview to create a Sense of **Security** and **Belonging**, role modelling throughout the process and developing rapport within the relationships.
Skills I have developed as a coach enable me to reflect on potential limiting assumptions, biases and hear what is being said and perhaps not being said- seeking to understand.
Therefore, quality needs to be explicit throughout the research process- through reflection and the use of memos I will strive to maintain this focus.

A significant part of this Constructivist inquiry involved the use of memos and reflexive diary notes as previously discussed in Chapter four, which provided an account of my personal learning journey and development of constructions throughout the process. This also had a positive impact on my ***Enhanced Awareness,*** as I navigated my way through the research journey and realised that with the vast amount of data gathered during the study, a pragmatic approach would be required as not all data could possibly be included in the thesis.

- ***How might I have influenced the writing and reporting of this study and subsequent thesis? How might the experience of undertaking this study have impacted upon me personally?*** Memos, as previously discussed, have been an important part of the discovery Phases in my research journey and have been used in various ways to capture my

reflections, ideas and thoughts. Since the outset of my Researcher Development Programme (RDP) I have kept a reflective diary, which I have found to be motivational, educational and therapeutic on occasions. Reading my reflective accounts enabled me to gain insights into my learning (***Enhanced Awareness)***, thinking processes, (***Encouraged*** and ***Enabled Action***), and has affirmed how steep a learning curve this whole experience continues to be.

Using NVivo to hold memos alongside transcripts, as described in Chapter four, section 4.9, I revisited, edited, updated and added to memos throughout the study, as I became more competent, aware and experienced. I found memos helpful to 'notice' and reflect upon, and they have significantly informed my 'writing' to enable me to piece together my research jigsaw (Glaser and Strauss, 1967).

Using a constant comparative method when analysing the data, my memos made my writing more meaningful and dynamic and were useful, supportive memory aides:

- *Operational Memos* recorded steps in my research process and my rationale and reasoning behind my decisions and progress during the Phases.
- *Coding memos* were used for exploring the Coding and categorising themes as they emerged from the data.
- *Analytical Memos* were for examining, explaining and conceptualising my data.

An example from an operational memo below, highlights how I often found that writing a small reflection was therapeutic at the time and also encouraging (***Encouraging Action***), at a later stage, when re-read, which supported self-management and maintained progress:

'Keeping things calm and in perspective- I feel it gaining momentum and speed now as there are so many conflicting priorities. I need to focus and gradually

*keep chipping away to create a Sense of **Achievement**- small hills to climb towards the summit.' (Memo extract, 14/8/16)*

Reflecting on my *personal* and *professional* journey, since I stepped into the role of student and part-time researcher, I have continued to develop my self-awareness on what I refer to as a life-long journey of discovery and learning.
I gained promotion during my second year of the RDP, which increased my responsibilities, whilst allowing me to work within the OD Team and to continue to lead on various leadership work streams. This created a Sense of **Significance** and enhanced my self-confidence, which contributed to my personal resilience and determination to enjoy my research experience, albeit challenging and incredibly busy.

Cultural influences and sub-cultures were an interesting dimension to consider within my OD role, particularly in a large organisation such as NHS Lothian. Variability is vast, even from ward to ward and this is often tangible the moment you walk into a clinical area and get a sense of the leadership, team dynamics and if it is an *enriched environment* or not. Having worked within this organisation for many years I was curious as to how to create the ***C**onditions* for *enriched environments* more consistently and was keen to explore my circle of influence within this.

I am passionate about leadership and developing clinical leaders within healthcare and over the past fifteen years I have observed leaders in action and developed my curiosity about what it is that effective leaders do, say, think and feel. My aspiration is to 'demystify leadership' and enable leaders at all levels of the organisation to understand what their role is as a leader and to support them to grow and sustain their development. Undertaking this research study has provided a platform, which I hope will allow me to continue this journey of discovery.

Throughout the research study my core values of honesty and integrity have been of paramount importance, particularly when engaging with participants, their managers and colleagues. Respecting confidentiality and maintaining professionalism at all times are fundamental to my professional self and identity. Being open and transparent when changing 'hats' from consultant/facilitator to researcher became explicit and part of the contracting conversation, which I employ when working with staff as a Coach within the organisation. Experience over many years has prepared me and enabled me to develop a level of expertise in articulating my **Purpose** and role within the various *relationships* and interactions I engage in with the diverse workforce.

- ***What role have my supervisors played in influencing my study?*** Ramalho et al (2015) suggest that this is an important additional aspect of reflexivity, especially for doctoral students who need to be explicit and clear about the part that supervisors played when writing their thesis. I have referenced my Supervisors and the role they have played, at several points throughout my thesis, particularly in Chapter one section 1.2 and will elaborate on this here. During the design of the pilot *Leading into the Future Leadership Programme*, as described in Chapter three, I had the privilege of meeting both my Supervisor Professor Jayne Brown and advisor Professor Mike Nolan, and subsequently working together to deliver the pilot programme along with Professor Sue Davies and Janet Nolan. I subsequently had the opportunity to work with both Professors over the past few years, on various projects, and learn from their experience and knowledge. Our developing and often geographically distant working *relationships*, then led to my current experience of undertaking a Doctorate and navigating the world of

research. Therefore, contracting and being explicit in terms of expectations, roles and responsibilities, has been crucial throughout this time. The positive factors of having had an existing *relationship* with both Professors prior to commencing the doctoral studies have included established mutual respect and trust, as well as confidence in one another's abilities to commit to agreed actions. Rapport had already been created prior to this study, which allowed effective communication over the telephone, as face-to-face meetings were only possible once or twice per year, due to the geographical distances involved and full time working commitments. Important conversations at the beginning of this research journey, based upon honesty and transparency, therefore enabled me to transition to the role of student. At the RCN International Research Conference in 2017, where Professor Brown and I co-presented a ViPER (Visual Presentation with Expert Review), about my research study (Moore et al., 2001), we were given positive feedback about how we had demonstrated and role modelled the importance of creating, building and sustaining a mutually respectful supervisory *relationship*, when pre-existing connections were present, and support was required from a distance, over time. Investment in effective communication and continually seeking mutual understanding has required a level of maturity, patience and honesty from all parties. Setting clear, realistic goals and sharing regular progress reports following supervision sessions has been important in ensuring a Sense of **Achievement** and movement towards the agreed timeline. Limiting assumptions and being open to challenge, has hopefully reduced the potential for bias and contributed to creating the ***C****onditions*

for an *enriched* doctoral *learning experience*- a parallel process to the participants engaged in the DBC LP and also in this study.

In conclusion, creating the Senses for myself as researcher throughout the doctoral journey has enabled an *enriched learning experience*, which could be described as a parallel process with the participants of DBC LP. I needed to feel **secure (**Sense of **Security)** at the start of the process and importantly throughout the journey. Creating a Sense of **Significance** and **Purpose** was possible through supervision and commitment to completing the RDP to my best ability. Creating a Sense of **Belonging** was at times challenging due to the geographic distance and subsequent challenges requiring virtual engagement and online meetings. Therefore, meeting face to face was required intermittently and planned well in advance. Creating a Sense of **Purpose** and **Achievement** was supported through participation in the RDP and following a 'PhD Gantt chart' timeline, which enabled me to map out my progression. Milestones such as the Faculty of Research Ethics Committee (FREC) and Proposal acceptance, Annual Review and Formal Review all contributed to the creation of a Sense of **Achievement** and **Purpose**. A Sense of **Continuity** was enabled through regular supervision, the RDP and support at work and by my family and friends. The longitudinal study and three Phases also created a Sense of **Continuity**, **Purpose**, **Significance** and **Achievement.**

7.7 Chapter summary

In summary, this Chapter has reflected upon the quality of the study, in relation to the research process itself and the substantive **Five C's** theory, which was developed. In addition I have suggested how the EA Framework might be expanded upon to include two new dimensions: ***Evaluate Action*** and ***Embed Action.***

I have also highlighted several lessons I learned during the research process, and have included an exploration of the impact of the interview process as part of the study. Limitations and strengths of the study have also been discussed, and given the role I have played within the research process itself and within the design and delivery of the DBC LP*;* an extensive reflexive section has concluded this Chapter.

The next Chapter will discuss how the substantive mid-range **Five C's theory** has advanced the concept of the *Senses Framework,* towards a 'formal' mid-range theory and will illuminate the **Significance** of creating *enriched environments* to enable *relationship-centred leadership.* The discussion will make reference to current literature and suggest what this means for leaders and leadership in healthcare.

Chapter Eight. The Significance of *relationship-centred leadership* and the *Senses Framework*

8.1 Chapter Overview

Having in the previous Chapter considered the quality of the work that lies at the heart of my thesis, this Chapter explores the potential **Significance** of my findings, both with respect to the substantive **Five C's** theory that was developed, and the contribution that the study has made to further establishing the importance of *relationships* and the notions of creating *enriched environments (**C**onditions),* which emerged from this study. As a result a new way of considering and promoting '*relationship-centred leadership'*, together with the Senses Framework (Nolan et al., 2006) will be proposed.

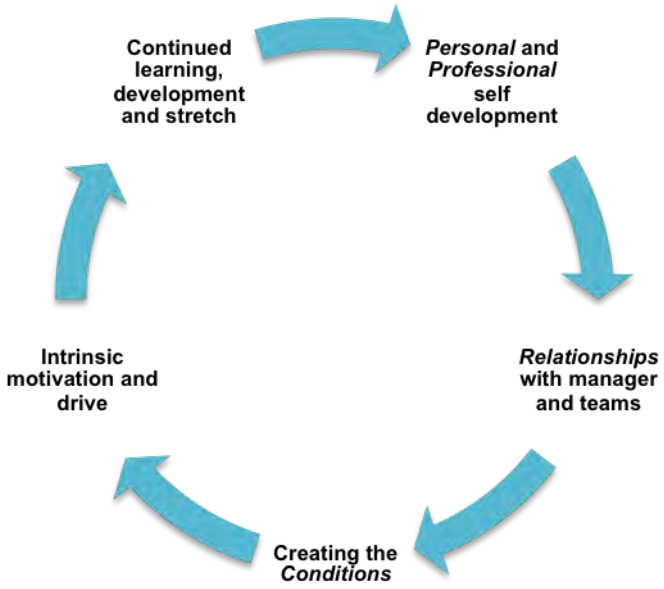
To recap, this study explored the experiences over time, of participants who embarked on the DBC LP, (see Chapter four sub-section 4.8.1), together with a number of their managers and peers, to gain a better understanding of the factors that might either enable or hinder any subsequent ***C**onsequences* or impact. To give direction to the study, a number of '*sensitising concepts'* were used to frame a series of '*foreshadowed questions'* (see Chapter three section 3.5). In addition to acting as my primary '*sensitising concepts*,' the *Senses Framework* and *enriched environments* also played a key part in my data analysis and the presentation of findings (see Chapters five and six). How the ***C**onditions* necessary to facilitate an *enriched environment* were created both during and following the programme were described, the whole being captured in the **Five C's** theory, highlighting the interaction of a range of factors: ***C**ontext, **C**atalyst, **C**hronology, **C**onditions* and ***C**onsequences.* This theory, when allied with the *Senses Framework,* has several implications for future developments in relation to leadership and associated initiatives that will be considered in this and the next Chapter.

This Chapter will focus primarily on how the substantive mid-range **Five C's** theory, which emerged from the study, has advanced the concept of the *Senses Framework,* moving it further towards a 'formal' mid-range theory, and will also

illuminate the **Significance** of creating *enriched environments* to foster *relationship-centred leadership.*

Focusing on ***how*** leaders build and sustain effective *relationships* and ***how*** they create the ***C****onditions* to do so, this study suggests that the *Senses Framework* (Nolan et al., 2006) provides an excellent underpinning mechanism to enable this to happen. I will discuss in this Chapter the key enabling factors that emerged from the study, which **Diagram 8.1** below illustrates.

Diagram 8.1 Creating the *Conditions*- key enabling factors



8.2 The Five C's theory: What is it and what does it add?

Ellis and Crookes (2004) describe a theory as being a representation of a situation, that comprises a number of concepts or constructs that are interrelated. Similarly for Charmaz (2014) a theory highlights a number of *relationships*, which promote understanding of the topic or situation under inquiry. A substantive mid-range theory is developed through investigation of one particular organisation or aspect, as in this study, rather than seeking to generalise across a broader area, as does a formal theory (Goulding, 2002).

However, I believe that the substantive theory, the **Five C's**, which was developed from this study, through focusing upon one specific programme, DBC LP, in one organisation, NHS Lothian, offers a foundation for further development and application to a range of related ***C****ontexts,* in other words, that it is potentially modifiable and is likely to resonate with others (Glaser and Strauss, 1967; Goulding, 2002). This potential is further enhanced by the linking of the **Five C's** theory with the *Senses Framework*, via the creation of an *enriched environment*.

As was explored in detail in Chapter three, there is significant empirical evidence to support the appropriateness and value of using the *Senses Framework* within older people's care, including people with dementia, and within student nurse education (Tresolini et al., 1994; Davies et al., 1999a; Nolan, Davies and Grant, 2001; Nolan et al., 2002b; Ryan et al., 2008). This study therefore builds upon this extensive research evidence and demonstrates the importance of creating the ***C****onditions* for developing and sustaining *relationships* in leadership. I suggest this concept is referred to as *relationship-centred leadership* and that the *Senses Framework* is pivotal in facilitating this to become a reality in practice.

Relationship-centred leadership therefore can enable leaders to implement, sustain and embed learning and impact to practice, which subsequently impacts positively on the team, patients, students and the wider organisational culture. Through investment in developing compassionate leaders who focus upon creating the ***C****onditions* for engagement and sustaining effective r*elationships*, organisations such as NHS Lothian have the opportunity to continue to promote a collective leadership culture.

The idea of *relational oriented leadership* is not new in the literature and variants have indeed been proposed since the 1950s (Stogdill and Coons, 1957; Likert, 1961; Graen and Uhl-Bien, 1995; Gerstner and Day, 1997; Liden, Sparrowe and Wayne, 1997; Bennis and Thomas, 2002; Tabernero et al.,

2009). For example, Hollander's proposed '*relational theory'* (1964; 1980) as a way of highlighting the importance and influence of followers and leaders' interactions on their *relationships,* whereas Howell and Shamir's (2005) work focused on *charismatic* leadership qualities in developing *relational* leadership. Other *relational* theories in the literature have included '*leader-member exchange'* (LMX theory) (Graen and Uhl-Bien, 1995; Gerstner and Day, 1997; Liden, Sparrowe and Wayne, 1997; Lichtenstein et al., 2006), people oriented collaborative models, and distributed approaches (Rost, 1993; Rost, 1995; Komives, Lucas and McMahon, 2013).

However, despite these suggestions, there has been limited work to date, on developing a framework that suggests how *relational leadership* can be created, especially in the ***C****ontext* of today's complex healthcare system (see Chapter two). When staff frequently feel under pressure due to excessive workload, and face crisis situations and deadlines; (described in the literature as being '*in the grip'*) (Briggs, 1976), they often feel unable to engage in a relational way (Chadwick and Jeffcott, 2013). In a recent study Dewar and Cook (2014) found that through supporting nurses in communities of practice, using appreciative inquiry and action learning tools, staff were enabled to influence and support compassionate *relationship-centred care* for their patients. This resonated with the findings from my study and suggests that with supportive *relationships* in place that foster a Sense of **Belonging, Security** and **Significance**, staff can be enabled to adopt a *relationship-centred leadership* approach. There is therefore a need to develop supportive and caring *relationships* within organisational cultures, so that staff feel valued (Perlo et al., 2017; West et al., 2017; Intezari and McKenna, 2018; Malila, Lunkka and Suhonen, 2018; Swensen, 2018; The Kings Fund, 2018c; The Kings Fund, 2018a).

The substantive **Five C's** theory that emerged from this Constructivist inquiry offers a means to enable this to become a reality within healthcare. Therefore this study offers a way of operationalising leadership to help to create compassionate caring *relationships*, where staff feel valued and supported.

Rather than paying homage to these relational ideas, the **Five C's** theory suggests practical ways in which an *enriched* culture can be created through leadership.

The following section will now explore the **Significance** of the **Five C's** theory and discuss how together with the *Senses Framework,* it can provide the facilitation mechanism to promote compassionate, collective leadership across complex healthcare systems such as the NHS. An exploration of how the literature supports each of the **Five C's**, or not, will also be provided.

8.3 Aspiring towards a compassionate, collective leadership culture

8.3.1 Leadership *Context*

The importance of the first '**C,' *C**ontext*** (as described in Chapter five) is cited widely in the extensive leadership literature, which describes a range of contextual circumstances in relation to leaders, followers and leadership situations (Bryman, Stephens and a Campo, 1996; Boud and Walker, 1998; Firth-Cozens and Mowbray, 2001; Shamir, 2012). However, until recently leadership in healthcare has centred on enhancing patient experience, improving the population's health, whilst ensuring cost effectiveness in the provision of safe, person-centred care of a high quality. This is referred to as the 'triple aim' (Berwick, Nolan, and Whittington, 2008; The Kings Fund, 2013b; The Kings Fund, 2014; West et al., 2017; Perlo et al., 2017; The Kings Fund, 2018c).

However, more recently there has been an aspiration across complex healthcare organisations such as the NHS, of creating a leadership culture based on collective, compassionate leadership, with a focus on transformation and innovation using quality improvement methodologies (West et al., 2014a; Rose, 2015; Knight et al., 2017; West et al., 2017; Perlo et al., 2017; NHS

Improvement, 2018; The Kings Fund, 2018b). This bold ambition aims to enhance care for frail older people, complex needs of children and adults, thus reducing health inequalities and aiming towards a sustainable model of health and care, supporting communities, and therefore reducing dependencies of individuals, whilst promoting health and well being. The ***C**ontext* for integration and collaborative working across health and social care, to enable compassionate, collective leadership to become a consistent reality, therefore requires *relationship-centred leadership* at national, local and immediate levels (Chreim et al., 2013; Scottish Government, 2016a; West et al., 2017). Consequently, the importance of improving staff experience and engagement is becoming recognised as a strategic priority (NHS England, 2014; Scottish Government, 2016a; Scottish Government, 2016b; NHS Scotland, 2017b; NHS Wales, 2018).

Extensive research by the Institute of Healthcare Improvement (IHI) now demonstrates that fundamental to the delivery of an effective healthcare system is an equivalent focus placed upon enhancing staff experience and engagement, referred to as the Quadruple aim (Perlo et al., 2017). My study has illustrated how the DBC LP supports and enables leaders to create a Sense of **Purpose** and **Significance** within their roles, and provides a platform for their continual growth and learning, which clearly aligns with the goals of the Quadruple aim (Perlo et al., 2017).

Table 8.1 captures key questions identified by the IHI, which are proven to be valuable in capturing data in relation to achieving the Quadruple aim. Finding '*joy in work'* emerged as one of the enabling factors to creating the ***C**onditions* for *relationship-centred leadership* and sustained impact in this study. Those participants who were passionate about their role and profession, who were energised and fulfilled by their work, created a Sense of *personal* and *professional* **Achievement** and thus experienced meaning, **Purpose** and joy.

Table 8.1 IHI Key Questions to achieving '*Joy in work'*

What matters to you at work? (What makes a good day for you?)
When we are at our best, what does that look like? (What brings joy in work?)
What gets in the way and doesn't allow you to perform at your best (what are the stones in your shoe?
What makes you proud to work here?

(Perlo et al., 2017)

Therefore, there are clear links between the concept of '*joy in work'* and understanding what matters to staff, to the development and sustaining of *relationship-centred leadership,* through the creation of the Senses, which this study illustrates. The importance of building and developing trust and respect is fundamental to this process, as captured in this quote: *'Leaders foster collaboration by building trust and facilitating relationships'* (Kouzes and Posner, 2012, p.21)*,* and something affirmed by several other authors (Covey, 2015; Stanley and Carvalho, 2016; Perlo et al., 2017; Stanley and Stanley, 2018).

Enabling and supporting staff to find joy, meaning and **Purpose** in their work must therefore be a priority for leaders at all levels of the organisation. Engaging in meaningful conversations around 'what matters' to an individual is pivotal in this process of staff engagement thus creating a Sense of **Significance.** The key factors that were described in Chapter five and summarised in diagram 8.1, support and promote staff engagement and experience. When people feel safe (Sense of **Security**), and that they **belong** to a team in which they have a clear role **Purpose**; they are more likely to feel that they are **Significant** and matter, which subsequently enables them to **Achieve**. With the presence of effective *relationships* and an *enriched environment*, this contributes to the Sense of **Belonging** and provides **Continuity**. This is now often referred to as '*compassionate leadership'* with

'*the challenge then being to nurture a strong culture of compassion in healthcare'* (West et al., 2017 p.3).

Compassionate leadership enables people to feel valued and that they personally make a difference, which has a positive impact on engagement, motivation, collaboration and team working (Swensen et al., 2013; Sharp et al., 2017; West et al., 2017). Creating a Sense of **Security** and **Belonging** (Nolan et al., 2006) are pre-requisites to modelling compassionate leadership, where people are able to work together, feel confident and consistently supported, which has a positive influence on the organisational culture and quality of care (Edmondson 1999; Atkins and Parker, 2011; Dutton, Workman, and Hardin, 2014; Schneider et al., 2017; Worline and Dutton, 2017).

Therefore the importance of ***C**ontext* is clearly evident within the literature and supports the findings from this study, which suggests that *relationship-centred leadership* and the creation of the *Senses,* promotes collective, compassionate leadership, which is fundamental to ensuring the delivery of safe and effective quality contemporary healthcare.

The following section will discuss how *enriched **C**onditions* are created for leaders, which impact upon the subsequent ***C**onsequences*.

8.3.2 Creating enriched *Conditions* to enable collective, compassionate leadership

This study has illuminated the importance of *creating the **C**onditions* for leaders, to develop and enable compassionate leadership to flourish, which subsequently impacts positively on patient safety, patient experience, staff experience and engagement, as well as organisational effectiveness (Shipton et al., 2008; Rynes et al., 2012; Perlo et al., 2017). The literature confirms the value of creating ***C**onditions* for 'authentic' leadership within teams; sharing leadership responsibilities amongst followers and leaders, and promoting

positive organisations (King, 2002; Ensley, Hmieleski and Pearce, 2006; Algera and Lips-Wiersma, 2012; Nielsen and Daniels, 2012; Macdonald, Burke and Stewart, 2017). However, there appears to be a gap in suggesting ***how*** such ***C****onditions* are created, which my study has begun to address. I feel that the **Five C's** and the *Senses Framework* offers a means to bridge this gap.

A shift in focus towards a collective, compassionate leadership approach, where leadership networks and effective *relationships* are required, has become increasingly important in times of complexity, system-wide learning and rapid change (Petrie, 2011; Swensen et al., 2013; West et al., 2017). The ever-changing environment (***C****onditions*) experienced by leaders at all levels, is often described as VUCA (Volatile, Uncertain, Complex and Ambiguous), a term which was derived from the Army (Horney, Pasmore and O'Shea, 2010; Johansen and Euchner, 2013; Mack et al., 2015). Therefore adopting a collective leadership approach, promotes a shared responsibility and clear **Purpose** to be developed, providing opportunities for leaders to play to their strengths, and to develop their leadership potential and circle of influence, whilst building organisational and systems wide leadership capacity and capability (Keller and Price, 2011; Covey, 2015; Barsh and Lavoie, 2014). Through collaborative working, engaging and inspiring others, systems leaders enable sustainable improvement and change, striving to enhance services and provide an optimal vision for the future (Hämäläinen and Saarinen, 2007; Eckert et al., 2014; Timmins, 2015).

The evidence from this study suggests that creating the **Senses** for staff (participants), their managers, teams and patients, leads to the development of an *enriched working and learning environment (enriched* **C**onditions*)*, which enhances the possibility of a compassionate leadership culture developing and flourishing (organisational ***C****onsequences*). With the increasing complexity across healthcare systems, the importance of promoting *enriched leadership environments*, where leaders are enabled to prioritise the health and wellbeing of staff, patients and carers, is now more than ever, of paramount importance.

However for this to happen, the 'system' must be truly engaged and open to change. This resonates with the work of Higgs and Rowland (2000; 2001; 2011), who illuminated the importance of mindfulness and 'systems thinking' being developed together, as enablers to change.

The next section will discuss the enabling factor of *intrinsic motivation*, which emerged as key to developing and sustaining *relationship-centred leadership*, and will explore how this was discovered as a ***C**atalyst* from the insights into the participants' experiences of DBC LP.

8.4 The *Catalyst* - skills versus drive

The development of leadership skills to build upon existing strengths and enhance personal effectiveness as leaders, was discussed as a ***C**atalyst* within Chapter five, as one of the key expectations of participants of the DBC LP. Emerging from the inquiry into their experiences was the **Significance** of *intrinsic motivation and drive*, as key enabling factors (see Chapter six). Participants who described themselves as proactive and engaged in their work and life, whilst participating on the programme and back in practice, continued to embed their learning, sustained their energy and enthusiasm for continued learning and invested in developing *relationships*.

However, not all staff are likely to have intrinsic motivation, and Chapter six described how, the ***C**onditions* created during the programme experience did seem to impact positively on those who were perhaps less intrinsically motivated at the start. This suggests that it is possible to influence and motivate participants if they are exposed to *enriched **C**onditions* in which the Senses are created. (See later in Table 8.2). Other studies would lend some support to this assertion.

Research suggests that humans have three essential psychological needs, which enable us to experience a Sense of wellbeing and self-motivation (Pink, 2011):

- Competence (the skills, knowledge and ability to do the job)
- Autonomy (the freedom, trust from others and independence to get on with the job)
- Relatedness (feeling connected and a Sense of **Belonging**)

The findings from this inquiry in relation to 'intrinsic motivation and drive' of leaders, align with the work of Daniel Pink (2011), who argued that old models of extrinsic motivation are not fit for purpose today, as drivers such as rewards or fear of punishment are no longer appropriate. Intrinsic motivation - rather *autonomy, mastery and **Purpose***, make a difference in Pink's view, which my study would support, with the *Senses Framework* providing the vehicle to enable these factors to be created. Autonomy was identified as an enabling factor in my study, which was linked to the importance of the *relationship* with the manager, and created a Sense of **Significance** and **Achievement** for participants. Being able to self-direct as a leader (Manz, 1986), was achievable with support and guidance, provided by the manager, giving a Sense of **Purpose**. Mastery was then achieved through creating a Sense of **Achievement** and skills development. Being clear about their individual contribution to the team enabled the creation of a Sense of **Significance** and subsequently the **Achievement** of **Purpose** and meaning. The effective *relationships* that were developed created a Sense of **Security** and **Belonging**, which if sustained over time, created a Sense of **Continuity** and the development of connections within a network or 'community' of open-minded leaders.

A Canadian study, which explored the social and motivational precursors to perceptions of transformational leadership, found that the more positive that *relationships* were perceived to be by the individual leaders, the greater their feelings of autonomy, motivation and effectiveness (Trépanier, Fernet and

Austin, 2012). This research supports the findings of my study, which suggests that *relationships* are fundamental to sustaining impact following leadership development. The work of Avolio et al (2009) also aligns with my findings, with their emphasis on the importance of caring for staff, ensuring effective communication and developing *relationships*, in particular with the manager, as was illuminated in Chapters five and six.

Clearly the manager/staff *relationship* is key to creating the ***C**onditions* for leaders to develop and fulfil psychological wellbeing, autonomy and competence as a leader (Wong and Cummings, 2007; Wong and Cummings, 2009; Laschinger, Wong and Grau, 2012; Wong, Cummings and Ducharme, 2013; Wong and Laschinger, 2013). However, as was highlighted in the findings Chapters five and six, when there was a lack of understanding and appreciation of differing preferences and styles, the *relationships* between staff and managers were less positive. This has been found in other studies (Briggs, 1976; Riding and Rayner, 2013). Explicit, honest dialogue around preferences and styles is therefore important within *relationships,* to ensure an appreciation and understanding of one another. This study suggests that the **Five C's** theory together with the *Senses Framework* provides a facilitation mechanism for the creation of such ***C**onditions* in which diversity and difference in preference of styles can be explored and appreciated.

This supports the need to promote a differing model of leadership development. For example, Edmonstone (2014, p.288) has argued that there has been a long held assumption that '*leadership exists within individuals, rather than in the relationships between them',* hence the focus on leader skills development through the investment in design and delivery of clinical leadership programmes and competency frameworks in healthcare. Over the past decade various programmes and models have emerged across the UK, that while differing in their approach and emphasis, all share the similar goal of developing effective clinical leaders to improve the patient experience (Edmonstone, 2014). The challenge, which remains, is that of the balance between 'leader' development

versus ‘leadership’ development, and agreeing which should be the priority (Edmonstone, 2009; Edmonstone, 2011a; Edmonstone, 2011b; Edmonstone, 2011c). This study supports the emerging argument within the literature that the focus should be upon supporting collective, compassionate leadership. I suggest that through leader development programmes such as DBC LP, and implementing the **Five C’s** theory, a more robust approach for leaders to work together and play to their strengths is provided. This should enable leaders at all levels to effectively achieve their expectations and motivations (***C**atalyst*) and to navigate the current complexities across systems within healthcare, which were described within Chapters one and two. Therefore, I propose that through the use of the Senses, it is possible to create the *enriched **C**onditions* for leaders to develop and sustain supportive *relationships*, which in turn should enable them to work collectively, efficiently and effectively, thus promoting collective compassionate leadership *(**C**onsequences*).

Evaluations of significant national programmes such as ‘The Darzi Clinical Leadership Fellow Programmes’ (Darzi, 2008; Mervyn, Malby and Meredith, 2017), identified barriers to creating the ***C**onditions* for leaders, which included lack of autonomy and inconsistent working environments (*impoverished*- see next section), as well as challenges between the aspirations of clinical leaders and managers. The importance of the leaders’ ability to develop, build and sustain effective *relationships* based upon mutual respect, and engage others within the team, is therefore pivotal and has a significant impact upon the system (Harlow and Suomi, 1970; Leary and Baumeister, 1995; Zukauskiene, 2007; Sinsky et al., 2013; West et al., 2014).

Having considered the importance of intrinsic motivation and drive (***C**atalyst)*, as enabling and supporting the creation of *relationship-centred leadership (**C**onsequences)*, the next section will now discuss the **Significance** of creating a Sense of **Belonging**, which contributes towards a collective compassionate and *relationship-centred* leadership approach (***C**onditions*).

8.5 All in the same boat

Creating an *enriched* learning *environment* that provides a safe space for participant's voices to be heard, enabled the facilitators to role model the importance of creating a Sense of **Security** and **Belonging** at the onset of the programme. This is especially important when *relationships* are just developing within a group (Kline, 1999; Nolan et al., 2006; Kline, 2009). The realisation that participants from a range of settings were experiencing similar challenges and opportunities, helped to foster the creation of ***C**onditions*, which were conducive to shared learning and networking. Consequently a Sense of **Belonging** emerged**,** in which participants felt they were '*all in the same boat'* no matter where they worked.

Creating a Sense of **Security**, which contributed to the emergent Sense of **Belonging**, involved participants being aware of the potential of human factors such as tiredness or cognitive overload, to hinder the implementation of learning or application of tools to practice. Therefore consideration needed to be given to the *timing* of interactions to promote self-reflection (Chadwick and Jeffcott, 2013; Russ et al., 2013).

The concept of *'timing'* (***C**hronology*) appears to be less cited in the literature relating to leadership in healthcare, although its importance during career transitions is acknowledged (Avolio, 2005; Avolio, 2011; Sonnino, 2016). However, the *timing* of leadership skills development is recognised an important feature of an educational ***C**ontext* in other settings. For example in the Army, the concept of 'leadership intuition' is used to describe a situation where the leader and /or their manager, knows when the *timing* is right for career development (Van Velsor and Musselwhite, 1986; Mumford et al., 2000). Such a concept might have useful application in a healthcare ***C**ontext.*

At the time of writing, at a national level in NHS Scotland, there is an aspiration to create a 'movement' of regional 'communities of practice' where likeminded

leaders of all levels can come together, to reflect, learn, share ideas and thus develop a Sense of **Belonging** and **Continuity**. The opportunity for this study to influence and support this work will be discussed in Chapter nine, Implications and Recommendations.

The following section will summarise the key enabling and hindering factors to creating the ***C****onditions* for an *enriched environment* and make links to relevant literature, whilst simultaneously mapping the factors to the Senses.

8.6 Creating the Conditions- enriched versus impoverished 'leadership' environments

The *enriched learning environment* and energy generated on the DBC LP, described by the Element A (current) participants in Chapters five and six, were confirmed by all Element B (past) participants. All participants it seemed, responded well to the flexible, informal approach adopted in the programme, which provided a safe environment conducive to adult learning (Cross, 1981; Malinen, 2000; Merriam, 2001; Hogan, 2005; Kolb and Kolb, 2005; Moon, 2013; Biggs, 2011).

In Chapters five and six, the factors that enabled and hindered the creation of an *enriched environment* for leaders were explored in detail. **Table 8.2** develops these further through illustrating the key leadership characteristics illuminated within this study. It differentiates between the enabling factors, which create an *enriched environment* (Nolan et al., 1997; Nolan, Davies and Grant, 2001), compared to the hindering factors that create an *impoverished environment*.

The table provides clear evidence of how the Senses were created for leaders, which is supported by the literature and affirms the value of using the *Senses Framework* as a facilitation mechanism for *relationship-centred leadership*. The synergy between the leadership characteristics and each of the Senses is

evident, which highlights the dynamic and adaptable potential of the *Senses Framework.*

Table 8.2 Creating the Senses for *enriched (leadership) environments - comparing to impoverished environments*

Enriched environments (Leadership)		Impoverished environments (Senses not created)	
Leadership characteristics	**Enabling factors to creating enriched environments (to enable any impact to be sustained beyond the programme)**	**Leadership characteristics**	**Hindering factors to creating enriched environment thus resulting in impoverished environments (Leadership)**
Role modelling relationship-centred leadership and demonstrating values (Csikszentmihalyi, 1993; Leithwood, Jantzi and Steinbach, 1999; Stanley, 2006; Dierckx de C.B. et al., 2008; Edmonstone, 2009; Akerjordet and Severinsson, 2010; Pepin et al., 2011; Csikszentmihalyi, 2013)	• Investing in developing and maintaining relationships • Investing time in building relationships with new staff • Robust relationship and on-going support with manager and team • Positive mind-set and attitude • Focusing on what went well through an appreciative lens • Using appreciative language • Motivating others to bring out the best in people (Appreciative approach) • Adapting approach to manage situations, calmly • Model self compassion and compassionate leadership towards others • Manager offering feedback, reassurance and affirmation • Demonstrating openness and honesty and being approachable • Developing relationships based on mutual respect and trust • Knowing who and what resources to connect with and who to contact within networks • Thriving on interpersonal contact and connections • Being visible and approachable • Facilitating opportunities for others • Giving and receiving feedback • Getting the balance right • Being creative and inspiring • Discussing on-going learning application to practice • Being and approachable and accessible leader • Knowing what matters to me	Indecisive leadership and inconsistency: Lacking effective leadership and responsibility (Davidson, Elliott and Daly, 2006; Mannix, Wilkes and Daly, 2013; Daly et al., 2014)	• Seeking advice from manager to avoid decision-making. • Inability to manage people effectively. • Avoiding conflict • Confusion about what is leadership and what is management. • Preferring 'push' and guidance from manager rather than making own decisions. • Manager not holding self and others to account
Creating clear professional boundaries (Nancarrow and Borthwick, 2005; Kempster, Jackson and Conroy, 2011)	• Developing mutual respect and understanding (with manager and team) • Feeling valued and I matter	Lack of mutual trust and respect for others	• Communication barriers-avoiding difficult conversations

Being authentic- Comfortable in self (Stanley, 2006; Stanley et al., 2008; Laschinger et al., 2010; Laschinger, H.K.S., Wong and Grau, 2012; Bamford, Wong and Laschinger, 2013)	• Demonstrating values • Being open and honest with self and others • Listening actively- seeking to understand • Seeking, hearing and acting on feedback • Having positive perceptions of self • Influencing and inspiring others • Feeling calm and able to deal with stress and conflict • Embedding core leadership qualities	Lack of authentic leadership	• No clear values
Seeing potential in others (Malby, 1996; Curtis, de Vries and Sheerin, 2011)	• Given time and permission to reflect and learn from others' stories • Motivating and inspiring others	Feeling out of place	• Lacking clarity and purpose
Giving autonomy within role (Hoegl and Parboteeah, 2006; Volmer, Spurk and Niessen, 2012; Kalshoven, Den Hartog and de Hoogh, 2013)	• Providing and receiving support and guidance when required	Game playing	• Negative staff behaviours
Feeling I matter and I am valued (Cho, Laschinger, and Wong, 2006; Bamford, Wong and Laschinger, 2013)	• Robust relationship with manager • Effective relationships with group/team • Feeling heard	Poor relationships with others	• Poor communication and lack of mutual respect and understanding. • Poor working relationship with manager. • No communication about learning and application to practice
Feeling supported (Johns, 2003; Cook and Leathard, 2004)	• Peer support and encouragement • Interrelated factors whilst participating on the programme all focusing on relationship building and interpersonal skills (with patients/families/team /manager)	Feeling out of place	•Lack of support •Lack of awareness and drive •Unclear direction and focus
Effective communication and respect for others (Harper, 1995; Rocchiccioli and Tilbury, 1998; Dierckx de C.B et al., 2008; Pepin et al., 2011)	• Discussing on-going learning and application to practice • Feeling I matter and I am valued • Able to challenge negative behaviours with confidence	Poor communication	•Lack of mutual respect and understanding •Not listening

Developing understanding of self (emotional intelligence-self awareness/self confidence/self management/self belief) 'Its ok to be me' – realisation and believing in self (Stanley, 2006; Dierckx de C.B. et al., 2008; Akerjordet and Severinsson, 2010; Smith et al., 2017)	• Support and autonomy from manager • Manager seeing potential and giving permission to lead • Feeling valued and that I matter • Knowing what matters to me- passion for the job, clear role purpose and meaning • Knowing personal strengths • Knowing what you do makes a difference • Feeling more confident to take on QI work • Happy to take on new opportunities • Increased confidence to enable and support others • Reflecting and developing understanding self (what makes me tick and what are my triggers) • Gaining confidence through workshops and giving presentation at end workshop • Gaining confidence in approach and how to articulate/communicate with others • Working with feedback • Gaining new tools for the toolbox • Gaining affirmation of what I knew before the programme • Understanding self and preferences, noticing difference and being more proactive more of the time, rather than reactive • Pausing and taking time to think before responding • Understanding role of leader and manager	No clear direction and purpose	•Unclear expectations of role •Uncertainty/ 'Rollercoaster'
Feeling motivated, engaged and inspired (Amabile, 1993; Ryan and Deci, 2000; Zhang and Bartol, 2010; Pink, 2011; Perlo et al., 2017)	• Intrinsic motivation and drive • Positive attitudes and behaviours • Finding joy in work • Having robust relationship in place with manager and team • Feeling more confident and having increased self belief to consider promotion • Application of the tools to practice • Continually learning and 'stretching'	Disengaged and demotivated	• Lack of enthusiasm and engagement • Disinterest and reactive
Enabling and developing others through feedback (Harper, 1995; Cunningham and Kitson, 2000; McCormack and Garbett, 2003b; Laschinger, Wong and Greco, 2006; Dierckx de C.B. et al., 2008; Kouzes and Posner, 2012; Smith et al., 2017)	• Recognising the need to delegate • Giving and receiving constructive feedback • Seeking, hearing and acting upon feedback • Knowing my strengths and team strengths • Leading by example • Collaborating with others and enabling others to collaborate • Connecting others • Practising tools whilst supervising colleagues • Team development continual (developing from strength to strength) and team becoming more cohesive • Allowing autonomy within role	Lack of interest in others (Negative attitudes and behaviour- e.g. tendency to be 'harsh')	• Lack of understanding and awareness of programme/ of individual's development • Making judgments before listening and hearing

	• Providing guidance and support when needed • Seeing the potential and opportunity • Getting the timing right • Giving permission to lead and develop • Trusting the process in the programme • Supportive challenge to others • Sharing knowledge and encouraging others to learn		
Clarity of role purpose (Nancarrow and Borthwick, 2005; Edmonstone, 2009; Kempster, Jackson and Conroy, 2011; Edmonstone, 2014)	• Ability to reflect and know strengths and areas for development- understanding self • Stability in role • Getting the timing right • Continual challenge and stretch (keeping you on your toes) • Interactions are authentic	Unsure of role (Firth, 2002; McCormack and Garbett, 2003a; Curtis, de Vries and Sheerin, 2011)	• Lack of clarity and understanding of leadership and management • Lack of opportunity to apply learning to practice • Constraints on service due to staffing changes • Turnover of staff due to retirements • Not taking time to build relationships with new staff
Create effective relationships (Curtis, de Vries, and Sheerin, 2011)	• Robust relationship with manager • Robust relationship with team • Investing time to build relationships and understand roles and purpose • Open, honest and approachable leadership	Indecisive	• Lacks taking responsibility for decision making
Being politically aware (Antrobus and Kitson, 1999; Cook and Leathard, 2004; Douglas and Ammeter, 2004; Hartley and Fletcher, 2008)	• Seeing the bigger picture • Understanding differing perspectives • Seeing through a different lens	Lack of motivation to try out new tools and see big picture	• 'If you don't use it you lose it' • No opportunity or encouragement to use tools and learning within role
Developing talent and succession planning (Cook and Leathard, 2004; Clark, 2012)	• Manager seeing potential and giving permission to lead • Seeing potential in others		

Taking time and being committed to reflect and continually develop and learn (McCormack and Hopkins, 1995; Senge, 1996; Kline, 1999; Mayfield and Mayfield, 2002; Peach and Horner, 2007; Bromley, 2007; Kline, 2009)	• Gaining promotion and being willing to 'stretch' outwith comfort zone • Gaining promotion and embracing new role • Taking on additional responsibilities • Reflecting and learning on application of tools to practice in small tests of change • Focusing on priorities and managing time more effectively • Developing understanding self (self awareness/self confidence/self management/self belief) • Taking time to consolidate learning, filter out what doesn't stick and apply to practice what does • Embedding key themes from programme • Foundations of DBC LP learning are in place • Continuing to grow and develop leadership skills	Motivation not sustained	• Lack of support and motivation to be able to commit
Coping with uncertainty during times of change (Parkin, 2009)	• Feeling self confident • Having support and autonomy	Unfocussed and inconsistent in role and approach (poor leadership)	• Lack of consistency in role
Sustaining commitment, engagement and drive	• Programme over time • Tools threaded through workshops keeps momentum and reinforces learning • Continuity of facilitators and peer support within group • Keeping tools and learning on the agenda	Fire fighting and being reactive	• Learning, reflection and application falls by the wayside

In summary, as **Table 8.2** illustrates, there is much more data highlighting the factors, which enable the creation of an *enriched environment,* than hindering factors, which create an *impoverished environment* (where the Senses are not created*)*. It is beyond the scope of this particular study to explore in detail the leadership characteristics and factors evident within *impoverished environments,* where potentially fewer staff are encouraged and supported to apply for the programme. Further research is suggested in this area and will feature in the recommendations in Chapter nine.

The final section of this Chapter will summarise the key messages from the discussion before moving on to the final Chapter, which will highlight implications and recommendations.

8.7 Chapter summary

To conclude, this Chapter has discussed how my study suggests that the **Five C's Theory** together with the *Senses Framework* can provide a facilitation mechanism for creating the ***C****onditions, which* enable leaders to develop and sustain *relationship-centred leadership* and has the potential to support the on-going aspiration of healthcare organisations towards the development of a collective, compassionate leadership culture.

Key to building and developing *relationship-centred leadership,* based on trust and respect, is the concept of 'joy in work' and the **Achievement** of the Quadruple Aim, which promotes **Purpose** and meaning for leaders at all levels of the organisation (Perlo et al., 2017). This has the potential to enhance staff engagement and experience across healthcare systems such as the NHS.

Fundamental enabling factors include intrinsic motivation and drive, and a commitment to continual learning and development of the individual leaders themselves. ***C****onditions* conducive to enabling this to happen are created through supportive *relationships* with managers and teams, with permission to lead, mutual trust, respect and understanding being made explicit by managers.

Getting the *timing* right (***C**hronology),* and promoting reflection about both *personal* and *professional* aspirations, helps to ensure that positive ***C**onsequences* are embedded and sustained.

The participants within this study have generously shared their *personal* and *professional* experiences of the DBC LP, which have provided insights into the importance and **Significance** of *relationship-centred leadership*, particularly given the current complex healthcare leadership landscape. Being '*comfortable with the uncomfortable'* was a key message and significant learning from many participants within this study. Those who were willing to embrace challenges and test out changes through self-reflection and developing their emotional intelligence, gained a rich understanding of self and also of how their interactions impacted upon others and their subsequent *relationships* (Goleman, 1996; George, 2000; Goleman, 2003; Goleman, D., Boyatzis and McKee, 2013; MacArthur, 2014).

The quote from Pat illustrates this elegantly:

'Get your wellies on and jump in! I'm not saying I was comfortable doing some of the things but I have got no negative things. You really have got to want to know, you really want to have to learn about yourself and if you are not interested in learning about yourself, it's not for you because everything comes from knowing yourself so only then can you appreciate the impact you have on other people, why people might react in certain ways and if you don't think about why, you won't move forward.' (Pat)

Having promoted the concept of '*relationship-centred leadership'* across organisations and systems, and suggested how this might be achieved, to create a compassionate leadership culture, the final Chapter of this thesis will discuss the implications and contributions to knowledge arising from this study and suggest recommendations and opportunities for further research.

Chapter Nine. Contributions to knowledge, Implications, Recommendations and Conclusion

9.1 Introduction

This Chapter discusses how my study might be considered to have contributed knowledge to the existing literature on *leadership*, and as a result have implications for developing leadership programmes. In addition, implications are suggested in relation to *immediate* (DBC LP), *local* (NHS Lothian) and *national* ***C****ontexts, with consideration given to* policy, practice, education, research, NHS organisations, individual leaders and teams. Attention is also given to the implications for leadership and leaders beyond the NHS and healthcare, across public sector, third sector and private sector. Therefore it is proposed that the learning and contributions to knowledge from this study are transferable and modifiable to other leadership ***C****ontexts.* The potential opportunities for leaders to use the extended EA Matrix 'cycle', as described within Chapter seven, with the two additional elements ***Evaluate Action*** and ***Embed Action****,* when leading change and reflecting on the quality of any study or programme, are also outlined.

Recommendations for further research are also explored, followed by a summary that includes my best hopes, which concludes this Chapter.
Outputs to date from my study are outlined within **Appendix 16.**

9.2 Extending and contributing to knowledge

It is hopefully now clear to the reader, how the **Five C's** theory, when used in conjunction with the *Senses Framework, can* provide both an underpinning theory and a facilitation mechanism; to support the creation of *relationship-centred leadership.*

The following points will summarise the key original contributions to knowledge, which have been illuminated by the study.

- **Creating *enriched environments***

Creating *enriched* ***C****onditions* using the **Five C's** theory, together with the *Senses Framework,* for developing and sustaining *relationships* at all levels, provides an indication as to ***how*** leadership programmes can be effective in implementing and sustaining change. This practical application has until now often been missing (see Chapters two and eight). This study has provided valuable insights from both a *personal* and *professional* perspective, of the experiences of participants on the DBC LP, (or its antecedents), over a period of almost ten years, and has further reinforced the fundamental enabling factors to creating *enriched leadership environments*. The findings can be considered as moving the concept of the *Senses Framework* towards a 'formal' mid-range theory, which has advanced its potential applicability and **Purpose**, as described in earlier Chapters. Therefore, the **Five C's** substantive mid-range theory together with the *Senses Framework* provides new understanding and a novel way forward for leaders in healthcare.

- **Demystifying leadership**

The **Five C's** theory provides a simple and structured approach, together with the *Senses Framework*, which in my experience is always well received and understood by all levels of staff within healthcare. Using easy to understand language within a framework, which promotes and enables the development of *relationship-centred leadership*, helps to 'demystifying' the concept of leadership, which as described in Chapters one and two is complex and challenging. Therefore I propose that using the **Five C's** theory could support an evolving culture of collective, compassionate leadership, where leaders at all levels understand and appreciate the **Significance** of their individual role and how they contribute to the wider collective ***C****ontext.*

West (2019), who has written and researched extensively about leadership in healthcare, in a recent blog, talked about a '*crisis in caring for staff in the NHS'*

and asked the question, '*what do we need to do?'* West (2019) suggests that staff have three core needs- '***Belonging**, competence and autonomy,'* to enable them to provide safe, effective, quality, compassionate care for patients. This resonates with the findings of my study, as described in Chapters five and six, where staff talked about the enabling factors of feeling they belonged and connected with their manager and team, and had support and autonomy to lead. Therefore I suggest that the **Five C's** theory, together with the *Senses Framework,* provides a solution to West's question and could be further developed to support and promote the creation of *relationship-centred* collective, compassionate leadership. This also supports MacArthur (2014), who recommended that *relationships* are key to providing and embedding compassionate care and influencing healthcare culture.

Every day in the NHS, compassionate care is provided and *relationship-centred* leadership happens across systems, despite the negative media and numerous complex challenges of targets, silo working, a focus on inspections and hierarchical sub-cultures, so how can we create *enriched environments* to make this happen more of the time and enable this to become the norm?

Bailey (2019) in her blog, which discusses the NHS England's long-term plan (NHS England, 2019) and its 500 actions, suggests that '*compassion is our greatest leadership contribution.'* Hence, I propose, there is an opportunity for the **Five C's** and the *Senses Framework to* contribute to addressing this healthcare leadership challenge.

- **Common sense versus common practice**

Although my **Five C's** substantive theory may seem like common sense, in practice, as evidenced within the complex healthcare environments, when faced with 'wicked problems', *relationship-centred leadership* is not always common practice (Heifetz, Grashow and Linsky, 2009; Grint and Holt, 2011; Covey,

2015). Therefore with its focus on sustaining effective *relationships,* the *Senses Framework* provides the necessary facilitation mechanism.

The idea of common sense versus common practice resonated with the work of Stephen Covey (2015), where he discovered that the '*Seven Habits of Highly Effective People'* are readily accepted and the principles are understood, yet not easy to implement consistently in reality. *Relationship-centred leadership* therefore supports the '*Seven Habits'* (**see Table 8.3**) and has the potential to enable these principles to be enacted both *personally* and *professionally*, thus promoting effective work-life balance.

Table 9.1 *Seven Habits of Highly Effective People* (Covey, 2015) linked to the 'Senses'

Seven Habits	**How the creation of the Senses can support and enable each 'Habit' to be enacted and vice versa**
Habit 1:Be Proactive	Sense of Purpose, Significance, Security, Belonging, Achievement, Continuity
Habit 2: Begin with the end in mind	Sense of Purpose
Habit 3:Put first things first	Sense of Purpose, Achievement, Significance,
Habit 4:Think win: win	Sense of Significance, Security, Belonging
Habit 5: Seek first to understand then be understood	Sense of Significance, Security, Belonging
Habit 6:Synergy	Sense of Purpose, Significance, Security, Belonging, Achievement, Continuity
Habit 7:Sharpen the saw	Sense of Purpose, Significance, Security, Belonging, Achievement, Continuity

- **Embedding learning to practice**

As well as enabling the creation of *enriched **C**onditions,* which support the development of *relationship-centred leadership,* the **Five C's** theory together with the *Senses Framework* and the extended EA Matrix 'cycle', also provides a means for implementing learning to practice, with the potential to embed and sustain any subsequent impact over time. The extended EA Matrix 'cycle' provides a potential *relationship-centred evaluation* framework to reflect on how learning has ***Enhanced Awareness, Encouraged Action, Enabled Action*** and importantly ***Evaluated*** and ***Embedded Action.*** This will be explored in more detail in the next section.

Therefore the ***C**onsequences* and significant new learning, which has developed from this study, has provided a range of contributions to knowledge, the implications of which will now be described below.

9.3 Implications

As described in earlier Chapters, the substantive theory, which emerged and was developed from this Constructivist inquiry, comprised of an alliteration of **Five C's**: ***C**ontext, **C**hronology, **C**atalyst*, ***C**onsequences, and **C**onditions.* The following sub-sections will consider the implications of this theory, in supporting organisational change and promoting the sustainability of impact, through the development of *relationship-centred leadership.*

9.3.1 Opportunities for leaders to use the extended EA Matrix 'Cycle'

A group of researchers has recently suggested that a new paradigm or perspective on evaluation is required, and they are proposing what they refer to as '*Fifth Generation Evaluation'* (Lund, 2010; Lund, 2011; Lund, 2012; El Dessouky, 2016; Sharp, Dewar and Barrie, 2016; Sharp, 2018). This comprises a methodological approach that combines Social Constructionism with action

research in a way that presents the underlying theory in a more simple and user-friendly way. Lund (2011) and colleagues acknowledge that such a development is still at an embryonic stage.

Based on my experiences, I would agree that a new model would be helpful and argue that this needs to be based on a practical and appreciative, relational approach. Therefore, I suggest the development of a *relationship-centred* evaluation approach, which builds on the principles of Fourth Generation Evaluation (Guba and Lincoln, 1989), in which *enriched environments* are created, using the *Senses Framework* as the facilitation mechanism.

As this study has illuminated, the *Senses Framework* has been demonstrated to 'work' at many levels, for many different groups in a range of ***C**ontexts.* The new and extended EA Matrix 'cycle' could be the vehicle to explore the extent, to which change based on the application of the *Senses Framework,* is true to Constructivist principles. It is hoped that this would provide the easy to understand and apply mechanism that is needed for such models to have day-to-day utility beyond a research setting.

To concur with Lund and Sharp (2010; 2011; 2012; 2018), appreciating what is working well and creating ***C**onditions* needed for this to happen more of the time, is at the heart of *relationship-centred leadership.* In creating the Senses and *enriched environments*, *relationships* can be developed and sustained, which supports the embedding of impact and subsequent ***C**onsequences.* Within this thesis, I have illustrated my original contribution to knowledge and to Fourth Generation Evaluation, in demonstrating how the extended EA Matrix 'cycle' can be used to evaluate the quality of a research study, leadership programme and substantive theory.

Moreover, based on my work, it appears that there are additional implications for enhancing and supporting practice, policy and education within a healthcare ***C**ontext*, through using the extended EA Matrix 'cycle', together with the **Five**

C's theory and the *Senses Framework*, to develop a *relationship-centred evaluation* approach. I suggest this also has implications and additional potential beyond healthcare, in a range of ***C**ontexts*, and subsequent implications for future research will be detailed in section 9.4 below.

The following section will provide details of recommendations and suggested next steps for leaders, policy makers, researchers, education providers and organisations at an immediate, local, national and wider ***C**ontext.*

9.4 Recommendations

Based on the above sections, which have illuminated the contributions to knowledge, which makes this study unique, as well as the subsequent implications, the recommendations that have emerged, will now be listed and outlined below.

9.4.1 Immediate *Context* (DBC LP) Recommendations

- In NHS Lothian, the DBC LP facilitation team, should enhance the programme aims to include *personal* and *professional* impact by: extending the programme aims and expectations, being explicit about planning how participants will sustain long-term impact and contribute to the organisational objectives to enhance and support an evolving collective compassionate leadership culture; with more explicit Health and Social Care focus in relation to the Integration agenda. The suggested changes could be evaluated using a *relationship-centred* evaluation approach using the extended EA Matrix 'cycle'.

- The DBC LP model should incorporate a more extensive evaluation process to enable participants to evaluate their actions beyond the programme timeline, using the extended EA Matrix 'cycle'.

- The DBC LP facilitation team should introduce and test out refresher workshops and one-to-one coaching conversations at 6-12 months post programme, either with a programme facilitator and /or peer, to enable reflection and reconnection, which will ultimately promote sustainability and the continued building of capacity and capability within the workforce. Follow up with participants of DBC LP should include a specific focus on impact on patient experience, as well as outcomes and impact on self/team/system.

9.4.2 Local *Context* (NHS Lothian) Recommendations

- The *Senses Framework* should be adopted as an underpinning theory and facilitation mechanism for *relationship-centred leadership* to be developed, utilising the **Five C's** theory, to create *enriched environments* (***C**onditions*) to enable leaders to sustain learning and impact. Facilitators and educators of programmes, including leadership development, should also endorse this approach.

- NHS Lothian should sustain continued investment in developing a Leadership Network, and connect with other existing networks e.g. Clinical Quality Change Forum, to create synergy and a Sense of **Continuity.**

- Further research is suggested in non-clinical environments to test out the **Five C's** substantive theory, together with the *Senses Framework* and the extended EA Matrix 'cycle'. There are opportunities currently within DBC LP, as participants are now from a range of areas including for example, administration and clerical. The potential for research within social care environments, voluntary sector and non-healthcare related ***C**ontexts* would also be encouraged.

9.4.3 National *Context* Recommendations

- The use of the extended EA Matrix 'cycle' incorporating ***Evaluate Action*** and ***Embed Action*** elements***,*** should be promoted at a local and national level for assessing quality of change initiatives, leadership programmes, ***C****onsequences* and impact.

- The **Five C's** theory could support and help to create the six C's of Care, Compassion, Competence, Communication, Courage and Commitment (NHS England, 2016), through the actions proposed by Dewar (2011): *Celebrate, Be Courageous*, *Connect Emotionally, Be Curious, Collaborate, Consider other perspectives and Compromise.* This could be explored, tested and evaluated using the extended EA Matrix 'cycle'. See **Diagram 9.1**.

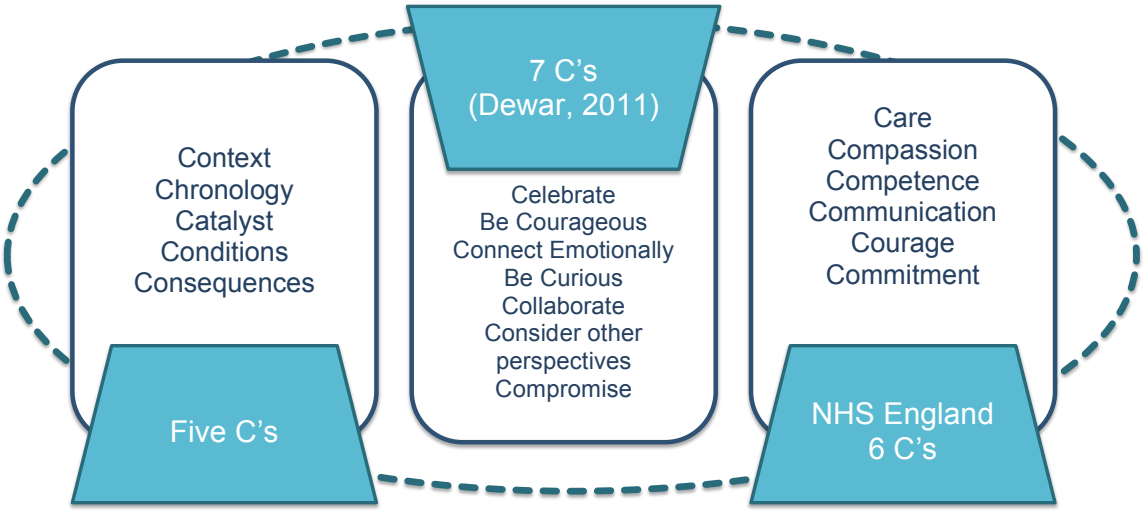


Diagram 9.1 How the Five C's can support other frameworks

9.4.4 Wider *Context* Recommendations

- The **Five C's** theory, together with the *Senses Framework* and EA Matrix 'cycle' should be tested in other NHS Boards in Scotland and potentially in NHS Trusts in England and Wales, as there is synergy with the

recommendations within *Developing People Improving Care*, NHS Improvement (2016), and *A Vision for Population Health Towards a Healthier Future*, Kings Fund (2018), therefore my theory could support implementation in NHS England.

- Consideration should be given to further testing and collaboration with contacts in USA (**see Appendix 16**) and internationally, to test out the **Five C's** theory within their study with leaders caring for older people in long-term care settings within USA.

- Further research should be considered using Constructivist inquiry methodology to explore return on investment and any subsequent impact on leadership culture at an organisational level, considering the question: *Can the link between investment in collective leadership and organisational performance (safe, effective, quality, compassionate, relationship-centred care) be demonstrated?*

- Further research should include an exploration of extrinsic versus intrinsic factors of motivation in relation to *relationship-centred leadership.*

- Research should be considered to explore the hindering factors, which create impoverished environments, for example where staff do not have support nor permission to lead and develop, using an appreciative approach and considering the **Five C's** and the *Senses Framework* in more detail.

In summary, there are a number of recommendations, which have evolved from this study, that have potential to maximise the inherent benefit of the findings from this study and implement the **Five C's** theory together with the *Senses Framework,* to practice, in a range of settings at a local and national level, which supports the development of *relationship-centred leadership.*

9.5 Conclusion

In conclusion, this study has provided an enhanced understanding and insights into the experiences of healthcare participants of a particular leadership programme, the DBC LP, and has demonstrated how leaders can create the ***C****onditions* to build, develop and sustain effective *relationships*, in order to implement their learning into practice, continue to develop, and sustain subsequent impact. The findings suggest that the *Senses Framework* provides an underpinning facilitation mechanism to enable this to happen and more importantly for any impact to be sustained over time, which has the potential to develop and influence a collective, compassionate leadership culture. This inquiry therefore provides additional evidence of the versatility of this valuable conceptual structure and its potential to influence and create *relationship-centred leadership*.

My best hopes going forward are that leadership cultures within healthcare and beyond, are continually enhanced, to consistently develop *enriched environments* where people feel safe **(**Sense of **Security)** and that they belong (Sense of **Belonging**), to a team in which they have a clear role **Purpose**; where they are able to feel that they matter (Sense of **Significance**), which subsequently enables them to achieve 'joy and meaning' (Sense of **Achievement**); with the presence of effective *relationships* (*relationship-centred leadership*) and *enriched environments,* which contribute to a Sense of **Belonging** and provide **Continuity.**

I feel inspired by, and grateful for, this incredible research experience and learning, and privileged to continue to have the opportunity of contributing to making a difference for leaders in healthcare, and ultimately patients. As Nelson Mandela once said '*It's not what happens, it's what you do about it that makes the difference'* (Burn, 2005), so for me this journey is only at the beginning.

Appendices

Appendix 1 - Delivering Better Care Leadership Programme 2015-2016

NHS Lothian and Edinburgh Napier University's *Delivering Better Care Leadership Programme* is an innovative leadership programme which focuses on caring, compassion and practice development. The programme will have participants from NHS settings and Edinburgh Napier University staff. It has evolved from *Leading into the Future* and the *Leadership in Compassionate Care* leadership programmes and actively supports current initiatives in NHS Lothian including *Leading Better Care*, *The Person Centred Health and Care Collaborative and The Scottish Patient Safety Programme*.

Aims of the programme are that participants will:

- Develop their personal qualities and skills as transformational leaders
- Work with others on the programme to exchange ideas, build upon expertise in the group and develop leadership and practice
- Develop an increased understanding of compassionate, safe, person-centred and relationship-centred care and actively use these concepts to develop practice
- Develop skills of using an appreciative inquiry approach to examine practice
- Develop skills of engaging members of their team and leading a practice development
- Develop a working understanding of policy that relates to quality in health care
- Share their learning and development and celebrate success

It is expected that participants and their managers will work and engage with their teams to develop practice. The Managers' role in providing support during the programme is of utmost importance.
Participants are encouraged to be open to ideas, work with possibilities rather than focus on limitations, and challenge their own values, beliefs and assumptions.

This is an intensive programme (12 workshops over 10 months) that involves a real commitment to attend each session and to carry out the "activities" between sessions in their areas; for example taking stories and gathering feedback from patients, carers, families and students, and observing practice.

The 2015 programme commences on September 16th/17th and will finish on June 24th 2016.

The programme is a significant on-going investment by NHS Lothian and Edinburgh Napier University which aims to build leadership capacity and

capability, and enable safe, person centred, effective compassionate care for our patients and families; therefore participants are encouraged to embrace and capitalise on this exciting opportunity.

Programme model outline

Date	Workshop topic
September 16th/17th	**Contracting for success** *Compassionate care theme: Involving, valuing and transparency* Introduction to; Compassionate care themes and model, The Senses Framework and relationship-centred care, Appreciative Inquiry and Action Research Sharing experiences and ensuring sustainability, exploration around practice development tools and techniques
October 28th/29th	**Valuing and working with feedback** *Compassionate care theme: Feedback, Caring conversations* Our values into action; exploring leadership theories, models and styles; Emotional Touchpoints and the power of storytelling Fish Philosophy!
November 27th	**Developing leadership through feedback** *Compassionate care theme: Feedback, Caring conversations* Quality Improvement and patient safety; introducing improvement methodology- small tests of change, tips and tools; engaging our teams and seeking, hearing and acting on feedback on our leadership qualities Working with data, presenting our findings
January 26th 2016	**Communication that works** *Compassionate care theme: Knowing you, knowing me Attitudes and behaviours, Transactional Analysis; meaningful conversations and enhancing our emotional intelligence*
February 25th	**Inquiring and acting appreciatively** *Compassionate care theme: Flexible person –centred risk taking, Caring conversations* Playing to the strengths of the team, understanding our roles and accountability
March 23rd	**The power of observation** *Compassionate care theme: Involving, valuing and transparency, Creating spaces that work* *(The environment)*
April 28th	**Enhancing the patient experience through valuing equality and diversity** *Compassionate care theme: Involving, valuing and transparency, Creating spaces that work* Adult Protection, Rapid Impact Assessment, Valuing the diversity of the team
May 26th	**Relationship-Centred Care and the Senses Framework in practice** *Compassionate care theme: exploring all CC themes* Enhancing the experiences of patients, staff, students and carers
June 24th	**Celebration of learning and sharing best practice**

Appendix 2 – Leading into the Future Pilot Programme Descriptor

Appendix 2

NHS Education for Scotland

NHS Lothian

Leading into the Future

Leading into the Future is a Relationship- Centred Leadership Programme based on the **Senses Framework** - a model underpinning practice with older people and their families.

This **yearlong programme** aims to develop, support and implement a vision for Person-Centred leadership where staff working with older people creates a community of practice where "age" is not used to define or make assumptions about the value or potential of an individual.

At its core the programme holds that the best care develops when all those who care: older people, families, carers, staff, experience **" a sense of belonging, continuity, purpose, security, achievement and significance".**

The programme will focus on how we care for older people as much as where we care for them and will complement and integrate with Public Service Reform agenda and local and national drivers.

Commences in December 2007 and is aimed at multi-disciplinary, multi-agency staff with a common commitment to improving older people's services.

Learning methods will include workshops, master classes, action learning and coaching.

Interested in finding out more or to obtain an application form?
Please contact: Sue Sloan

Lead Practitioner Clinical leadership
NHS Lothian
Tel: 01506 524416 or 07740841626
E-mail: sue.sloan@wlt.scot.nhs.uk

Appendix 3 – Leading into the Future Participant Information (5 page booklet adapted from pilot booklet)

Leading into the Future

INFORMATION BOOKLET

Leading into the Future is a relationship-centred Leadership Programme based on the **Senses Framework** - a model underpinning practice with older people and their families. The programme is delivered in conjunction with the Leadership in Compassionate Care project in NHS Lothian.

Commences in March 2009 and is aimed at multi-disciplinary, multi-agency practitioners with a common commitment to improving older people's services.

Purpose and Focus

The programme uses the concept of relationship-centred care and the Senses Framework (Nolan et al, 2006) to demonstrate ways in which health and social care practitioners can take the lead in developing enriched care environments for older people.

Within the programme the position is taken that care cannot be person-centred unless it is relationship-centred, and both concepts are fully explored. The programme focuses on **how** we care for older people as much as **where** we care for them.

Although the notion of relationship- centred care provides a theoretical model for the development of enriched care environments, nurses and other practitioners need guidance in identifying ways of interacting with older people and their families that best support relationships. With this is mind the Senses Framework was developed.

The Senses Framework has been built upon many years of research in a range of care settings (Nolan 1997, Davies et al 1999, Nolan et al 2001, Nolan et al 2002). The Framework suggests that the best care for older people involves the creation of a set of senses or experiences, for older people, for family caregivers and for staff working with them. These are:

- A sense of **security** - of feeling safe and receiving or delivering competent and sensitive care
- A sense of **continuity** - the recognition of biography, using the past to contextualise the present
- A sense of **belonging** - opportunities to form meaningful relationships or feel part of a team
- A sense of **purpose** - opportunities to engage in purposeful activities or to have a clear set of goals to aspire to
- A sense of **achievement** - achieving meaningful or valued goals and feeling satisfied with ones efforts
- A sense of **significance** - to feel that you matter, and that you are valued as a person (Nolan et al, 2002)

The Senses Framework has been shown to resonate with older people, their families and staff in a range of care environments. An important component of the programme involves enabling participants to use the tool as an effective strategy for implementing a work based project and evaluating change aimed at achieving relationship-centred care. The programme builds upon the knowledge skills and values required for relationship-centred care as identified by Pew Fetzer et al (1994)
These relate to the following areas:

- Self awareness
- Patient experience of health and illness
- Developing and maintaining caring relationships
- Effective communication.

Although relationships are prerequisite to effective care and healing, there has been little formal acknowledgement of their importance and few formal efforts to help students and practitioners learn how to develop effective relationships in health care (Nolan et al 2006).

Leading into the Future enables practitioners to take a lead role in developing effective partnerships with older people and their families, and with colleagues, other agencies and students in the field of gerontological care.

This programme facilitates participants to challenge and question current thinking and practice and to engage in courageous conversations that facilitate change in teams and lead to change in practice.
The workshops are designed to enable an interactive approach, which encourages participants to draw upon and learn from their own and others' experiences.

The significant role leadership plays in the success of an organisation is widely acknowledged, but never has the need for effective leadership been expressed more strongly than now.

This **nine month long programme** will be delivered in **conjunction with the Leadership in Compassionate Care project**, and aims to develop, support and implement a vision, where staff working with older people creates a community of practice where "age" is not used to define or make assumptions about the value or potential of an individual.

Anticipated Outcomes

- Participants will develop their personal qualities and skills as leaders of Older People's Services
- An embryonic Community of Practice will develop and evolve
- Participants will co-create changes in practice that demonstrate increased capability in creating a service that is person-centred/relationship-centred
- Participants will develop and apply an understanding of the policy context
- Participants will develop increased capability in person-centred/relationship-centred practice
- Participants will develop and utilise skills in leadership, which can be transferred in to influencing person-centred/relationship-centred planning and delivery.

Learning methods

- Workshop based (including 2 days Residential workshops in April)
- Mix of didactic and experiential
- Workshops with external facilitators/experts
- Action Learning
- Coaching
- Project and feedback /presentation of project outcomes

Evaluation

The evaluation of the Programme will include:

- Development of the individual participants using a variety of tools
- Impact on service using a variety of methods including service user stories

Costs will be met from NHS Education Scotland funding allocated to NHS Lothian. (No fees/costs charged to participants)

Application process

- Advertising of programme from **January 19 2009**
- Application forms to be completed (including supporting statement plus outline of project you would like to undertake during the programme) and returned by **closing date February 13 2009**
- Informal interview with applicants mid February (to ensure support in place, commitment to participate is evident, this is the right programme and right time to participate and you have all the right information etc)
- Successful applicants informed by **end February/early March**

References

Davies, S., Nolan, M., Brown, J. and Wilson, F. (1999) *Dignity on the Ward: Promoting Excellence in Care*. London: Help the Aged.

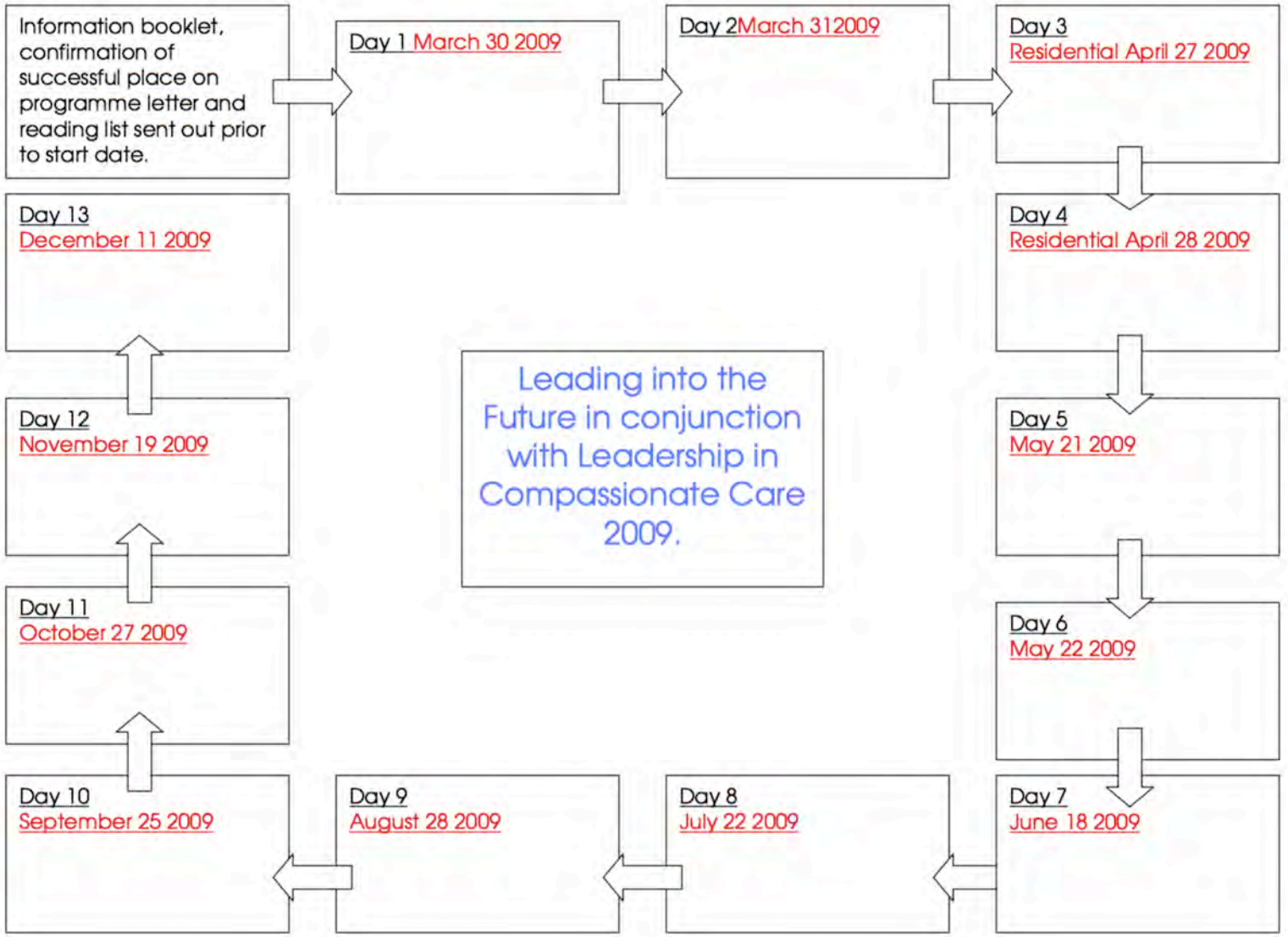
Nolan M, Brown J, Davies S, Keady J, Nolan J (2002) *Advancing Gerontological Education in Nursing:* final report of the AGEIN project. Report to the English National Board for Nursing, Midwifery and Health Visiting, University of Sheffield.

Nolan M, Davies S, Brown J, Nolan J, Keady, J (2006) *The Senses Framework: Improving Care for Older People Through a Relationship-Centred Approach,* Getting Research Into Practice Series, University of Sheffield.

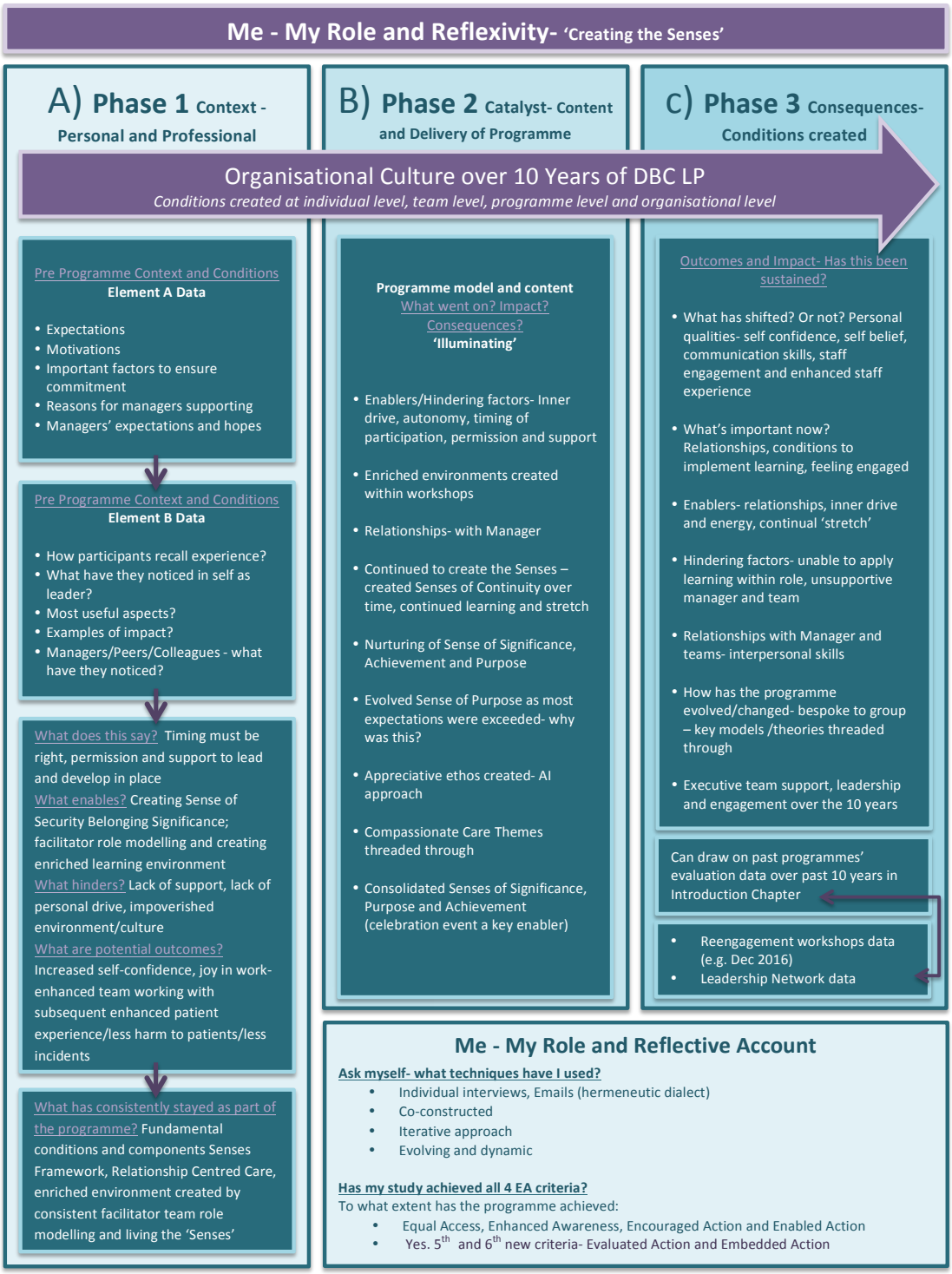
Tresolini, C.P. and the Pew-Fetzer Task Force (1994) *Health professions, education and relationship-centred care*: a report of the Pew-Fetzer Task Force on advancing psychological education, Pew Health Professions Commission, San Francisco CA.

For more info please contact:

Sue Sloan
Lead Practitioner Clinical Leadership
NHS Lothian
Tel 01506 524416 or 07740841626
E-mail sue.sloan@wlt.scot.nhs.uk


Information booklet, confirmation of successful place on programme letter and reading list sent out prior to start date.
Day 1 March 30 2009
Day 2March 312009
Day 3
Residential April 27 2009
Day 4
Residential April 28 2009
Day 5
May 21 2009
Day 6
May 22 2009
Day 7
June 18 2009
Day 8
July 22 2009
Day 9
August 28 2009
Day 10
September 25 2009
Day 11
October 27 2009
Day 12
November 19 2009
Day 13
December 11 2009
Leading into the Future in conjunction with Leadership in Compassionate Care 2009.

Appendix 4 - Temporal Dimensions of study Phases



Appendix 5- Participant Invitation and Information sheets

Participant Invitation and Information sheet (a)

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and to decide if you want to take part. Talk to others about the study if you wish.

This information sheet tells you the purpose of the study, what will happen to you if you take part and gives detailed information about the conduct of the study.

If there is anything that is not clear or if you would like more information please contact Sue Sloan, [redacted] Email: [redacted]

What is the purpose of this study?
This research will form the basis of a PhD submission to De Montfort University by Sue Sloan. Over the past decades numerous studies have highlighted the importance of effective leadership in delivering safe, effective patient care. There is limited evidence however about what factors influence the sustainability of impact following leadership development in Healthcare. This study will explore expectations and motivations for participating in leadership development and processes that influence any subsequent impact.

Who is organising and funding this study?
De Montfort University in Leicester is the sponsor for the study, providing insurance and funding.

What is the reason I have been invited to take part?
You have been invited because you will be a participant on Delivering Better Care Leadership Programme (DBC LP) 2015-2016, starting in September. Your views and experiences are valued and it would be really helpful to learn from these.

Do I have to take part?
No – taking part is entirely voluntary. If you would prefer not to take part, you need do nothing and you do not have to give any reason and this will not in any way influence your experience on the Delivering Better Care Leadership Programme

What will I have to do?
If you are willing to take part, you will be invited to have an interview or take part in a focus group at 3 stages of the study-at the start, at the end and a year later. Each interview or group will be digitally recorded so that they can be transcribed and analysed at a later stage. You will be given the opportunity to read the transcripts of the interviews or groups and to make comments on the analysis of them.

The interviews can take place at a mutually convenient venue such as your workplace or at an Edinburgh Napier University Campus for example, or by telephone if you prefer**.** The focus groups will take place at an Edinburgh Napier Campus.
The interview or focus group will last about an hour depending on how much you have to say. It will focus on your experience of the programme and reasons for applying to participate on the Delivering Better Care Leadership Programme, and in particular what

aspects of leadership you hope to develop. The second and third interviews will focus on how the programme has been helpful or not to you in your role, how your expectations have been met, how you are sustaining your development and will give you the opportunity to share examples of any impact or changes you have made.

If you choose to take part you will be asked to sign a consent form.

What are the possible benefits of taking part?
There are no direct benefits to you; however some people enjoy having the opportunity to reflect. It is hoped the information we get, will help us to understand how to sustain impact following leadership development more effectively in the future, which ultimately will benefit staff, patients and the NHS.

What are the disadvantages to taking part?
The interview/focus group will involve prioritising your time. You might find exploring aspects of your role in relation to your participation on the leadership programme challenging or upsetting, however this is unlikely. The researcher is an experienced coach/facilitator, as well as a registered nurse so is well able and confident in working with groups and individuals.

Expenses and Payments
Participants will not be paid to participate in the study.

Will my taking part in the study be kept confidential?
As part of the study, your manager will be invited to take part, as their experiences are also valued and it will be helpful to learn from these. With your permission, a junior colleague and a peer will also be invited to participate in the study. This will be discussed and agreed with you at 2 or 3 stages during the study. Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. However, your name or details that will identify you or any other person will not be used in any report of the findings. No one other than your manager and the 2 colleagues we agree to invite to participate will be informed that you have taken part in the research. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998. Ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by the researcher and authorised persons from De Montfort University and academic supervisors of the researcher, who will check that the study is being carried out correctly; all have a duty of confidentiality to you. All information, which is collected, about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any personal information (address, telephone number for contact for example) will be kept for 6 months after the end of the study so that you can be contacted about the findings of the study and possible follow-up studies (unless you advise that you do not wish to be contacted). All other information (the interviews/focus group notes) will be kept securely for 5 years. After this time your data will be disposed of securely.

What happens if I don't want to carry on with the study?
Your participation is voluntary. You are free to withdraw at any time and without giving a reason, and if that is up to a week following participation, your information from your interview(s) will be destroyed. Once data analysis starts it will not be possible to remove your specific information however.

What will happen to the results of the research study?
Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. These publications and presentations will contain verbatim quotations from interviews so although you will not be identified you may if reading these papers recognise something you have said. The study outcomes will provide evidence and recommendations to NHS Board Executives and education leads as to which areas require attention and focus to sustain impact and continue to develop leadership across healthcare.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS through the De Montfort University, Faculty of Health and Life Sciences, Faculty Research Ethics Committee on August 28th 2015. Approval Number: 1616

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If this is not satisfactory then please contact [redacted] **who is the Professor supervising the study, by telephone on** [redacted] **or by email** [redacted] or failing that please contact the Head of the Faculty Research Ethics Committee by email via [redacted]

What if I have any queries or concerns after reading this information sheet?

Please feel free to contact the researcher Sue Sloan Telephone direct dial: - [redacted]
Or you can write to: Sue Sloan, Research Fellow, [redacted]

What do I do if I want to take part?
Please complete and send back the return slip below to Sue Sloan via the NHS Lothian internal mail or email [redacted] to confirm that you are interested in taking part. Sue will then contact you.

Thank you for reading this information sheet.

Return slip to opt in
If you decide to take part in the research study please keep this information sheet, complete the slip below and return to Sue Sloan, [redacted] via the NHS Lothian Internal mail or email [redacted] Thank you.

Contact Details:
Work email:
Telephone number (work landline or mobile):
Best time to phone you:

Participant Invitation and Information sheet (b)

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and to decide if you want to take part. Talk to others about the study if you wish.

This information sheet tells you the purpose of the study, what will happen to you if you take part and gives detailed information about the conduct of the study.

If there is anything that is not clear or if you would like more information please contact Sue Sloan, mobile number [redacted], Email: [redacted]

What is the purpose of this study?
This research will form the basis of a PhD submission to De Montfort University by Sue Sloan. Over the past decades numerous studies have highlighted the importance of effective leadership in delivering safe, effective patient care. There is limited evidence however about what factors influence the sustainability of impact following leadership development in Healthcare. This study will explore expectations and motivations for participating in leadership development and processes that influence any subsequent impact.

Who is organising and funding this study?
De Montfort University in Leicester is the sponsor for the study, providing insurance and funding.

What is the reason I have been invited to take part?
You have been invited because you are a past participant of Delivering Better Care Leadership Programme (DBC LP). Your views and experiences are valued and it would be really helpful to learn from these.

Do I have to take part?
No – taking part is entirely voluntary. If you would prefer not to take part, you need do nothing and you do not have to give any reason.

What will I have to do?
If you are willing to take part, you will be invited to have an interview face to face or on the telephone, during the study. The interview will be digitally recorded so that it can be transcribed and analysed at a later stage. You will be given the opportunity to read the transcripts of the interview and to make comments on the analysis of them. The interview can take place at a mutually convenient venue such as your workplace or at an Edinburgh Napier University Campus for example, or by telephone if you prefer**.** The interview will last about an hour depending on how much you have to say. It will focus on your experience of Delivering Better Care Leadership Programme, your original reasons for applying to participate on the programme, how your expectations have been met, what aspects of leadership you had hoped to develop and how you are sustaining your development. You will have the opportunity to share examples of any impact or changes you have made. If you choose to take part you will be asked to sign a consent form.

What are the possible benefits of taking part?
There are no direct benefits to you; however some people enjoy having the opportunity to reflect. It is hoped the information we get, will help us to understand how to sustain impact following leadership development more effectively in the future, which ultimately will benefit staff, patients and the NHS.

What are the disadvantages to taking part?
The interview will involve prioritising your time. You might find exploring aspects of your role in relation to your participation on the leadership programme challenging or upsetting, however this is unlikely. The researcher is an experienced coach/facilitator, as well as a registered nurse so is well able and confident in working with groups and individuals.

Expenses and Payments
Participants will not be paid to participate in the study.

Will my taking part in the study be kept confidential?
As part of the study and with your permission, your manager, a junior colleague and a peer will be invited to take part, as their experiences are also valued and it will be helpful to learn from these. Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. However, your name or details that will identify you or any other person will not be used in any report of the findings. No one other than your manager and the 2 colleagues we agree to invite to participate will be informed that you have taken part in the research.
Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998. Ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by the researcher and authorised persons from De Montfort University and academic supervisors of the researcher, who will check that the study is being carried out correctly; all have a duty of confidentiality to you. All information, which is collected, about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any personal information (address, telephone number for contact for example) will be kept for 6 months after the end of the study so that you can be contacted about the findings of the study and possible follow-up studies (unless you advise that you do not wish to be contacted). All other information (the interview notes) will be kept securely for 5 years. After this time your data will be disposed of securely.

What happens if I don't want to carry on with the study?
Your participation is voluntary. You are free to withdraw at any time and without giving a reason, and if that is up to a week following participation, the information from your interview will be destroyed. Once data analysis starts it will not be possible to remove your specific information however.

What will happen to the results of the research study?
Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. These publications and presentations will contain verbatim quotations from interviews so although you will not be identified you may if reading these papers recognise something you have said. The study outcomes will provide evidence and recommendations to NHS Board Executives and education leads as to

which areas require attention and focus to sustain impact and continue to develop leadership across healthcare.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS through the De Montfort University, Faculty of Health and Life Sciences, Faculty Research Ethics Committee, on August 28th 2015. Approval Number: 1616

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If this is not satisfactory then please contact [redacted] **who is the Professor supervising the study, by telephone on** [redacted] **mobile** [redacted] **or by email** [redacted] or by post to [redacted] or failing that please contact the Head of the Faculty Research Ethics Committee by email via [redacted]

What if I have any queries or concerns after reading this information sheet?
Please feel free to contact the researcher Sue Sloan Telephone direct dial: - [redacted], work mobile [redacted] email [redacted]
Or you can write to: Sue Sloan, Research Fellow, [redacted]

What do I do if I want to take part?
Please complete and send back the return slip below to Sue Sloan via the NHS Lothian internal mail or email [redacted] to confirm that you are interested in taking part. Sue will then contact you.

Thank you for reading this information sheet.

Return slip to opt in

If you decide to take part in the research study please keep this information sheet, complete the slip below and return to Sue Sloan, [redacted], via the NHS Lothian Internal mail or email [redacted]
Thank you.

Contact Details:
Work email:
Telephone number (work landline or mobile):
Best time to phone you:

Participant Invitation and Information sheet (c)

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and to decide if you want to take part. Talk to others about the study if you wish.

This information sheet tells you the purpose of the study, what will happen to you if you take part and gives detailed information about the conduct of the study.

If there is anything that is not clear or if you would like more information please contact Sue Sloan, mobile number [redacted], Email: [redacted]

What is the purpose of this study?
This research will form the basis of a PhD submission to De Montfort University by Sue Sloan. Over the past decades numerous studies have highlighted the importance of effective leadership in delivering safe, effective patient care. There is limited evidence however about what factors influence the sustainability of impact following leadership development in Healthcare. This study will explore expectations and motivations for participating in leadership development and processes that influence any subsequent impact.

Who is organising and funding this study?
De Montfort University in Leicester is the sponsor for the study, providing insurance and funding.

What is the reason I have been invited to take part?
You have been invited because you are the Manager or colleague of a participant on *Delivering Better Care Leadership Programme* (DBC LP). Your experiences are valued and it would be really helpful to learn from these.

Do I have to take part?
No – taking part is entirely voluntary. If you would prefer not to take part, you need do nothing and you do not have to give any reason.

What will I have to do?
If you are willing to take part, you will be invited to have an interview either face to face or on the telephone, at 2 or 3 stages of the study-at the start (if you are a Manager), at the end (Managers and colleagues) and possibly a year later (a selection of Managers and colleagues will be invited). Each interview will be digitally recorded so that they can be transcribed and analysed at a later stage. You will be given the opportunity to read the transcripts of the interviews and to make comments on the analysis of them. The interviews can take place at a mutually convenient venue such as your workplace or at an Edinburgh Napier University Campus for example, or by telephone if you prefer. The interview will last about an hour depending on how much you have to say. It will focus on your experience of working with your colleague who participated on the programme, and for Managers, your reasons for supporting their application. The second and third interviews will focus on how you think *Delivering Better Care Leadership Programme* has been helpful or not to your colleague, and will give you the opportunity to share examples of any changes or impact you have observed since they participated on the programme. If you choose to take part you will be asked to sign a consent form.

What are the possible benefits of taking part?
There are no direct benefits to you; however some people enjoy having the opportunity to reflect. It is hoped the information we get, will help us to understand how to sustain impact following leadership development, more effectively in the future, which ultimately will benefit staff, patients and the NHS.

What are the disadvantages to taking part?
The interview will involve prioritising your time. You might find discussing aspects of your colleague's role in relation to their participation on the leadership programme challenging or upsetting, however this is unlikely. The researcher is an experienced coach/facilitator, as well as a registered nurse so is well able and confident in working with groups and individuals.

Expenses and Payments
Participants will not be paid to participate in the study.

Will my taking part in the study be kept confidential?
Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. However, your name or details that will identify you or any other person will not be used in any report of the findings. No one will be informed that you have taken part in the research. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998.
Ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by the researcher and authorised persons from De Montfort University and academic supervisors of the researcher, who will check that the study is being carried out correctly; all have a duty of confidentiality to you. All information, which is collected, about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any personal information (address, telephone number for contact for example) will be kept for 6 months after the end of the study so that you can be contacted about the findings of the study and possible follow-up studies (unless you advise that you do not wish to be contacted). All other information (the interview notes) will be kept securely for 5 years. After this time your data will be disposed of securely.

What happens if I don't want to carry on with the study?
Your participation is voluntary. You are free to withdraw at any time and without giving a reason, and where possible, up to a week following participation, your information from your interview(s) will be destroyed. Once data analysis starts it will not be possible to remove your specific information however.

What will happen to the results of the research study?
Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. These publications and presentations will contain verbatim quotations from interviews so although you will not be identified you may if reading these papers recognise something you have said. The study outcomes will provide evidence and recommendations to NHS Board Executives and education leads as to which areas require attention and focus to sustain impact and continue to develop leadership across healthcare.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS through the De Montfort University, Faculty of Health and Life Sciences, Faculty Research Ethics Committee, on August 28th 2015, Approval Number: 1616.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If this is not satisfactory then please contact [redacted] **who is the Professor supervising the study, by telephone on (**[redacted] **or by email** [redacted]
or by post to De Montfort University, [redacted]

What if I have any queries or concerns after reading this information sheet?
Please feel free to contact the researcher Sue Sloan Telephone direct dial: - [redacted], work mobile [redacted] email [redacted]
Or you can write to: Sue Sloan, Research Fellow, [redacted]

What do I do if I want to take part?
Please complete and send back the return slip below to Sue Sloan via the NHS Lothian internal mail or email [redacted] to confirm that you are interested in taking part. Sue will then contact you.

Thank you for reading this information sheet.

Return slip to opt in

If you decide to take part in the research study please keep this information sheet, complete the slip below and return to Sue Sloan, [redacted], via the NHS Lothian Internal mail or email [redacted]t
Thank you.

Contact Details:
Work email:
Telephone number (work landline or mobile):
Best time to phone you:

Participant Invitation and Information sheet (d)

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and to decide if you want to take part. Talk to others about the study if you wish.

This information sheet tells you the purpose of the study, what will happen to you if you take part and gives detailed information about the conduct of the study.

If there is anything that is not clear or if you would like more information please contact Sue Sloan, mobile number [redacted] Email: [redacted]

What is the purpose of this study?
This research will form the basis of a PhD submission to De Montfort University by Sue Sloan. Over the past decades numerous studies have highlighted the importance of effective leadership in delivering safe, effective patient care. There is limited evidence however about what factors influence the sustainability of impact following leadership development in Healthcare. This study will explore expectations and motivations for participating in leadership development and processes that influence any subsequent impact.

Who is organising and funding this study?
De Montfort University in Leicester is the sponsor for the study, providing insurance and funding.

What is the reason I have been invited to take part?
You have been invited because you will be a participant on *Delivering Leadership Excellence for Allied Healthcare Professionals Leadership Programme* (DLE for AHPs) cohort 9, starting in September. Your views and experiences are valued and it would be really helpful to learn from these.

Do I have to take part?
No – taking part is entirely voluntary. If you would prefer not to take part, you need do nothing and you do not have to give any reason and this will not in any way influence your experience on the *Delivering Leadership Excellence for Allied Healthcare Professionals Leadership Programme*

What will I have to do?
If you are willing to take part, you will be invited to have an interview or take part in a focus group at 3 stages of the study-at the start, at the end and a year later. Each interview or group will be digitally recorded so that they can be transcribed and analysed at a later stage. You will be given the opportunity to read the transcripts of the interviews or groups and to make comments on the analysis of them. The interviews can take place at a mutually convenient venue such as your workplace, or by telephone if you prefer**.** The focus groups will take place at an Edinburgh Napier University Campus. The interview or focus group will last about an hour depending on how much you have to say. It will focus on your experience of the programme and reasons for applying to participate on the *DLE for AHPs Leadership Programme*, and in particular what aspects of leadership you hope to develop. The second and third interviews will focus on how the programme has been helpful or not to you in your role, how your expectations have been met, how you are sustaining your development and

will give you the opportunity to share examples of any impact or changes you have made. If you choose to take part you will be asked to sign a consent form.

What are the possible benefits of taking part?
There are no direct benefits to you; however some people enjoy having the opportunity to reflect. It is hoped the information we get, will help us to understand how to sustain impact following leadership development more effectively in the future, which ultimately will benefit staff, patients and the NHS.

What are the disadvantages to taking part?
The interview/focus group will involve prioritising your time. You might find exploring aspects of your role in relation to your participation on the leadership programme challenging or upsetting, however this is unlikely. The researcher is an experienced coach/facilitator, as well as a registered nurse so is well able and confident in working with groups and individuals.

Expenses and Payments
Participants will not be paid to participate in the study.

Will my taking part in the study be kept confidential?
As part of the study, your manager will be invited to take part, as their experiences are also valued and it will be helpful to learn from these. With your permission, a junior colleague and a peer will also be invited to participate in the study. This will be discussed and agreed with you at 2 or 3 stages during the study. Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. However, your name or details that will identify you or any other person will not be used in any report of the findings. No one other than your manager and the 2 colleagues we agree to invite to participate will be informed that you have taken part in the research. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998. Ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by the researcher and authorised persons from De Montfort University and academic supervisors of the researcher, who will check that the study is being carried out correctly; all have a duty of confidentiality to you. All information, which is collected, about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any personal information (address, telephone number for contact for example) will be kept for 6 months after the end of the study so that you can be contacted about the findings of the study and possible follow-up studies (unless you advise that you do not wish to be contacted). All other information (the interviews/focus group notes) will be kept securely for 5 years. After this time your data will be disposed of securely.

What happens if I don't want to carry on with the study?
Your participation is voluntary. You are free to withdraw at any time and without giving a reason, and if that is up to a week following participation, your information from your interview(s) will be destroyed. Once data analysis starts it will not be possible to remove your specific information however.

What will happen to the results of the research study?
Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. These publications and presentations will contain verbatim quotations from interviews so although you will not be identified you may if reading these papers recognise something you have said. The study outcomes will provide evidence and recommendations to NHS Board Executives and education leads as to which areas require attention and focus to sustain impact and continue to develop leadership across healthcare.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS through the De Montfort University, Faculty of Health and Life Sciences, Faculty Research Ethics Committee on August 28th 2015. Approval Number: 1616

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If this is not satisfactory then please contact [redacted] **who is the Professor supervising the study, by telephone on** [redacted] **or by email** [redacted] or by post to De Montfort University [redacted] or failing that please contact the Head of the Faculty Research Ethics Committee by email via [redacted]

What if I have any queries or concerns after reading this information sheet?
Please feel free to contact the researcher Sue Sloan Telephone direct dial: - [redacted]
Or you can write to: Sue Sloan, Research Fellow, [redacted]

What do I do if I want to take part?
Please complete and send back the return slip below to Sue Sloan via the NHS Lothian internal mail or email [redacted] to confirm that you are interested in taking part. Sue will then contact you.

Thank you for reading this information sheet.

Return slip to opt in

If you decide to take part in the research study please keep this information sheet, complete the slip below and return to Sue Sloan, [redacted], via the NHS Lothian Internal mail or email [redacted]
Thank you.

Contact Details:
Work email:
Telephone number (work landline or mobile):
Best time to phone you:

Participant Invitation and Information sheet (e)

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and to decide if you want to take part. Talk to others about the study if you wish. This information sheet tells you the purpose of the study, what will happen to you if you take part and gives detailed information about the conduct of the study. If there is anything that is not clear or if you would like more information please contact Sue Sloan, mobile number [redacted], Email: [redacted]

What is the purpose of this study?
This research will form the basis of a PhD submission to De Montfort University by Sue Sloan. Over the past decades numerous studies have highlighted the importance of effective leadership in delivering safe, effective patient care. There is limited evidence however about what factors influence the sustainability of impact following leadership development in Healthcare. This study will explore expectations and motivations for participating in leadership development and processes that influence any subsequent impact.

Who is organising and funding this study?
De Montfort University in Leicester is the sponsor for the study, providing insurance and funding.

What is the reason I have been invited to take part?
You have been invited because you are the Manager or Colleague of a participant on *Delivering Leadership Excellence for Allied Healthcare Professionals Leadership Programme* (DLE for AHPs) cohort 9. Your views and experiences are valued and it would be really helpful to learn from these.

Do I have to take part?
No – taking part is entirely voluntary. If you would prefer not to take part, you need do nothing and you do not have to give any reason.

What will I have to do?
If you are willing to take part, you will be invited to have an interview or take part in a focus group at 3 stages of the study-at the start (if you are a Manager), at the end (Managers and colleagues) and possibly a year later (a selection of Managers and colleagues will be invited). Each interview or group will be digitally recorded so that they can be transcribed and analysed at a later stage. You will be given the opportunity to read the transcripts of the interviews or groups and to make comments on the analysis of them. The interviews can take place at a mutually convenient venue such as your workplace, or by telephone if you prefer. The focus groups will take place at an Edinburgh Napier University Campus. The interview or focus group will last about an hour depending on how much you have to say. It will focus on your experience of working with your colleague who is participating or has participated on the programme, and for Managers your reasons for supporting their application. The second and third interviews will focus on how you think the programme has been helpful or not to your colleague, and will give you the opportunity to share examples of any impact or changes you have observed since they participated on the programme. If you choose to take part you will be asked to sign a consent form.

What are the possible benefits of taking part?
There are no direct benefits to you; however some people enjoy having the opportunity to reflect. It is hoped the information we get, will help us to understand how to sustain impact following leadership development more effectively in the future, which ultimately will benefit staff, patients and the NHS.

What are the disadvantages to taking part?
The interview/focus group will involve prioritising your time. You might find exploring aspects of your colleague's role in relation to their participation on the leadership programme challenging or upsetting, however this is unlikely. The researcher is an experienced coach/facilitator, as well as a registered nurse so is well able and confident in working with groups and individuals.

Expenses and Payments
Participants will not be paid to participate in the study.

Will my taking part in the study be kept confidential?
Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. However, your name or details that will identify you or any other person will not be used in any report of the findings. No one will be informed that you have taken part in the research. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998.
Ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by the researcher and authorised persons from De Montfort University and academic supervisors of the researcher, who will check that the study is being carried out correctly; all have a duty of confidentiality to you. All information, which is collected, about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any personal information (address, telephone number for contact for example) will be kept for 6 months after the end of the study so that you can be contacted about the findings of the study and possible follow-up studies (unless you advise that you do not wish to be contacted). All other information (the interviews/focus group notes) will be kept securely for 5 years. After this time your data will be disposed of securely.

What happens if I don't want to carry on with the study?
Your participation is voluntary. You are free to withdraw at any time and without giving a reason, and if that is up to a week following participation, your information from your interview(s) will be destroyed. Once data analysis starts it will not be possible to remove your specific information however.

What will happen to the results of the research study?
Quotes from the interviews will be used in the academic doctoral studies and in reports of the research, articles and presentations at professional and educational meetings and conferences. These publications and presentations will contain verbatim quotations from interviews so although you will not be identified you may if reading these papers recognise something you have said.
The study outcomes will provide evidence and recommendations to NHS Board Executives and education leads as to which areas require attention and focus to sustain impact and continue to develop leadership across healthcare.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS through the De Montfort University, Faculty of Health and Life Sciences, Faculty Research Ethics Committee on August 28th 2015. Approval Number: 1616

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If this is not satisfactory then please contact [redacted] **who is the Professor supervising the study, by telephone on (**[redacted] **or by email** [redacted] or by post to De Montfort University, [redacted] or failing that please contact the Head of the Faculty Research Ethics Committee by email via [redacted]

What if I have any queries or concerns after reading this information sheet?
Please feel free to contact the researcher Sue Sloan Telephone direct dial: - [redacted] work mobile [redacted] email [redacted]
Or you can write to: Sue Sloan, Research Fellow, [redacted]

What do I do if I want to take part?
Please complete and send back the return slip below to Sue Sloan via the NHS Lothian internal mail or email [redacted] to confirm that you are interested in taking part. Sue will then contact you.

Thank you for reading this information sheet.

Return slip to opt in

If you decide to take part in the research study please keep this information sheet, complete the slip below and return to Sue Sloan, [redacted], via the NHS Lothian Internal mail or email sue.sloan@nhs.net
Thank you.

Contact Details:
Work email:
Telephone number (work landline or mobile):
Best time to phone you:

Appendix 6 - Participant Consent Form

Title of Study: A Constructivist Evaluation of a clinical leadership programme and its subsequent impact

Approved by: De Montfort University, Faculty of Health and Life Sciences, Faculty Research Ethics Committee
(Project ethics reference number: 1616)
Name of Researcher: **Sue Sloan**

	Please initial box
I confirm that I have read and understand the information sheet version number *4* dated *04/09/2015* for the above study and have had the opportunity to ask questions.	
I understand that the interview will be digitally recorded and that anonymous direct quotes from the interview may be used in the researcher's PhD study Thesis, study reports, and subsequent publications	
I understand that authorised individuals may look at relevant sections of information collected in the study from, the research team, De Montfort University and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study.	
I understand that my participation is voluntary and that I am free to withdraw without giving any reason, and without legal rights being affected.	
I understand that my personal details will be kept confidential.	
I agree to take part in the above study.	

Name of Participant _____

Signature _____

Date _____

Name of person taking consent _____

Signature _____

Date _____

Appendix 7 - Phase 1 Element A Research Interview questions

For participants:

- What are the views, expectations and motivations of participants for applying to undertake this leadership programme?
- What will success look like for them at the end of the programme?
- What factors are important to ensure full commitment and engagement in all elements of the programme?

For managers:

- What are your reasons for supporting X on the programme?
- What are your expectations and best hopes for their participation on the programme?
- What will success look like? What expected outcomes do you have?
- What will your role be in supporting them?
- What factors are important to you ensuring full commitment and engagement in all elements of the programme?

Appendix 8 - Phase 1 Element B Research Interview questions

- How do they recall their experience of *Delivering Better Care Leadership Programme*?
- What have they noticed in themselves as leaders since participating on the programme? *(For managers/colleagues-What have they noticed about their colleague since they participated on the programme?)*
- What aspects of the programme have been most useful?
- How would they describe their leadership role now, compared to before participating on the programme?
- What examples of impact, if any, can they provide to illustrate how they are implementing their learning from the programme? *(For managers/colleagues- what examples of impact, if any, can they provide that illustrates how their colleague has been implementing their learning since their participation on the programme?)*

Appendix 9 - Phase 2 Research Interview questions

For participants:

- How was their experience of the leadership programme?
- What have they noted in themselves personally and professionally within their role since participating on the programme? (Depending on response I will probe in terms of insights into personal qualities such as self awareness, self confidence, self management; impact of leadership role on team/on patient care/on service/on organisation).
- What did they notice during the programme?
- Have they noticed anything significant since completion?
- What do they anticipate/hope for over the next few months going forward, to sustain their leadership development?
- To what extent have their expectations been met?
- What aspects of the programme were most useful? What aspects could be improved?

For managers and colleagues:

- What did they notice about X whilst they were participating on the programme?
- What have they noticed since they completed the programme?
- To what extent have their expectations been met? (Managers)
- What aspects of the programme do you think have been most helpful?
- What tools/techniques are you aware of X taking forward?
- What aspects of the programme could be improved?
- How will you maximise the use of X as a resource within the team
- What do you think will help to sustain any impact? What might hinder?
- Anything else?

Appendix 10 - Phase 3 Research Interview questions

- What examples of impact, if any, since participation on the programme, have the participants themselves, their managers and peers noted?
- How has their leadership role been influenced since participating on the programme (or not)?
- What elements of the programme have been most useful and why?
- Who and what has enabled them, or not, to implement their learning and continue their development?
- What has been their most significant learning about themselves as leaders?

Appendix 11 - Interviews undertaken at each Phase and coding matrix

Phase 1

Code	Role		Band	Gender
EA01	Deputy Charge Nurse (DCN)	Participant	6	M
EA02	Staff Nurse (SN)	Participant	5	F
EA03	Advanced Nurse Practitioner	Participant	7	M
EA04	DCN	Participant	6	F
EA05	Occupational Therapist	Participant	6	F
EA06	Physio Team Leader	Participant	7	F
EA07	Physio Team Leader	Participant	7	F
EA08	Occupational Therapist (OT)	Participant	6	F
EA09	Community Team Leader	Participant	6	F
EAM01	Senior Charge Nurse (SCN)	Manager of Participant	7	F
EAM02	SCN	Manager of Participant	7	F
EAM03	Clinical Nurse Manager	Manager of Participant	8a	F
EAM04	SCN	Manager of Participant	7	F
EAM05	Allied Health Professions (AHP) Manager	Manager of Participant	8a	F
EAM06	AHP Manager	Manager of Participant	8a	F
EAM08	AHP Manager	Manager of Participant	8a	F
EA09	Community Team Leader	Manager of Participant	8a	F

Phase 1=
17 interviews
9 Participants and 8 Managers

Phase 2

EA01	Deputy Charge Nurse (DCN)	Participant	6	M
EA02	Staff Nurse (SN)	Participant	5	F
EA03	Advanced Nurse Practitioner	Participant	7	M
EA04	DCN	Participant	6	F
EA05	Occupational Therapist	Participant	6	F
Ea06	Physio Team Leader	Participant	7	F
EA07	Physio Team Leader	Participant	7	F
EA08	Occupational Therapist (OT)	Participant	6	F
EA09	Community Team Leader	Participant	6	F
EAM01	Senior Charge Nurse (SCN)	Manager of Participant	7	F
EAM02	SCN	Manager of Participant	7	F
EAM03	Clinical Nurse Manager	Manager of Participant	8a	F
EAM04	SCN	Manager of Participant	7	F
EAM05	Allied Health Professions (AHP) Manager	Manager of Participant	8a	F
EAM06	AHP Manager	Manager of Participant	8a	F
EAM07	AHP Manager	Manager of Participant	8a	F
EAM08	AHP Manager	Manager of Participant	8a	F
EAM09	Clinical Manager	Manager of Participant	8a	F
EADR01	SN	Direct Report/Junior Colleague	5	F
EAP02	DCN	Peer	6	F
EAP05	AHP Manager	Peer	7	M
EADR05	OT	Direct Report/Junior Colleague	6	F
EAP07	Physio	Peer	7	F
EADR07	AHP Assistant	Direct Report/Junior Colleague	4	F
EAP08	OT	Peer	7	F
EADR08	OT	Direct Report/Junior Colleague	6	M

Phase 2=
26 Interviews
9 Participants
9 Managers
4 Peers
4 Direct Reports

Phase 3

EA01	DCN	Participant	6	M
EA02	DCN	Participant	6	F
EA05	OT	Participant	6	F
EA06	Physio Team Leader	Participant	7	F
EA07	Physio Team Leader	Participant	7	F
EA08	OT Team Leader	Participant	7	F
EA09	Community Team Leader seconded to new role as Complaints Officer	Participant	7	F
EAM02	SCN	Manager of Participant	7	F
EAM05	AHP Manager	Manager of Participant	8a	F
EAM06	AHP Manager	Manager of Participant	8a	F
EAM07	AHP Manager	Manager of Participant	8a	F
EAM08	AHP Manager	Manager of Participant	8a	F
EADR02	Health Care Support Worker	Direct Report	2	F
EAP07	OT	Peer	7	F
EADR07	AHP Assistant	Direct Report	4	F
EAP08	OT	Peer	7	F
EAP08	OT	Direct Report	6	M

Phase 3=
17 interviews
7 Participants
5 Managers
2 Peers
3 Direct Reports

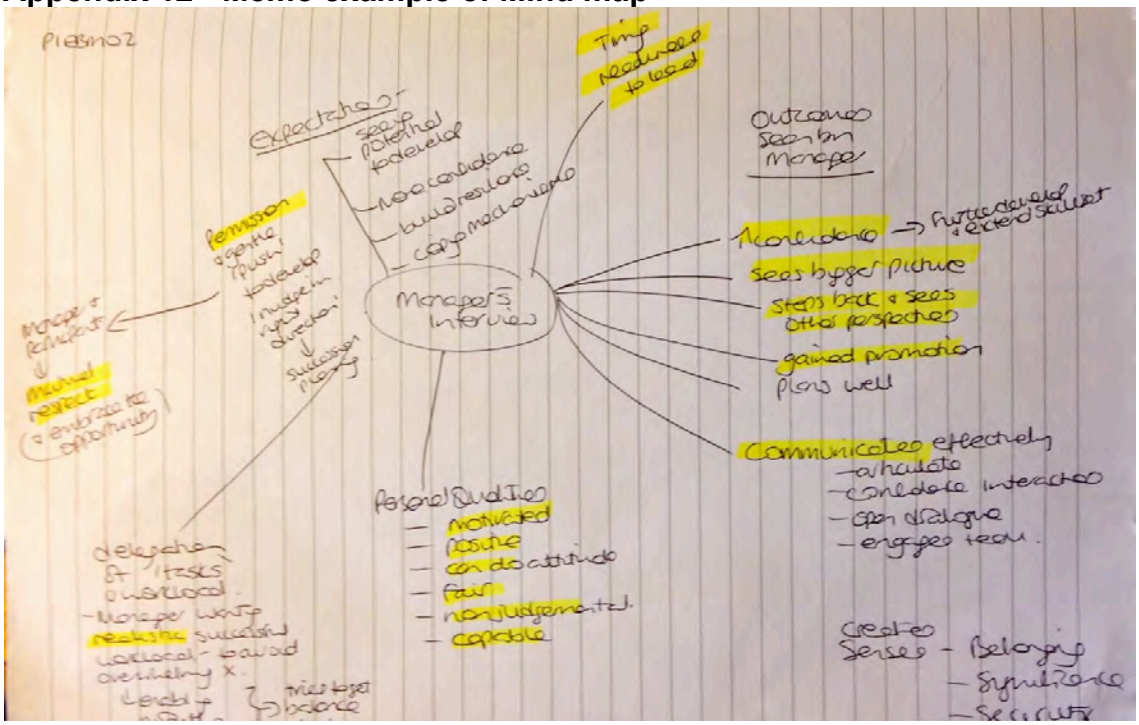
Element B

EB01	SN	Participant	6	F
EB02	Clinical Nurse Manager	Participant	8a	F
EB03	Nurse Director	Participant	-	F
EB04	Care Lead Nurse	Participant	-	F
EB05	SN	Participant	5	F
EBM01	Clinical Services Manager	Manager of Participant	8b	M
EBM02	Associate Nurse Director	Manager of Participant	-	F
EBM04	Care Home Manager	Manager of Participant	-	F
EBM05	SCN	Manager of	7	F

EBP01	Community Nurse	Participant Peer	6	F
EBDR04	SN	Direct Report	5	F
EBDR05	Support Worker	Direct Report	2	M

Element B=12 interviews
5 Participants
4 Managers
1 Peer
2 Direct Reports

Appendix 12 - Memo example of Mind map



Appendix 13 - Memo Extract Initial Coding

Extract of initial coding from Amy's Transcript, Phase One, Element A. (Pseudonyms for all participants engaged in the study are provided in Tables 6.1 and 6.2 within Chapter six.)

Amy was asked '*What motivated you to want to come on the programme?'*

'Initially it was a conversation with Aria my Charge Nurse, she mentioned it away last year, there was somebody already from the ward on the course and I had just come back from maternity leave and Aria had said you would really enjoy this, you would absolutely thrive on it and so think about it for next year, so she didn't push it and I went back to her a few months later and speaking to Ann about what it was all about really. So that's why I wanted to get involved really cos I absolutely love the ward I am on and I have a fantastic team so anything we can do to improve the care for our patients and also to make our job, not easier but to make it more meaningful. I suppose really so.	Creating a sense of continuity Seeing the potential Getting the timing right Being motivated Having joy in work Enhancing team working
The opportunity to take a step back from what we are doing on a day to day basis and kind of think what is this all about what are we doing here, not just doing your shift but really thinking about the impact we are having on the patients we are with. Seeing how we can, you know, cos when you are on shift as much as we have a staff support meeting every fortnight when we can talk about things,	Getting the timing right- to reflect Increasing self awareness

we have our handovers every morning but you're talking about individual care you're not talking about all the processes, all the people we meet on a day to day basis so it felt a great opportunity to take stock of what's going on there's so many changes in the NHS from one month to the next and lots of amazing things going on, the Scottish Patient Safety Programme, all the quality improvement work, the walk-a-rounds, you know, just a chance to pull that together really and see what its all about not just another process or another buzz word.	Communicating as a team Getting the timing right- to reflect Seeing the bigger picture

Summary of Initial Coding example

- Creating a sense of continuity
- Seeing the potential
- Getting the timing right
- Being motivated
- Having joy in work
- Enhancing team working
- Getting the timing right- to reflect
- Increasing self awareness
- Communicating as a team
- Seeing the bigger picture

Appendix 14 - Memo Extracts

'My initial approach to coding was straight to detail coding- making nodes as I needed. As I reflected and re-read each transcript several times at various stages of each phase of the study, I noted content of interest and coded to particular nodes, then grouped codes relating to the 6 Senses, which is topic coding. As the Senses are an underpinning theory as well as a facilitation and delivery mechanism, this was not only the logical process to follow but also felt intuitive to do so. I later analysed the descriptive codes, noting who was speaking and I began to deepen my analysis, asking myself- 'what is the data telling me?'

I cross-checked transcripts of the participants with their manager and colleagues where possible and also at each phase of the study- looking for consistency in emerging 'themes' or categories and congruence in the messages I was hearing. I continually asked myself 'why is this of interest to me?' and 'what is emerging?' (Extract from Memo 22/2/18)

'Coding, theming and categorising was a continual process throughout my study, whilst keeping abreast of the literature and cross checking notes taken at various stages of the journey. Initial coding, followed by focused coding and finally theoretical coding with continual reflexivity, provided a structure to support my research journey and allowed me to focus.

Another significant element of my research-learning journey was navigating and working with NVivo data management system, which supported the organisation and management of my data. NVivo supports the processes and reflexivity with the use of memos, which was particularly helpful due to the complexities of my insider-outsider role (Dwyer, S.C. and Buckle, J.L. 2009).

Considering the meaning and context i.e. is this a current or past participant or manager or direct report or peer? What is similar? What is different? What does this mean?

I created several nodes and sub nodes (child nodes) then coded at existing codes as I progressed. I tested out In Vivo coding as part of my learning

exploratory journey navigating NVivo. This is when selecting a particular word or phrase creates nodes. For example the actual 'Senses' were often referred to during the interview, such as achievement, purpose and became a code in their own right. This allowed me to reflect the actual language used by the participants and I was able to compare Element A and Element B participants as well as their managers and colleagues. Often content was coded at multiple nodes and I was able to run a 'query' to gather material in different combinations e.g. security and belonging, achievement and purpose.

Key messages to remember: define categories and be clear what I am saying; be analytical and break up the data; develop a substantive theory; avoid assumptions, don't take meaning for granted.' (Extract from Memo 22/3/18)

Appendix 15 - Constructivist Interpretive Framework - Coding framework of enabling and hindering factors

Used as a Constructivist Interpretive Framework as described in Chapter Four
Coding framework

Enabling factors

Creating relationships that matter

- ✓ Relationship with manager
- ✓ Being supported by manager
- ✓ Being supported by team
- ✓ Relationships with team
- ✓ Feeling valued
- ✓ Feeling safe and that you belong
- ✓ Being authentic

Leadership practices

- ✓ Supporting others
- ✓ Appreciating and valuing others
- ✓ Appreciating what's working well and enabling this to happen more of the time
- ✓ Enabling others to lead and develop
- ✓ Creating clarity of role purpose and meaning
- ✓ Creating the conditions to develop and learn continually over time
- ✓ Developing mutual respect and trust

Leadership qualities

- ✓ Being confident in self and intrinsically motivated
- ✓ Being supportive
- ✓ Being appreciative
- ✓ Being clear about role purpose and meaning

Creating the conditions

- ✓ Creating environments to enable development and learning continually over time
- ✓ Creating meaning and joy in work
- ✓ Having autonomy within role
- ✓ Getting the timing right for development
- ✓ Encouraging and giving permission to lead

Personal leadership qualities

- ✓ Being driven to continually learn
- ✓ Positive and motivated approach

Hindering factors

Ineffective relationships

- ✓ Poor relationship with manager
- ✓ Poor relationship with team
- ✓ Lack of support

Ineffective leadership practices

- ✓ Not creating autonomy
- ✓ No continuity or consistency
- ✓ Not providing clarity, support and purpose
- ✓ Lacking collaboration and engagement of others

Ineffective leadership conditions

- ✓ Timing not right
- ✓ No continuity of learning

Ineffective leadership qualities

- ✓ Lack of drive and motivation
- ✓ Unsupportive of others
- ✓ Lack of trust and respect

Appendix 16 – Outputs to date

Outputs from the study, at time of writing and examples of how I am influencing others' thinking include:

- Influencing corporate and senior management teams at a local, regional and national level through conversations about my study and the developed substantive **Five C's** theory together with the *Senses Framework*. Conversations include new work-streams currently underway with the Director of Medical Education, in relation to Doctors in training, which aim to promote the mental health and wellbeing of Doctors.
- Sharing insights and learning with *Project lift* team (national initiative to succession planning and talent development)
- Supporting the application for a 'Grant' in Kentucky State, USA, exploring ways in which a *relationship-centred* approach could be developed and implemented in long-term care settings for older people. Their aim is for residents to experience an improved quality of life and for staff to achieve job satisfaction and enhanced staff experience. I supported them in reflecting on the potential to implement the *Senses Framework* and I intend to promote the ***Five C's*** theory.
- I have supported the project leader from the Welsh Government, who is working with Caplor Horizons Charity, with her work with artisan families in India, supporting their development as weavers/ leaders (Jaipur Rugs Foundation), using the *Senses Framework* to design focus groups and questions.

My intention is to continue to be involved at a local (organisational) and national level, and to share my learning and propose the implementation of my substantive **Five C's** theory together with the *Senses Framework*, into practice, to promote and enable *relationship-centred leadership* at all levels.

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