SENIOR CLINICIANS' ROLE PROFILE

A Qualitative Evaluation

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Executive Summary

Background

- This report investigates findings arising from in-depth interviews with nine senior clinicians of the Cumbria Partnership NHS Foundation Trust, evaluating their experiences of using the Senior Clinicians Role Profile tool (henceforth SCRP) during its 2013 pilot.

Methodology

- This report employs a qualitative-thematic approach to evaluation data collected from interviews with participants, which allows us to take account of the depth and variety of data for a comprehensive evaluation of the SCRP.
- The SCRP was distributed by email to senior clinicians of the Cumbria Partnership NHS Foundation Trust, and participants were invited to use the tool and then take part in an interview to provide feedback. A total of **N=9** interviews were conducted with clinicians of varying seniority.
- Interviews were semi-structured, conducted and recorded by telephone and transcribed verbatim. Key identifiers were removed to preserve participant anonymity.
- A Straussian Grounded Theory approach (Strauss & Corbin, 1998) was used to investigate qualitative contributions, in which responses were initially free-coded, and then grouped into sub-themes and meta-themes.
- Finally, these meta-themes were collected into common evaluative categories.

Findings

- A broadly equal number of success and development themes were evident in the data.
- The theoretical information contained in the SCRP was praised for defining a leadership competencies framework, which can be used as a theoretical template for leadership development within and across roles.

- The SCRP was also praised for providing a tool that facilitates self-reflection and action-planning, and the framework contained therein provides a structure to these processes.
- Participants found that the theoretical information required interpretation for individual roles and contexts, and newer leaders had significant difficulty in doing this due to their limited background knowledge of leadership competencies in practice. Those who found this hardest were unable to complete the tool and drew limited value from it.
- The SCRP was strongly criticised for relying on self-assessment, thus neglecting others' perspectives and allowing for an accuracy gap between the two.
- Participants reported struggling to produce a meaningful assessment and strongly questioned the value of doing the SCRP without feedback.
- All participants agreed that the number of categories and the detail provided is comprehensive and, while some participants felt this is appropriate, others were overwhelmed by this level of detail and did not complete the SCRP.
- In contrast, the most experienced senior clinicians criticised the three levels for insufficiently capturing the range of senior clinical roles.
- Participants were divided on the SCRP's user-friendliness.
- Approximately half of interviewees were able to use the SCRP without any significant problems, and were comfortable with the time and effort required and the language used.
- For remaining participants the time and effort required in the face of otherwise busy schedules was too much, the SCRP's "management speak" was unintuitive, and the structure starting with the most advanced impact 'strategy' and breaking impacts up across two sections was sub-optimal.
- The Profile Summary was considered the strongest part of the SCRP, encouraging participants to produce examples of when they had demonstrated competencies, giving 'colour' to the content of the previous tick-box section and encouraging a deeper level of self-reflection.
- The SCRP's deployment was criticised for being unsupported, in that there was no brief explaining how and when to use it, no assistance, no feedback, and no time or space carved out for it. This compounds difficulties in using the tool.
- The SCRP's deployment was also criticised for poor continuity with other leadership training, being unlinked to other training and containing some similar information.
- The SCRP had four areas of positive areas of impact on professional development:
  1. Participants gained knowledge of a leadership competencies framework;

2. Participants level of self-reflection and awareness of their strengths and development areas was improved;

3. Participants produced outputs including a measure and evidence of their present competencies, and action plans to direct development;

4. Participants were personally impacted, validated by evidence of good existing levels of competencies and confident in their development direction.

- In addition to the SCRP's impact being generally limited by difficulties in use, participants highlighted that:

    1. Some participants were unable to understand how the framework should be applied in a practical sense;

    2. There can be no improvements to awareness of other's perspectives or correction of self-assessment errors;

    3. Any outputted measures or evidence are unreliable;

    4. Some participants felt overwhelmed, unsupported and off-put by difficulties in use.

- Participants reported that the SCRP provides a different facility to the LEA 360, providing a theoretical template for self-assessment on leadership competencies as opposed to feedback and bespoke information on leadership behaviours. Their impacts are different in line with their different facilities.

- Participants found that SCRP and the LEA 360 use a similar language but the SCRP is less supported than the LEA 360 and is also weaker in its absence of feedback. The SCRP can be more convenient though, and is 'safer' in not exposing participants to inadequately safeguarded feedback.

- Participants generally preferred the LEA 360 over the SCRP for its support and feedback, though some recognised that they each had strengths and weaknesses and favoured them equally.

- The primary development suggested by participants was to use the SCRP as a training/mentoring aid, planning learning aims around the theoretical template. Adding a trainer could resolve some of the primary difficulties with the SCRP, for example by using their experience in interpreting the tool for practical use and by providing support.

- Other development suggestions were:

    1. To use the SCRP in parallel with the LEA 360, or to combine them into a single tool, for comprehensive evaluation of the full leadership role with competencies and behaviours;

2. To use the SCRP in longitudinal measurement of leadership progression, comparing outputted measures over time;
3. To use the process of producing evidence in the SCRP in preparing evidence to take to formal appraisals.

Conclusions

- Using a qualitative-thematic approach, this report identifies that the SCRP had strengths and limitations in broadly equal measure for the participating clinicians. The limitations are, however, particularly problematic where the tool may be most needed (e.g. for less experienced clinicians, or those with weaker self-reflection skills).
- Evidence indicates that the SCRP would probably be most effective as a component of a broader process, but will likely have limited efficacy as a free-standing instrument.
- Core findings are discussed in terms of five issues that arose across themes. These are:
    1. The SCRP provides a good theoretical template;
    2. Newer senior clinicians found that the SCRP is more problematic in practical terms than their more experienced counterparts;
    3. The SCRP's reliance on self-assessment was problematic;
    4. Senior clinicians were unsupported in using the SCRP, compounding its practical difficulties;
    5. The SCRP could be developed in a variety of ways. Most importantly, adding a mentor could resolve its main limitations.

Acknowledgement

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1. Introduction

This report investigates findings arising from interviews with nine senior clinicians at Cumbria Partnership Foundation Trust (henceforth CPFT), evaluating their experiences of using the Senior Clinicians' Role Profile tool (henceforth SCRP) during its pilot in 2013.

1.1. The SCRP

The SCRP was developed for use by senior clinicians working at/towards an accountable decision-making level in response to requests for a tool that would describe the leadership competencies and behaviours of a corporate clinician. Using the SCRP is intended to provide "details of behaviours that are highly relevant to success in a senior clinician role," and "valuable information regarding your strengths and areas for development." (NHS North West Leadership Academy, 2012, p.4). Moreover, it is based on four key primary impact traits of a senior clinical leader, each incorporating two competencies . These are:

1. Strategy Impact:
   a) "Understands, plans for and anticipates changes and trends. Quickly assesses the relevance and consequences of the strategic environment and priorities of the organisation in addition to the whole healthcare economy;"
   b) Competencies: Strategic and External Focus; Dealing with Change and Ambiguity.

2. Knowledge Impact:
   a) "Can use clinical and commercial knowledge to make effective and efficient decisions;"
   b) Competencies: Business Acumen and Clinical Expertise; Organisational Perspective.

3. Personal Style Impact:
   a) "Respected as a leader and able to influence peers, internal and external stakeholders effectively;"

b) Competencies: Partnership, Stakeholder Reputation and Engagement; Leading Others and Conflict Management.

4. Performance Impact:
   a) "Effectively leads positive clinical performance and patient outcomes, and mitigates risk;"
   b) Competencies: Drive for Results; Risk.

Within the Role Profile, desired behaviours for each of these primary impact traits are listed at three levels of operational focus:

1. Level 1: Focus on developing strategy, operating within a national-social context. Typically those at board or accountable body level;
2. Level 2: Focus on implementation of strategy, operating at an organisational level;
3. Level 3: Focus on delivery at a departmental and local level.

The tool itself is, meanwhile, divided into two parts:

1. Leadership Competencies and Behaviours, and;
2. Senior Clinical Leaders Role Profile Summary.

Accompanying guidance recommends that senior clinicians begin by working through the first section. This includes a list of all of the competencies and levels, as above, and clinicians are asked to rate which level they reach for each of the competencies using tick-boxes (see Figure 1 – below - for an example). They should then move on to the second section where they are asked to provide a paragraph evidencing each competency. Here they should identify their key strengths and development areas, and produce an action plan for each competency (see Figure 2).

Figure 1: Snapshot of tick boxes

STRATEGY IMPACT

2.2 Dealing with Change and Ambiguity		
Level 3	**Level 2**	**Level 1**
☐ Adapts their leadership style in order to meet the requirements of the individual they are working with	☐ Adapts their leadership style to meet the demands of the situation or the requirements of the individual they are working with	☐ Adapts leadership style fluidly to meet challenges according to the strategic nature of change
☐ Clearly communicates realistic and quantifiable objectives to their team and ensures these are understood	☐ Widely communicates objectives and targets and relates these to the organization's strategy in a way that is meaningful for people	☐ Has a vision of what the future will 'look like' and the steps needed to get there at a variety of levels, (e.g. organisation, specialties, care pathways and any impact on partner organisations)
☐ Engages with change and	☐ Engages with changes and	☐ Collaboratively helps others

Figure 2: Snapshot of profile summary

3.1 STRATEGY IMPACT

Strategic and External Focus

Evidence: Provide at least one example of how you have demonstrated this competency area.

Key Strengths	Key Development Areas	Action Plan

1.2. Report structure

The remainder of this report is organised around the following structure:

- In the **Methodology** (p.5), the sample, data collection and analytic procedures are outlined.
- In **Participant Feedback** (p.8), the central qualitative trends emerging from analysis of interview transcripts is presented and discussed.
- In the **Conclusion** (p.37), a synthesis of all central themes is advanced, alongside a reflection on how this might direct further development to the SCRP.
- In **Appendix 1** (p.43), the interview schedule utilised in the evaluation is included.

2. Methodology

This report employs a qualitative-thematic approach to evaluation data collected from interviews with participants. This approach allows us to take account of the depth and variety of data for a comprehensive evaluation of the SCRP.

2.1. Participants & procedure.

The SCRP was distributed by email by the commissioners to senior clinicians of the Cumbria Partnership NHS Foundation Trust. The clinicians were invited to use the tool and then take part in an interview to provide evaluative feedback. A total of **N=9** interviews were conducted, which included participants ranging from new senior clinicians to experienced clinicians at director level.

It is of note that participants self-selected to some extent, as only a portion of those who received the tool provided an interview. It is also worth noting that it was originally planned that there would be a greater number of participants; however, participant numbers were reduced after a delay between the SCRP's distribution and the time at which interviews could be conducted.

2.2. Design

Data were collected through a programme of semi-structured interviews, conducted and recorded via telephone over a period of three months in 2013 from May to July.

Interviews were conducted according to an interview schedule, which was developed with a view to elucidating all priority issues (See Appendix 1). Semi-structured (or "focused") interviews are organised around a series of central broad and open questions, with subsidiary topical "prompts," rather than a rigid set of pre-defined inquiries. As such:

> '...the interviewer asks major questions the same way each time, but is free to alter their sequence and probe for more information. The interviewer can thus adapt the research instrument... [to] handle the fact that in responding to a question, people often also provide answers to questions [they] were going to ask later.' (Fielding & Thomas, 2008, pp. 246-247)

The core strengths of this technique in qualitative research are three fold:

1. Lateral comparability of findings is still fully feasible across participants, but:
2. The respondent is also given the opportunity to voice ideas and thoughts that might not have been strictly specified within the question; i.e. there is space for new and potentially valuable themes to arise.
3. The respondent can link topics and themes in their own way, providing a sense of how they themselves understand the 'bigger picture', rather than being tied to a structure that demands they (a) repeat things they have already said, and/or (b) answer questions in a sequence that does not seem logical to them – both of which can often 'frustrate and annoy' participants (Suchman & Jordan, 1990).

At the beginning of each interview, and in line with formal academic research ethics, each respondent was provided with the following information, and consent to proceed sought:

1. The interview would be recorded.
2. Data from the interview would be disseminated as part of the Senior Clinicians' Role Profile Tool Evaluation.
3. These data will be rendered anonymous in all outputs.
4. The participant has the right, with no negative consequence, to:
   a. Refuse to be interviewed.
   b. Withdraw their whole contribution, or any part of thereof, after the interview itself, or within a 7 day 'cooling off' period.
   c. See all outputs of the research once completed.

In all reported data, the anonymity of participants is preserved insofar as practically achievable. This intention was made clear to participants at the beginning of each interview as a constructive research strategy designed to stimulate the most open and honest feedback possible. With respect to the participants themselves, the label 'clinician' was attached to their contributions in place of names.

Each interview was anticipated to take between 20 and 30 minutes in total, though some were longer and some shorter (contingent on the level of detail the respondent provided). Sound files from all interviews were transcribed verbatim, but are presented in

this report with necessary deletions for clarity of reading wherever practically possible. These deletions are:

1. 'Minimal continuers' (Hutchby & Wooffitt, 1998), such as 'uhm', 'erm' and 'err'.
2. Word repetitions and stutters.
3. Aborted or reformulated sentence starts.
4. Linguistic idiosyncrasies, such as 'you know', 'kind of like' and 'sort of'.

All data were transcribed and prepared for analysis by late August 2013.

2.3. Data analysis

A Straussian Grounded Theory approach (Strauss & Corbin, 1998) was used to investigate the qualitative contributions, in which responses were initially free-coded, and then grouped into sub-themes and meta-themes. Finally, these meta-themes were collected into common evaluative categories.

It is essential to keep in mind that this mode of thematic analysis is designed to display the *range* of themes emergent of the qualitative data, and not accord significance according to frequency of occurrence. From a Straussian point of view, every issue has potential ramifications and it would be myopic to dismiss an innovative idea or suggestion because it is less statistically significant. Indeed, innovation itself is often defined by the fact that it is not widely posited.

3. Participant Feedback

Data collected from participant feedback reveal a broadly balanced distribution of positive and negative commentary regarding the Role Profile Tool. While there is a significant amount of variation between responses addressing the same issues, six broad areas of focus emerged. Findings are, thus, presented below in terms of these global themes:

1. SCRP content;
2. SCRP user-friendliness;
3. SCRP deployment;
4. Professional development;
5. SCRP vs. LEA 360;
6. Prospective development.

It should be noted that graphical representations are schematisations of thematic occurrence, dimensions and linkage, but not are *not* quantifications thereof. As such, the charts below reflect the range and depth of themes, rather than the frequencies with which they were raised.

3.1. SCRP content

The first major theme to emerge from participant feedback relates broadly to the content of the tool. Considering the findings, which are schematically outlined in Figure 3 and Figure 4 (below), it is evident that positive and negative themes emerged (in approximately equal weight) with respect to three central domains:

1. Information provided by the SCRP;
2. How the SCRP functions as a tool, and;
3. The detail contained therein.

As noted above there was a broadly even distribution of positive and negative themes. However, it was the case that those who provided positive feedback regarding the SCRP's content were less inclined to expand upon their assertions. Those with largely negative views, meanwhile, expressed them more strongly and in greater detail.

Figure 3: Content strengths
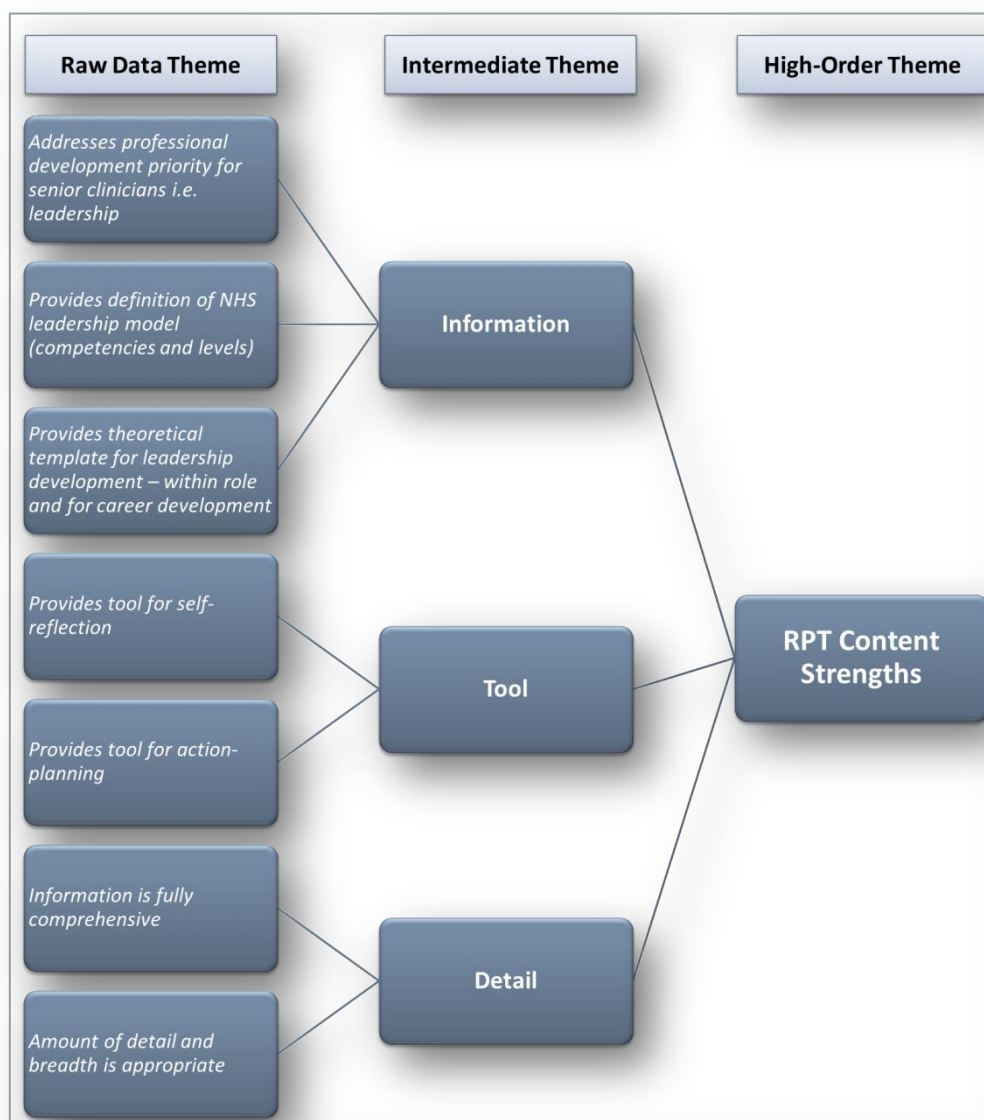
Figure 4: Content limitations

Raw Data Theme	Intermediate Theme	High-Order Theme
Does not provide explanation of theory in practice for individuals' particular roles or contexts	Information	
Does not relate levels framework to role requirements		
Relies on self-reflection, does not include feedback	Tool	RPT Content Limitations
Excessive number of categories and detail therein	Detail	
Number of levels insufficient for range of leadership roles		
Some repetition across categories and levels		

For balance, positive and negative themes are expanded upon below in a manner reflecting their range and occurrence; it is, however, of value to note the differences in language used in terms of addressing strengths and weaknesses.

3.1.1. Content strengths

Information: With regard to positive matters, clinicians reported appreciating the theoretical information provided by the SCRP. They found that the SCRP's focus on

leadership addressed one of their professional development priorities, as already-competent clinicians who are now concerned by developing within their leadership roles. They praised the tool for definitively setting out the NHS leadership model, which clarified their understanding of what competencies and levels of competencies are required of them as leaders. This model, thus, served as a theoretical template for leadership development within their roles, and some clinicians also found that there is scope to use it as a template for development, with a view to taking on more senior leadership roles.

Newer leaders (i.e. those in a leadership role for less than two years) were especially positive about this information being made available to them, as they were not already aware of it. In contrast, experienced leaders were less positive, as the materials embedded within the template were already broadly familiar to them. Nevertheless, they praised the SCRP for bringing hitherto disparate information together into one document.

- *"I feel that as a consultant... leadership qualities take a quite high importance when compared to the clinician skills."*
- *"This is the first time I have seen such a kind of breakdown, which is quite interesting."*
- *"It highlighted areas that if it hadn't have been lain out I wouldn't of necessarily seen it in quite that way."*
- *"[It gave] me an indication where I am at, at the moment, and where I can be if I want to be, and what should I do further."*

Tool: Clinicians also praised the SCRP for providing a facilitatory tool for self-reflection and action-planning, noting that its use was a valuable opportunity to take time-out from their busy roles for self-development. Furthermore, they praised the tool for guiding them in their self-development process, because the template (as outlined above) provides a structure *for* self-reflection and action-planning.

- *"I suppose where it was helpful was partly what it allows, offers you indirectly in that it helps you to focus."*
- *"They're looking at personal development in a more reflective way.*

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- *"It asked you for key strengths, development areas and action plan in each of the different areas."*

Detail: With regards to the third key theme, clinicians were divided. The majority of participants agreed that the definition of the leadership model covers every aspect of leadership in depth, yet only approximately a third of the interviewed clincians were positive about how useful this actually is (see 3.1.2 for negative views).

- *"It tried to include everything that one might want to achieve in a leadership role and all the things in the NHS that you might need to know and also all the leadership competencies."*
- *"There was certainly a comprehensive amount of work to work on, so I think this was certainly well thought-out."*
- *"I think the length is probably about as correct as it can be. They've tried to keep each sentence as short as possible, so I wouldn't probably change the length or the breadth."*

3.1.2. Content limitations

Information: While clinicians were generally positive about the theoretical information provided by the tool, a group therein complained that such theoretical information needs a level of bespoke interpretation to facilitate practical use, and that there were no provisions for this in the tool itself. These clinicians highlighted how the tool does not explain or give examples of how competencies are exhibited in practice for individuals' particular roles or environmental contexts, and also reported that they therefore had difficulty with making sense of how the competencies are relevant to them. Similarly, some clinicians also criticised the SCRP's explanation of how the levels framework relates to role requirements, as they had difficulty understanding which level they should fit into.

It was generally newer leaders who reported the most difficulty in interpreting the tool for practical use; the more experienced leaders did not experience the same problem.

Some newer leaders suggested that this is, simply, because they do not have as much background understanding to draw upon.

- *"Theoretically it's a start, but for actual practical application, which is what we're all interested in, it perhaps doesn't do that. I see it as slightly being disengaged from the whole process."*
- *"I think it's not only finding out where your shortcomings are or where you need further development, but actually being able to put that into practice, and perhaps actually being able to discuss with somebody how it's relevant... just having that practical relevant input."*
- *"I thought it was a bit of an idealised world... the reality of working in a political arena brings something quite different into the way that you do end up working."*
- *"[The levels] confused me a little bit, you know what level should I be aiming at as community nurse?"*

Tool: As an evaluative tool, some participants (from all levels of leadership) strongly criticised the SCRP for relying exclusively on self-reflection. Because it does not include feedback from, for example, colleagues or managers, it thus neglects their perspectives or the impact a leader may have on them.

Clinicians also expressed concern that this provides for an assessment biased towards an individual's own self-image, which can in turn vary with self-confidence or ability in the self-reflective domain. Furthermore, the same clinicians expressed concern that this allows for discrepancies between personal and external viewpoints to go unrecognised and that, therefore, inconsistencies in assessment may prevail and developmental areas may go unnoticed.

- *"In terms of scoring yourself, I think it's got very limited use because it's a self-assessment tool and I think with the best will in the world you can say yes I can do that, but other people might have a different view."*
- *"I think we need to know what others, how other people experience their leadership behaviours really – because what we might think we are and do might be completely mismatched in what we actually do."*

- *"If you have a blockage there and you think you're really good at doing something and you're not, and you did this on your own or with a mentor who didn't know you very well, say, you might just tick that and move on, so you've lost that opportunity to explore that area."*

Detail: As outlined above, all participants agreed that the SCRP is very comprehensive in terms of detail. Whilst there were those who thought this is appropriate, approximately half of participants argued that this resulted in a completion-process that was excessive and laborious. They specifically complained that there were:

1. Too many categories;
2. Too many sub-categories with the categories, and;
3. Some repetition across categories and levels.

As with practical limitations, this complaint was predominantly voiced by newer leaders. In contrast, the most senior clinicians were underwhelmed by the number of levels, expressing a view that - from their experienced perspective - that three levels are insufficient to cover the full range of leadership roles:

- *"It's very long… I only got to page 12 after an hour… and then I gave up to be honest!"*
- *"I just wondered if you could have said the same, all this, in a great deal less time and still have got the most important bits in it."*
- *"After I'd done a few of the sections, they all sort of blurred into one."*
- *"It was a little bit gross in terms of its 3 levels."*

3.2. SCRP user-friendliness

The second major theme to emerge from participant feedback relates broadly the user-friendliness of the SCRP, and this is schematically outlined in Figures 5 and 6 (below).

As evident, there was a roughly equal division between participants who reported being able to use the SCRP without any problems and those who did experience significant difficulties in using it. While the *range* of positive and negative themes raised reflected the symmetry of this split, the negative themes were (once again) expatiated upon by clinicians rather more substantially than the positives.
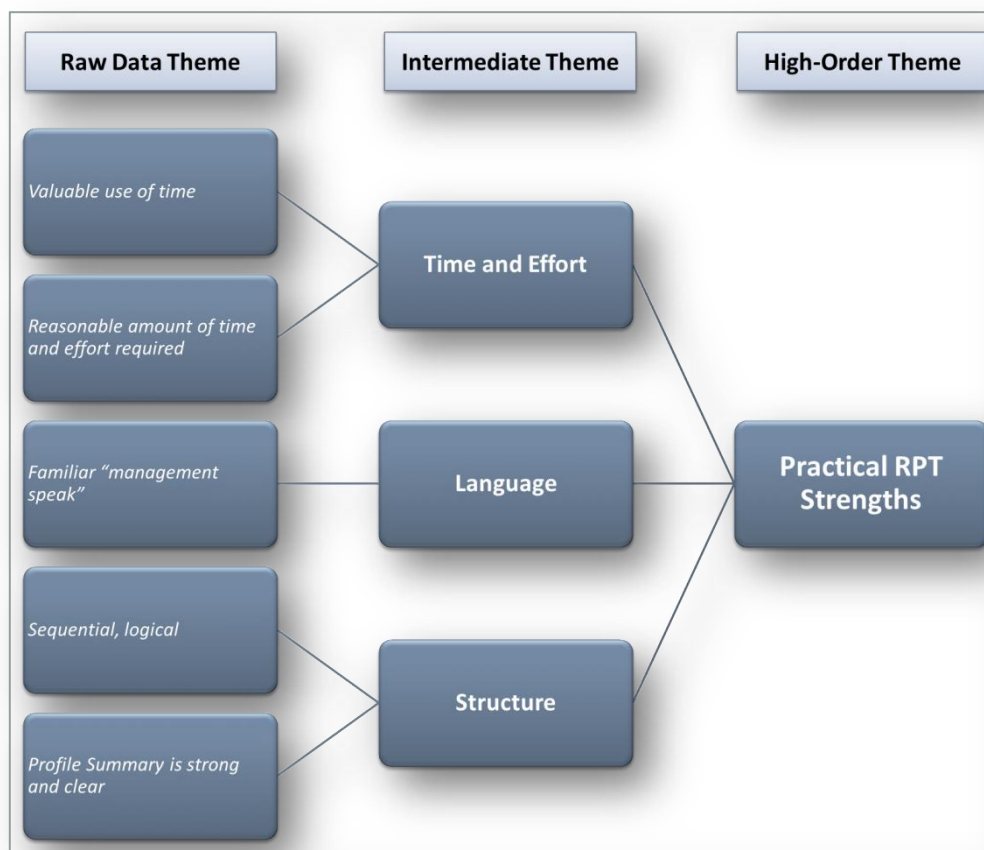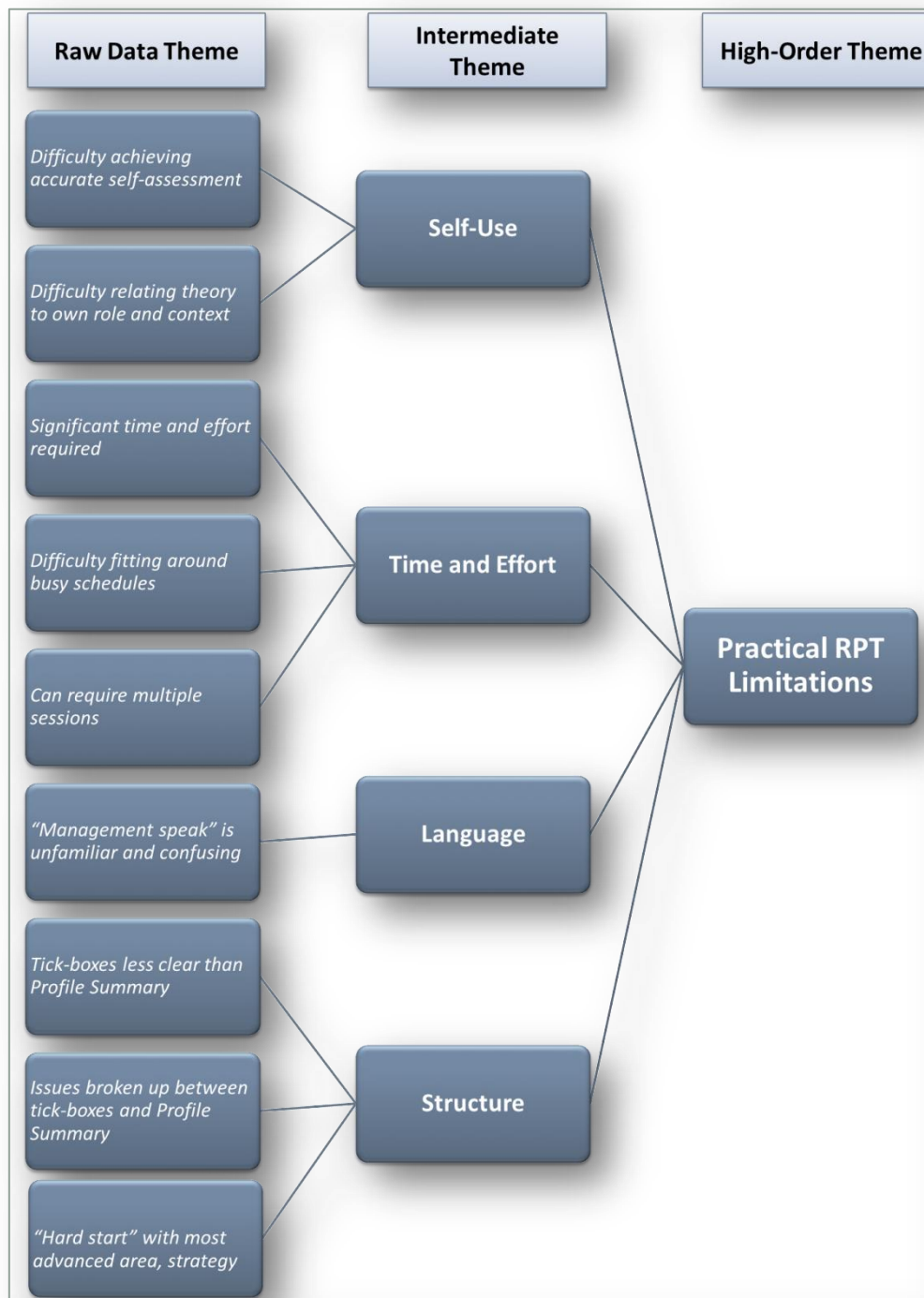
Figure 5: Practical strengths

Figure 6: Practical limitations

Both positive and negative themes group in three key domains: (1) the time and effort required to use the tool, (2) the language it uses, and (3) SCRP's structure. Additionally a fourth difficulty emerged, regarding "self-use."

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3.2.1. Practical strengths

Time, effort and language: Approximately half of interviewed clinicians reported no significant problems pertaining to the levels of effort required to complete the SCRP, or language used within it. These participants further asserted that it was a valuable use of a reasonable amount of their time. By and large, it was the clinicians with more managerial experience that reported being most comfortable with the language, or "management speak," used in the SCRP, having been familiarised with it through consistent exposure at pertinent levels.

- *"It's quite good to use – it's quite a simple one to use, that's what I felt... and quick."*
- *"It took a bit of time for me to think and then write it down, but once I did it, it was good."*
- *"It used a language that I recognised from an NHS perspective. I didn't struggle to understand what the questions asked."*

Structure: One of the most striking positive themes raised by (a wide range) of participants pertained to the stucture of the SCRP. Participants accorded high praise to the profile summary of the second half for encouraging them to produce examples of when they had *used* a competency. By providing their own examples, they found that this "coloured in" the theoretical template, which was instrumental:

1. In clarifying the information given in the tick-box section;
2. In clarifying how the SCRP itself related to their own practice, and:
3. In ameliorating problems with understanding the theoretical information given by the tool (as outlined above and below).

Example-giving also forced participants to justify how they had rated themselves in the tick-box section, which they argued encouraged a deeper level of thought, and greater accuracy.

Also in terms of structure, clinicians agreed that the SCRP presents information (and structures reflection and action-planning) in a sequential and logical fashion:

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- *"I felt that ok it was a tick box so what am I getting from it so I can keep on saying that I am at the level of 1/2/3 but when I came to the point where I had to summarise… it took a bit of time for me to think and then write it down, but once I did it, it was good."*
- *"I think once I'd got to the part at the back where you're actually looking at the action planning and the evidence and the strengths and areas to develop, I found oh it sort of makes sense really, it all came together."*
- *"It is completely logical to me."*

3.2.2. Practical limitations

Time and effort: Participants strongly expressed that the time and effort required by the tool were excessive and, in some cases, they reported not being able to complete the tool at all. In other cases, interviewees reported completing the tool over a number of sessions, which caused disruption and a need to continually revise prior work. Participants were particularly negative about having to do these things in the face of schedules which were already very busy, which encouraged complete deprioritisation of the whole enterprise for some[1].

- *"Sometimes you get to the end of a section and you think gosh how many more questions are there regarding this particular issue."*
- *"I had to in two definite, two distinct bites really… the disadvantage was that actually an awful lot of going through the boxes prepared you about what you would write [in the Profile Summary]."*
- *"Filling this in at a time when I was told to do it and also a time when we're extremely busy, the start felt a bit negative.*

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[1] Additionally, it is noteworthy that the reduction in participant numbers for the evaluation itself (reported in Section 2) was itself a direct output of a lack of spare time in Senior Clinicians' schedules, which further reflects this particular difficulty.

Language: Some Clinicians with less managerial experience criticised the language of the tool for being unintuitive "management speak." This was highlighted as a further component in rendering impenetrable the information contained therein.

- *"I think any GP who read that sentence would be banging their head on the table slightly... it's not our language, it's management language."*
- *"Like in LEA 360, some of the questions used a lexicon that I would be more familiar with in the business world, and that really jarred with me."*

Structure: Two further, and highly incisive, points on structure were also raised. Firstly, it was noted by two participants that the SCRP's tick-boxes start with the most advanced and unfamiliar leadership topic ("strategy") and then work towards the area in which they have most experience ("clinical performance"). They suggested that this starting point is immediately discouraging, and that a reversal of this order of topics might provide more of a mental "warm-up." Another participant, meanwhile, noted that the first and second sections are distinctly separate. In order to complete the latter it was necessary to keep referring back to the information given in the former, and that they had difficulty in keeping track of the interrelations between parts. To remedy this, it was suggested, tick-boxes and profile summaries for given topics might be presented together.

- *"[It] goes straight into strategic focus. I'm not sure that was probably best... I think I might have preferred to have been more warmed up."*
- *"[I found it harder at the beginning because] being a new consultant it started with strategic and external focus, so that wasn't quite my forte."*
- *"Obviously the second part links with the first but it was difficult I suppose... I got muddled up because you have to flick back and forth."*

Self-use: In addition to these three areas of practical difficulty in using the SCRP, a further negative theme emerged: what we might term "self-use." Newer leaders broadly expressed the view that the theoretical template provided by the SCRP required extensive interpretation for practical use. In terms of user-friendliness, this made it significantly more

difficult for the less experienced respondent to use and understand the information. This had serious implications, since those clinicians who could not use the tool well reported having gained very little meaningful experience from the exercise.

- *"I think it's not only finding out where your shortcomings are or where you need further development, but actually being able to put that into practice."*
- *"I didn't finish it off basically because I just felt I couldn't do all of the second bit where you're trying to actually think of examples about how you demonstrate this competency… I just found that impossible."*
- *"We don't normally use level 1, 2, or 3 in any… I wasn't sure at the start how I was going to transfer those levels."*

It has been previously outlined that participants repeatedly questioned the SCRP's reliance on self-assessment without external feedback. In terms of self-use, however, they also recounted difficulty in trying to achieve an unbiased or accurate assessment *of themselves*. Critically, some raised significant doubts that the exercise was valuable *at all* without some form of external regulation.

- *"Erm, goodness knows, can I do that, I really don't know, I really don't know. I – erm – probably bits that I'm doing, I probably am doing that without realising it, but – erm yeah…"*
- *"Subconsciously I was marking myself down, thinking you know I can't possibly be doing those things because I'm not high up in the level of command if you will."*
- *"I think it's the – the difficulty in knowing what you don't know."*

3.3. SCRP deployment

The third global theme to emerge from feedback relates to the manner in which the SCRP was deployed, as schematized in Figure 7 (below).
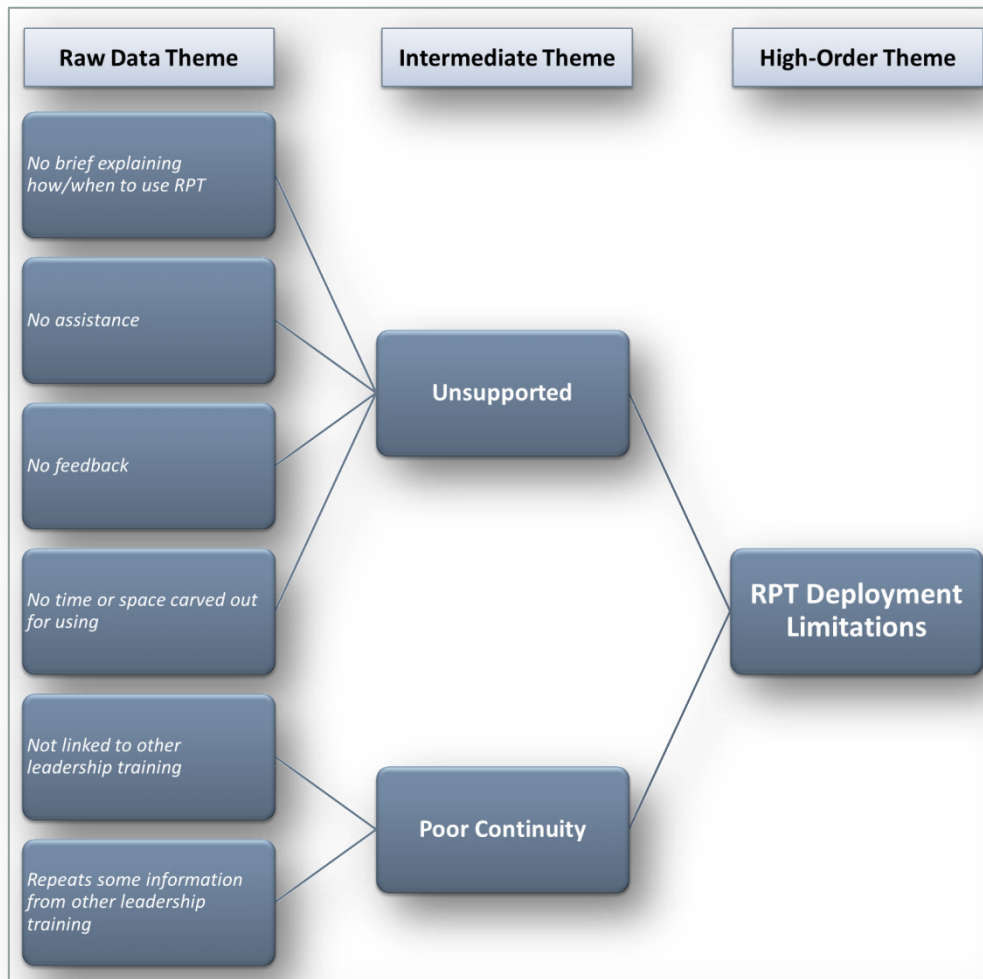
Unsupported: Feedback in this domain covered a smaller range of issues than the previous themes however it was striking for being universally unfavourable. Firstly, interviewed clinicians reported receiving no support in implementing the tool. There was:

1. No brief explaining how and when to use it;
2. No facility for assistance;
3. No facility for feedback, and;
4. No time or space "carved out" for them to use it.

Evidently these criticisms link to some of the difficulties previously highlighted. For instance, it was suggested that:

1. A brief may help to clarify how the content of the tool is relevant to a particular individual's role or context;
2. A facility for assistance from an experienced colleague or manager may help with difficulties understanding and using the tool;
3. A facility for feedback would rectify problems with relying on self-assessment, and;
4. Carved out space and time would provide a greater opportunity for busy clinicians to use the tool.

Commentary in this domain was stated in somewhat vehement terms:

- *"Nobody's ever talked to me about it, I've only just sort of picked it up off a computer and been asked to fill it in, there's…no context around it, so for me it was like oh…what's this going to be for?"*
- *"The point for me with the Partnership Trust is they haven't actually done very much in terms of support with somebody coming into role, and then you have to fill in a really detailed document that you don't really get the hang of – do you know what I mean?"*
- *"Someone just needs to try and carve out time… otherwise you have to be really bull-headed."*
- *"I think people saw it as an opt-in rather than actually this is a requirement if you do this very important high profile crucial job you need to be doing this… [they]weren't held to account to do it really I think."*

Continuity: Further to feeling unsupported, interviewed clinicians were not positive about the continuity of the SCRP with other role-specific tools. They commented that it is not linked to any other leadership training (in contrast to other available tools, such as the

LEA360; see 3.5). Also, the SCRP covers some information provided by other tools, so the tool's specific impact is diluted by other leadership training instruments. This is perhaps an inevitable upshot of there being a number of leadership training tools available, but worth noting nonetheless.

- *"For me it was just a bit sort of random I suppose, in that it's not clearly in a leadership development programme."*
- *"I was in deep in these things already, and so I suppose strategically for me it probably helped me less than if I weren't already doing a raft of other things – so it touched on things that I was already being assessed, self-assessed and developed on already."*
- *"I didn't find it offered me anything I haven't been given before."*

3.4. Professional development

Perhaps the most important theme to emerge from the data concerns whether the tool is "fit for purpose," i.e. whether it has any impact on professional development. The dimensions of this global theme are schematized in Figures 8 and 9 (below).

Commentary included an even balance of positive and negative feedback, and covered four key areas:

1. Knowledge of leadership competencies;
2. Self-awareness of one's own leadership competencies;
3. Output generated by using the tool, and;
4. The personal impact it had on a people.

Significantly, these sub-themes strongly relate to issues previously raised with respect to the SCRP's content, user-friendliness and deployment.

Figure 8: Professional development impacts

Figure 9: Professional development - impact limitations
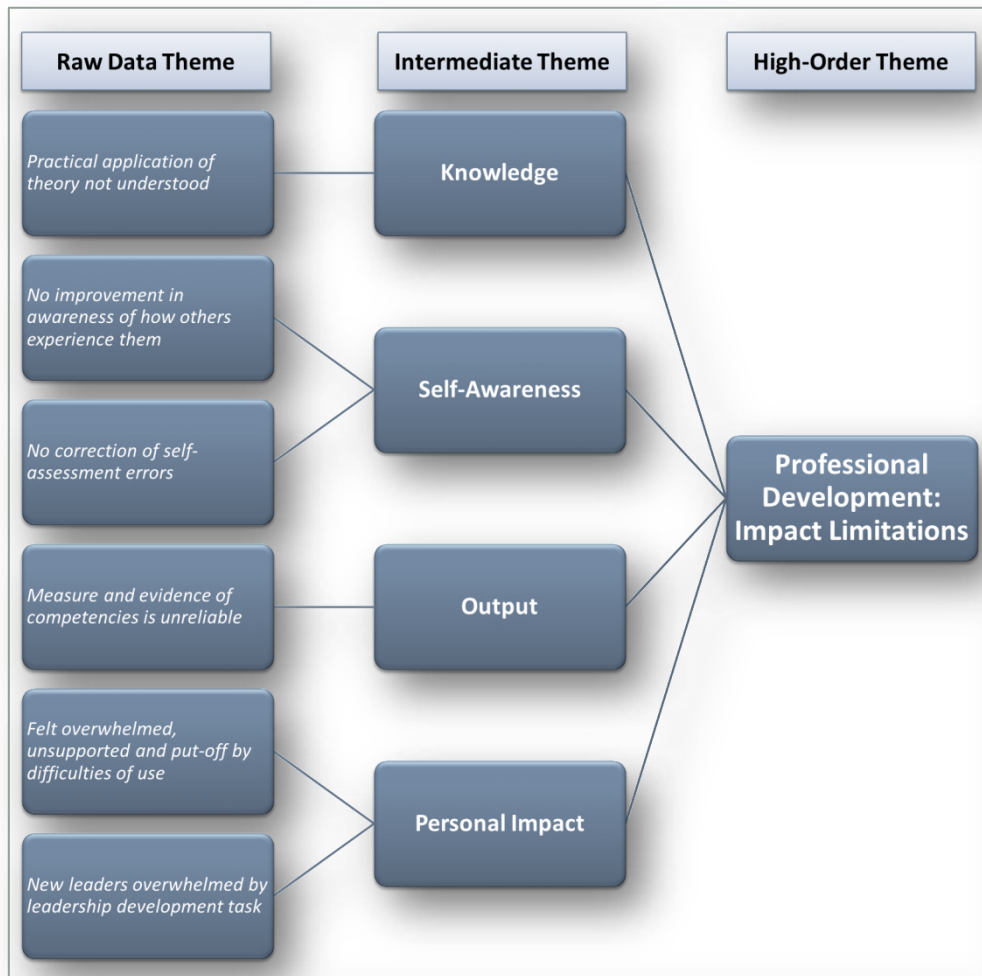
3.4.1. Professional development – impacts

Knowledge: The first impact theme naturally follows from the theoretical information provided by tool, namely knowledge. Those who were able to understand the tool were favourably-disposed towards its efficacy: i.e. they argued that it develops:

1. A better understanding of the competencies that are required of them as leaders, and;
2. A better understanding of the higher levels of competence to which they can aspire for career progression.

- *"It breaks down into the Role Profile impacts, about how I can impact, and this is the first time I have seen such a kind of breakdown, and which is quite interesting."*
- *"It was quite good for me to actually go through the system and reflect on it a little bit… and think about things that I may not have thought of."*
- *"It highlighted areas that if it hadn't have been lain out I wouldn't of necessarily seen it in quite that way."*

Self-Awareness: Those who did not have any real difficulty with using the SCRP for general self-reflection also reported that the tool had provided a valuable opportunity to improve their reflection on themselves specifically as leaders, and had facilitated an improvement in their awareness of their own strengths and/or areas for development.

- *"It was useful to me to kind of look at my own strengths about where I stand."*
- *"It did make me think about how I could prove that I'd reached those competencies, and look at strengths and weaknesses."*
- *"It's the sort of thing that if you never do stuff like this then you know you never develop and really pick out what you need to do differently."*

Output: Additionally participants reported that using the tool produced some further, and novel, results. Following from the action-planning section, some participants (perhaps predictably) reported that through using the SCRP they had produced a portable development action-plan, and this was valuable to them. However, it also emerged that participants had taken to using the output from the self-assessment in:

1. Longitudinal measurement of levels of competencies, and;
2. Preparing evidence of those competencies for appraisals.

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With regard to longitudinal measurement, participants had compared tick-box assessments over time for quantitative measurement and profile summary assessments over time for qualitative measurement; these clinicians asserted how useful such measurement could be. With regard to evidence-production, a number of participants were keen to express that they had indeed used SCRP output to prepare for their upcoming appraisals, maintaining that the role-profiling process complemented the existing appraisal process.

- *"It actually gives you something to work towards and progress to."*
- *"I can look back on it in a year's time and say well actually yeah that was an issue last year, it's not anymore, I've moved on, I've got lots of other key areas now."*
- *"I've got an appraisal tomorrow and I'll be taking this with me… it linked in with the paperwork I have to do for my appraisal anyway."*

Personal Impact: Participants who were broadly positive about the tool also recounted feeling validated by solid evidence that they are showing good levels of key competencies; using the tool, thus, improved confidence. There was also a sense of improved confidence regarding the directions in which they should take their professional development:

- *"It made me summarise that I've actually come a long way on the last 2.5 years… it gives you the opportunity to think actually I know I don't feel I'm achieving something sometimes because the NHS is difficult… but actually I've done a lot."*
- *"I wouldn't have answered that the same way three months ago, actually I can do that."*
- *"I will do [it] now every year because I am looking to be a better leader."*

3.4.2. Professional development – limitations to impact

Knowledge: In the same way that those who were able to clearly understand the tool reported having gained knowledge, those that had problems in this domain were rather more sceptical regarding the SCRP's efficacy. Newer leaders most commonly reported this difficulty. This is itself problematic, since newer leaders also recurrently highlighted that they are the group in greatest need for leadership development.

- *"I think it wouldn't be beneficial in isolation, I just, I think it needs someone to go through with the individual and discuss further."*
- *"I just found that impossible!"*
- *"I think that might be an issue to just set it out in a way that people get the hook."*

Self-reflection and output: Participants who questioned the validity of the SCRP as a self-reflective instrument also stressed that their own resultant improvements in this domain were limited. Without external feedback, it was suggested, there could be no changes in awareness of how others experienced the participant, and therefore no corrections to self-assessment errors. This group suggested that the exercise was therefore, to a greater or lesser extent, "meaningless." Pertinently, one respondent suggested that this meant the SCRP is weakest in exactly the sphere where it is most needed. They suggested that clinicians who perform their role most poorly often have poor self-reflection skills. Consequently, in self-assessments, such clinicians often award themselves elevated ratings, and self-assessment tools will not, therefore, pick up on their weaker performance.

On a related note, it was also suggested that other outputs such as longitudinal measurement of leadership development or evidence-production for appraisals are intrinsically unreliable:

- *"It didn't seem that meaningful to just tick it yourself."*
- *"I think there's much more value in having someone to go through it with … I don't think it's much use just to do it on your own."*
- *"Some people if they don't have that intrinsic [self-reflective] style, it probably won't work for them."*

Personal Impact: Approximately half of interviewed clinicians indicated that they derived limited personal value from it. Senior clinicians from a range of backgrounds reported feeling overwhelmed, unsupported and generally discouraged by the impracticalities of the tool. Among these, participants newer to leadership roles - in particular - expressed feeling overwhelmed by the leadership development pressures of their new roles. In these cases the SCRP itself magnified attention on a strongly negative aspect of working experience and, therefore, had a distinctly detrimental impact.

- *"I lost the will to live whilst I was doing it."*
- *"Oh crumbs, it's almost a thesis on you."*
- *"I thought 'oh my gosh, when am I going to do that?'"*

3.5. SCRP vs. LEA 360

Clinicians were asked how they felt the SCRP compares with the LEA 360, leading to the fifth theme to have emerged from the data, as schematized in Figure 10 (below).

Commentary can be organised according to the same broad themes that emerged from global feedback on the SCRP: Content, user-friendliness/deployment, and professional development impact, plus an additional theme of preference.

Raw Data Theme	Intermediate Theme	High-Order Theme
Both are leadership development and assessment tools		
RPT covers competencies; LEA 360 covers behaviours	Content Comparison	
RPT uses self-assessment; LEA 360 uses feedback		
RPT provides theoretical model; LEA 360 provides bespoke information for practice		
Similar language		
RPT unsupported; LEA 360 provides facilitator and time set-aside	User-friendliness/Deployment Comparison	
RPT has self-assessment difficulties; LEA 360 avoids these with feedback		RPT vs. LEA 360
RPT is private and safe; LEA 360 exposes people to feedback		
Both improve leadership and self-awareness		
RPT develops knowledge/competencies; LEA 360 develops practice/style	Professional Development Impact Comparison	
LEA 360 improves self-assessment		
RPT involves more action-planning		
LEA 360 preferred	Preference	
RPT and LEA 360 favoured equally		

Content: Those clinicians who were familiar with both tools generally maintained that, while they were both fundamentally tools for leadership development and assessment, they offer very different practical facilities. For example, the SCRP addresses leadership competencies and offers a theoretical template for self-reflection, whereas the LEA 360 addresses leadership behaviours or style, and offers bespoke information and feedback.

- *"The Role Profile concentrates on what I know about... and I find the LEA 360 comments more on the personality and attitudes."*
- *"To be honest I don't think they're asking about the same thing."*
- *"Feedback through 360 may give me something more to work on, to give me a different perspective to how effective I am."*
- *"[The LEA 360 provides a] skilled facilitator who can interpret your feedback, and with a discussion with you in a way that makes it much more bespoke to you."*

User-friendliness and deployment: The SCRP and the LEA 360 are structured using similar language, what participants generally regarded to be "management speak." However, the same participants found that there was a significant gulf in practicality between the two instruments, for a variety of reasons. Use of the LEA 360 was reported to be a more "supported" activity; it has time set-aside for it, and participants have the assistance of skilled facilitators. The LEA 360 also involves a strong element of feedback from colleagues, which the majority of senior clinicians found preferable to self-assessment methods (with the difficulties noted above).

The SCRP, on the other hand, was reported to offer convenience and privacy. Some participants recounted difficulty obtaining feedback from busy colleagues with the LEA 360. A number also expressed concerns about there being inadequate safeguards surrounding the anonymity of LEA 360 feedback, leaving participants potentially vulnerable to critical feedback without being able to discuss it with the provider. As a tool that can be used without from such scrutiny, the SCRP thus also negates such problems.

- *"[They have] similar wording and similar style… [because they have] come out of the same sort of place."*

- *"The LEA being more embedded in the other development and support processes, that was more effective, because when I needed help with it for example, I've got someone to go to and ask 'what does this bit mean' sort of thing."*

- *"I think there's much more value in having some feedback that you can then discuss with somebody."*

- *"I'd probably feel a bit awkward asking everyone to [give feedback] about me."*

Professional development impact comparison: As leadership development tools, both the SCRP and the LEA 360 were both reported to improve leadership and self-awareness. The documented aspects of these things that they each improve, however, varied. As also outlined in section 3.4, participants registered the SCRP's focus upon the development of competencies and knowledge, whereas the LEA 360 was characterised as an instrument that develops style and practice. Comparing feedback from the LEA 360 *with* self-assessment, it was thus suggested, may improve self-assessment accuracy. As a subsidiary theme here, it was also noted that the SCRP results in a stronger and/or more structured action-planning output, which was deemed useful.

- *"The strengths are that they get people to think about how they take up their roles and to think about what their own strengths are and what their own development needs are."*

- *"What I like about the 360 was that comparison between self-appraisal, self-assessment, and a reasonable sampling of assessment by other people, so you can begin to see the sort of self-awareness gap."*

Preference: As the LEA 360 resolves two significant limitations that the clinicians experienced with the SCRP – the need for support and feedback – participants generally favoured the LEA 360. However, a number of participants who were impressed by the SCRP's competency-focus - and its anonymity - rated the two tools equally, claiming that each has different strengths and benefits. Only one participant expressed a clear preference for the SCRP over the LEA 360, placing great weight on the information safety concerns endemic to the LEA 360 in balancing the decision.

- *"I thought the LEA was very perceptive… so by itself I don't think [the role profile tool] is anywhere near as strong."*
- *"The 360 process is far more challenging because it's somebody else telling you what they think of you."*
- *"I find it's better to do both."*

3.6. Prospective development

Findings so far indicate that the SCRP could be used in knowledge-development, self-reflection and action-planning. Interviewees also raised, however, a number of limitations that did significantly impair the tool's impact. This connects to the sixth and final global theme to emerge: how to develop the tool in the future. Within this meta-theme, the manners in which participants suggested the tool might be developed were four-fold:

1. As a training/mentoring aid;
2. For comprehensive evaluation of the leadership role;
3. In longitudinal measurement of leadership competencies, and;
4. In appraisal preparation.

These are schematised in Figure 11 (below).

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Figure 11: Development
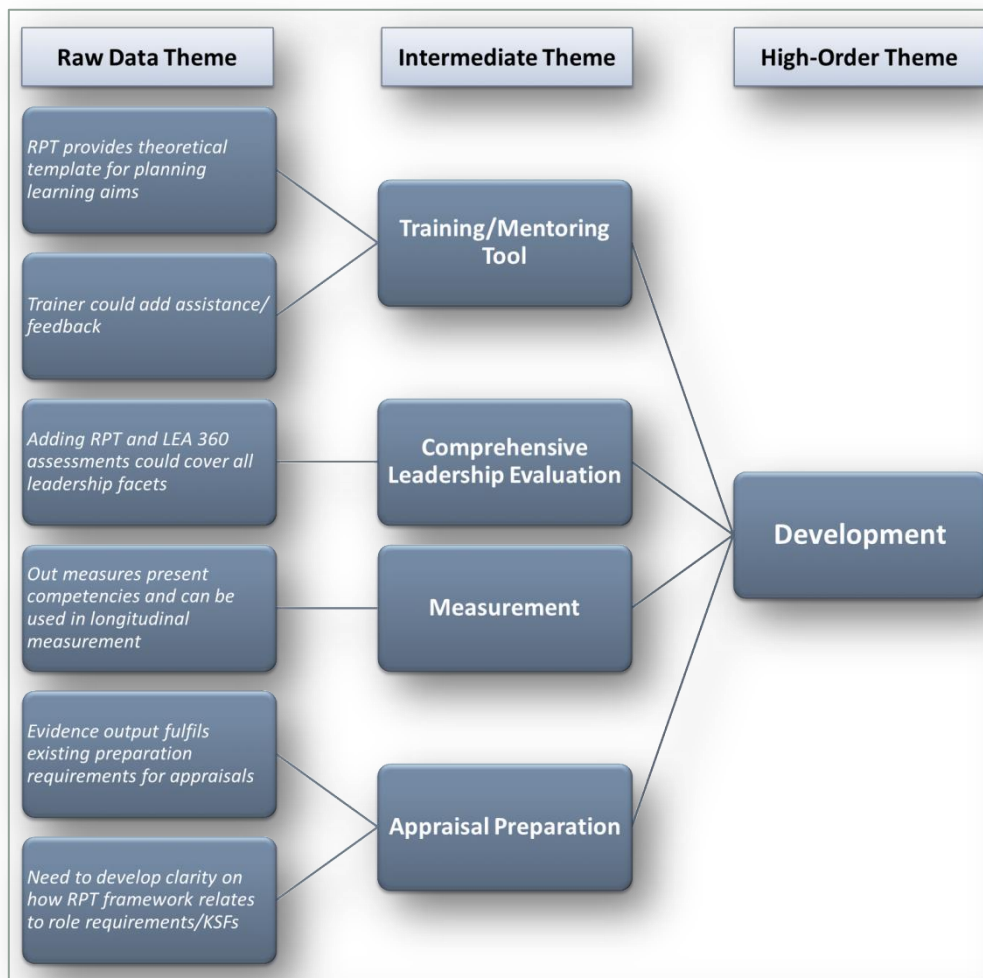
Training and mentoring aid: Participants proposed that the nature of the SCRP particularly lends to use in training, in that it delivers a theoretical template around which clinicians and their trainers may plan learning aims. Participants were persistent in the suggestion that adding trainers would resolve the issue of there being no facility for assistance in using the tool. Furthermore, experienced trainers could also assist with interpreting theory for individuals' roles and contexts. They could prompt clinicians to look at themselves critically, and, if they have some personal familiarity with the clinician (such as a manager), they could also provide tailored feedback. The addition of a trainer could, therefore, make a significant contribution towards resolving the SCRP's limitations in its present format.

- *"This could the initial basis people understand and go through what they don't understand and how it applies, and then they're allocated a mentor,*

> *who will then look at the individual circumstances and work through that together and see how it could benefit."*

- *"It's something that maybe someone should go along with a mentor and say these are things that a senior clinician should be aspiring to and this is how it applies to my service and how it could be put into place, or otherwise it doesn't really apply to me here."*
- *"[A mentor could be] challenging you and asking you the difficult questions."*

Comprehensive Evaluation: It was proposed by two participants that there is potential for the SCRP to inform a multifaceted assessment of the full leadership role. At present, the LEA 360 is the dominant assessment tool used. Its focus is, however, is limited mostly to leadership *behaviours* (see section 3.5). These participants noted that the SCRP provides a facility for assessing leadership competencies, and that it could therefore be added to the usual assessment process to enhance comprehensiveness. This may involve using the tools separately but in parallel, and drawing *post-hoc* comparisons. Alternatively, a very powerful new tool could be synthesised from the extant two.

- *"It would certainly be useful if you could smartly tie it in with other sources of feedback, so if you can triangulate it with other things."*
- *"I think it would be a very powerful thing to have the LEA and this and someone with coaching facilitation skills, looking at and triangulating these two sources of information about yourself."*

Longitudinal measurement: As outlined above, some clinicians reported that they were prepared to use the SCRP's assessment output for longitudinal measurement of their own leadership development. They had made formal records of their assessment results, and conveyed their intention to compare the difference between them and future tick-box outputs for quantitative measurement and examples generated for qualitative measurement. In this way, they could generate a detailed and structured account of their progression in leadership.

- *"I suppose where it might fit in for example is kind of the reflective part and one's own benchmarking, and in a slightly more structured way over time look at change and individual effectiveness maybe."*
- *"I like the way they've done it level 3/2/1. I think it's highlighted my vast improvement over the last 2.5 years."*
- *"I'm thinking if you were to do it at the start and end of the leadership course to get a baseline really."*

Appraisal preparation: Finally, it has been outlined that some clinicians reported that they had used the output of the SCRP in preparing evidence for their upcoming appraisals. They had found that producing evidence of their competencies in the Profile Summary section of the SCRP fits neatly with the existing paperwork requirements of the appraisal process. To develop this further, it was suggested that it should be made clear *how* the competencies and levels framework relates to senior clinicians' role requirements or KSFs.

- *"I would have thought really for an appraisal so long as it's done properly, it's written properly what's expected of you, I think it would work very well."*
- *"Certainly a lot of the action plan issues are things that crop in appraisals anyway."*
- *"In an appraisal it would have to be somehow linked to the KSF because you wouldn't know necessarily whether you were meant to be in level 1/2/3 for your job."*

4. Conclusion

In summary a broadly equal distribution of positive and negative commentary emerged, suggested that the SCRP was found effective and ineffective in equal measures. It has been detailed that nine higher-order themes emerged from the data, and it is evident that different facets of a number of the same issues were raised across themes. These cross-cutting themes were expressed in strong terms and ubiquitously, thus emerging as our key findings and summarised here. They are:

1. The SCRP provides a good theoretical template;
2. Newer senior clinicians find that the SCRP is more problematic in practical terms than their more experienced counterparts;
3. The SCRP's reliance on self-assessment is problematic;
4. Senior clinicians are unsupported in using the SCRP, compounding its practical difficulties;
5. The SCRP could be developed in a variety of ways. Most importantly, adding a mentor could resolve its main limitations.

4.1. Theoretical template

The SCRP effectively describes the leadership competencies of senior clinicians, allowing clinicians to gain a theoretical understanding of the requirements of their leadership roles. This template can also facilitate and structure self-reflection, assessment and action-planning for leadership development. The Profile Summary is, in this respect, especially useful, bringing together and clarifying this information, and resolving any confusion resulting from the preceding theory-heavy tick-boxes. For those clinicians who were able to engage with this effectively, the SCRP achieved its intended impacts, and further imbues senior clinicians with self-confidence and a sense of positivity for leadership development.

While the template is broadly effective in this sense, some weaknesses in its formulation were repeatedly highlighted, and require investigation. The overall amount of detail and the time it takes is often overwhelming, and should therefore be revisited. By contrast, the specificity of the levels and the explanation of how they relate to different seniorities are currently limited and should be enhanced. For the many individuals who are not accustomed to "management speak," the language is unfamiliar and could be made more

intuitive. In addition the division of leadership impacts into two domains is sub-optimal, and the tick-boxes and Profile Summaries could instead be grouped by impacts.

With that noted, it is important to bear in mind that qualitative feedback is inherently biased towards criticism and, with regard to the SCRP, this should not mean that the strengths of the SCRP's theoretical template are underestimated. When giving negative feedback participants persistently display a tendency to explain how and why they experienced it negatively, generating a significant volume of negative data; however when giving positive feedback, participants display a tendency to, for example, state that it is simple, without then justifying their position, thus generating a lower volume of positive data. For this reason, points on the template's formulation and the following three key findings are dominated by criticisms, perhaps suggesting that the SCRP is plagued by inefficacy. However this should be balanced by remembering that only approximately half of participants were broadly negative about the SCRP while, for the remainder, using the SCRP was a broadly positive experience.

4.2. New leaders and practical limitations

Whilst the SCRP is relatively strong in a theoretical sense, for approximately half of participants it encounters a number of difficulties in practice that significantly impair its ability to convey information and encourage leadership development processes. This is especially an issue for senior clinicians who have been in leadership roles for less than two years. In addition to limiting the tool's impact for newer leaders, on a personal level it can actually overwhelm and discourage, thereby inducing a significant counter-productive effect.

It follows that the SCRP is weakest in its service to the group who arguably most need it. As a theoretical template the SCRP mandates that users to add a degree of interpretation for individual circumstances, which presupposes some existing awareness of how the leadership competencies can be demonstrated in practice. This is naturally problematic for newer leaders, who do not have as much background leadership experience to draw upon. As newer leaders, however, this group is on the steepest learning curve, so their need for the intended outcomes of the SCRP to be manifest is greatest. Practical weakness is therefore a key development area, as addressed below (4.5).

4.3. Self-assessment limitations

Further to limitations to theoretical understanding gained from the SCRP, other intended leadership development processes are limited by its heavy reliance on self-assessment. The quality of self-awareness improvements (and other outputs such as action-plans) relies on assessment to be accurate. However, self-assessment is inherently oriented to individuals' self-perceptions, and there may be an accuracy gap between those and the perceptions of others' on the same issues. This significantly compromises the SCRP's value for those who have limited self-awareness or self-reflective skills. Therefore, it again follows (though in an entirely different manner to that illustrated in 4.2) that the SCRP is least effective for the class of clinician who arguably need it most.

Consequently the SCRP may pick up on good leadership when used by clinicians with good self-reflection skills; however it could well be blind to poor leadership when used by clinicians with poor self-reflection skills, if there is no external feedback. The addition of feedback is hence another key development area, as addressed under (4.5).

4.4. Support

Compounding the difficulties outlined above (such as having enough time, understanding how to use the tool or the language it uses, in addition to practical interpretation and forming a meaningful self-assessment) senior clinicians reported having been offered limited (if any) support in using the document itself. The more popular LEA 360 is also centrally organised around documentation, but this documentation is embedded in a process involving feedback and facilitation which supports senior clinicians in leadership development. This was consistently identified as its key strength over the SCRP. If the SCRP were shored-up with similar resources, such as time delineated for its use, or a facilitator to provide guidance and challenge self-assessments, its major limitations could potentially be resolved. Therefore, the SCRP could well form a central component in a leadership development process, but this could be best actualised by incorporating aspects of the LEA 360.

4.5. Development

It is important, thus, to recognise the strengths of the SCRP as a theoretical template, but also its intrinsic limitations to effective operation in isolation. The latter limits the SCRP's efficacy where it is most needed, and implication of a programme of support might well be viewed as a priority. Interviewed clinicians were keen to suggest that support could take the form of adding a trainer or mentor, who would be a more experienced senior clinician. The SCRP has the potential to form a template around which training could be structured, while the trainer could assist with use of the tool and interpretation of the theoretical information in a bespoke way (see 4.4). Furthermore tweaking the template's formulation (as noted in 4.1) and properly developing this as a training programme - borrowing inspiration from the LEA 360 - may resolve some of the remaining difficulties, such as the need for additional time.

Finally, the SCRP may then be utilised in other ways. For one, it could be employed in parallel with the LEA 360 to provide a comprehensive evaluation of both leadership behaviour and competencies; alternatively, the two tools could be combined into a single powerful instrument. It could also be used in longitudinal measurement of leadership progression and, if linked clearly with specific role requirements, in preparing evidence for formal appraisals.

4.6. Impact statement

Using a qualitative-thematic approach, this report identifies that the SCRP had strengths and limitations in broadly equal measure for the participating clinicians. The limitations are, however, particularly problematic where the tool may be most needed (e.g. for less experienced clinicians, or those with weaker self-reflection skills). Evidence indicates that the SCRP would probably be most effective as a component of a broader process, but will likely have limited efficacy as a free-standing instrument.

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Appendix 1: Interview Schedule

NAME	
ROLE	
DATE OF INTERVIEW	

PREAMBLE:

- Greeting.
- Interview should take no more than 30 minutes, though if you have the time you can go on for as long as you want.
- In the final outputs, all contributions will be <u>anonymised</u>. The research commissioners will have no access to the raw data itself, only the interviewer/transcriber will have that, so you can be *as candid as you wish*.
- The interview will be recorded, so your verbal consent is required – are you happy for us to do this?
- All responses are voluntary. You do not have to answer a question, or address a topic, if you do not want to.
- The interview will be very free form – we are not really looking for specific answers so much as for you to just tell us about your experience of using the Senior Clinicians SCRP, focusing on whatever *you* think is important.

	QUESTION	PROMPT ON (WHERE NECESSARY)	√
1	**Did you find using the Role Profile tool helpful? If so, in what ways? In what ways not?**	• *As a clinician?*	
		• *In relation to your leadership role?*	
2	**How do you feel that using the tool might best be tied-in to future work?**	• *As an appraisal instrument?*	
		• *As part of a leadership training programme?*	
		• *As an accessory to mentoring?*	
3	**How intuitive did you find the tool to use?**	• *Logical flow of issues?*	
		• *Obvious connections to practice and your own experience?*	
4	**Have you previously used the Leadership Effectiveness 360?**	YES / NO	
	If Q4 = "yes," proceed to Q5. If Q4 = "no," proceed to 'Finalising'.		

5	How do you feel the Role Profile Tool worked in comparison the 360?	• *Is there a comparison, in your view? How?*	
		• *Which is most useful to you? Why?*	
		• *Is anything replicated?*	
		• *Where do they complement each other?*	
		• *Any strengths or flaws that they share?*	

FINALISING.

- Thank you.
- There will be a follow-up interview later in the programme.
- Printed outputs of study will be made available to you via the Trust systems, and it is also hoped that the researchers will be able to put together a presentation for stakeholders at a later date. If the latter were to take place, would you be interested in attending such an event?

Yes / No