The role of coaching in the development of nurse managers

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Abstract

There is evidence of the importance of the role of nurse managers who are first line managers of a team of nurses within any health sector. This puts the issue of the development of nurse managers on the agenda within the context of improving health care. However, there appears to be little understanding of the UK wide scope of nurse manager development and the means to increase its effectiveness. At the same time, it appears that some nurse managers receive coaching to help in their development. The aim of this study was to explore empirically the role that coaching is playing in the development of nurse managers in order to inform further research and policy makers about the potential utility and value of this means of development.

This mixed methods study, using a pragmatist paradigm, gathered data from a quantitative survey and qualitative interviews. The survey was administered to elicit the national picture of nurse manager development and what role coaching was playing in this. Qualitative interviews were undertaken with nurse managers, coaches and directors of nursing to draw out their own experiences of coaching for nurse managers. Thematic analysis was the framework used for data interrogation, identifying new patterns and emerging themes.

Nurse manager development was being undertaken across all four UK countries, with larger organisations being more likely to develop their managers than smaller ones. Themes that emerged from interviews included how nurse managers were introduced to coaching, how they balanced transitions, the role of reflection, the value of relationships and overlaps between clinical supervision, mentoring and coaching.

Findings show that following coaching, nurse managers gained increased resilience, confidence and better coping mechanisms. This resulted in improved team management and cohesion and appeared to lead to better quality of care for patients. This study suggests the importance of nurse managers accessing coaching, to enable transformational leadership of their teams of nurses. It suggests also the importance for organisations to support a coaching culture, to ensure staff satisfaction, motivation and improved quality of patient care. A Coaching Impact Circle framework has

been developed to illustrate the impact of coaching on the self, the team and the organisation.

Key words: nurse manager, coaching, development of self, resilience, leadership, coaching culture, impact circle.

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Chapter 1 - Introduction

My story starts - I was appointed into my first nurse manager post in 1989 having been a staff nurse on a similar ward for a number of years. My new line manager selected a suitable buddy for me who had been a senior nurse for many years. She was a valuable support and we chatted through the vagaries and ups and downs of being a nurse manager and how to tackle some of the myriad of problems faced by a nurse who was new to the manager role and was a first line manager. There was some development available in the post but, generally, I learnt from the things that went well and from my mistakes. I made some good decisions while in this role but also handled some situations badly and learnt, through reflection, to undertake the role as effectively as I could.

Jump forward to 2007 when I was fortunate enough to receive coaching upon appointment to a senior education management role in a British university. Coaching was a revelation and I wished immediately that I had been introduced to coaching and this valuable development opportunity much earlier in my career.

1.1 Introduction

This introductory chapter will set the scene for the study, why it was initiated and its aims. The current context, and the history, of the role of nurse managers will be explored, and their development needs within the context of coaching will be discussed.

The nurse manager role is a first line manager role undertaken by nurses who manage a team of nurses in any health sector. This role is found throughout the world wherever a group of nurses undertaking care require a more senior nurse to manage them. In the UK the team can be ward-based in an acute hospital in the NHS or private sector, or based in the community. Given the variety of specific role titles, the term nurse manager will, in this thesis, be used to refer to a nurse manager, nurse team manager, charge nurse, ward sister, ward manager or nurse team leader in the community. These terms are used interchangeably in health care

settings, being used to describe nurses who have a leadership role and manage a group of nursing staff within a unit or community team and have responsibility for these staff (Royal College of Nursing, RCN, 2007).

Nurses in this role have responsibility for the quality of care undertaken by their staff (Lee and Cummings, 2008; Currie, 2013; Fenton and Phillips, 2013), including giving and supervising direct patient care, performance reviews, staff rotas, finance management, recruitment and measuring quality indicators. In addition, the role is a pivotal link between education and management (Ashworth, 2010; Leah and Fenton, 2012).

It has been argued that the challenges of being a nurse leader and manager in health care and the NHS are complex, enormous and stretch professional and personal reserves on a daily basis (Savage, 2001; McNichol, 2002; Care and Udod, 2003; Fenton and Phillips 2013).

Given this, the development of nurse managers to undertake this role effectively is crucial if they are to function effectively (Platt and Foster, 2008; Freeman, 2010; Middleton, 2012; Willcocks, 2012). However, there is no national development programme for nurse managers, no requirement of employers to develop them and, at a national level, there appears to be little understanding of the scope of nurse manager development (Platt and Foster, 2008). Although as recently as 2012 the Prime Minister's Forum promised a national programme, it has yet to be implemented (Snow, 2012)

Coaching has been suggested as a valuable asset in the development of leaders and managers (West and Milan, 2001; Burke and Hutchins, 2008; Institute for Employment Studies, 2012). The presence of coaching in a development programme for senior managers in the public sector, has been found to be correlated with improvement of both management and leadership skills (Ponte et al., 2006; Coates, 2013).

Despite the variable development available for managers in the health care sector, some programmes do introduce managers to coaching. However, there appears to be little empirical research on the value of coaching to develop the nurse manager role (Rivers et al., 2011; Law and Aquilina,

2013) and this situation has been particularly under-researched from the perspective of the nurse managers themselves (Medland and Steinhauer, 2009).

This study addresses these issues with the aim to explore the role that coaching is playing in the development of nurse managers.

The objectives of the study are:

1. To critically evaluate literature relevant to nurse manager development and the current role of coaching in nurse manager development programmes, in health care management and in first line manager development.
2. To explore empirically how coaching is used in nurse manager development on a national scale.
3. To explore empirically the experiences of nurse managers who have received coaching.
4. To present a multi-faceted analysis of the use of coaching in the development of nurse managers.
5. To advance the theoretical understanding of the coaching context and to develop practical recommendations to inform policy and practice for future developmental programmes.

The following section will set the context for the current and historical role of the nurse manager and why this role is so crucial to the delivery of health care, whether in acute hospital settings or in the community. It will explore the context of coaching in the development of managers and introduce the current understanding of coaching for nurse manager development. Building on this, the rationale for the study will be described in turn leading to a particular methodological approach. Finally, the organisation of chapters in this thesis will be outlined with a summary of each chapter.

1.2 Who are nurse managers and what challenges do they face?

Health care managers currently face pressure from the public, professional and regulatory bodies, advances in technology, reductions in public funding and an ever-increasing and aging population (Fenton and Phillips, 2013).

Within this pressured environment, nurse managers have a pivotal role in the management and leadership of staff and the quality of patient care (Squires et al., 2010).

Figure 1-1 illustrates that nurse managers are the crucial interface between clinical staff delivering patient care and senior health managers, undertaking this role at the front line of service delivery (Lee and Cummings, 2008; Currie, 2013; Fenton and Phillips, 2013). This interface involves working with staff in their organisations, in the medical and allied health professions, as well as with finance managers and directors of services.

Figure 1-1 Components of the nurse manager role.

There is a view supported by the nursing profession in the UK, Secretaries of State for Health and recent Government commissions, that the nurse manager should be the cornerstone of the patient experience and nursing standards (Castledine, 2001; Great Britain. House of Commons Hansard Parliamentary Debates, 2008; RCN, 2009; The Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010). The Francis Enquiry (2013) in examining the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 drew attention to the crucial role of the nurse manager as a gatekeeper for the standard of care undertaken in their area. The need for stronger health care leadership was included in the Enquiry's two hundred and ninety recommendations.

Nurse managers should be ideally placed to coordinate and supervise all nursing services offered to patients so ensuring that high quality care is given (Prime Minister's Commission on the Future of Nursing and Midwifery, 2010; Dean, 2010). However, in recent years, the role of the nurse manager has become confused and less powerful than, for example, 40 years ago and with this has come a change in responsibility and control (Lewis, 1990; Bradshaw, 2010; Doherty, Gatenby and Hales, 2010). These issues are explored in section 1.3.

Naish (2009) has identified that nurse managers face burnout as they endeavour to balance all the varying pressures and expectations of their role and face more stress than the general population (Lee and Cummings, 2008). Burnout is not surprising given the great deal of responsibility and wide variations in workload and demands placed on staff in this role (Sprinks, 2010). This is echoed nationally in the workforce by research indicating that work-related stress, depression or anxiety leads to 11.4 million days of work lost per year in the employed workforce in the UK (Health and Safety Executive, 2011).

Hales (2005) and Lee and Cummings (2008) identified that the style and qualities of the nurse manager will have a considerable influence on team ethos and behaviour. It has also been suggested that leadership style influences the culture of a practice area and therefore, has an effect on the quality and standard of care (Platt and Foster, 2008; RCN, 2009). Additionally studies by the RCN (2009) report that nurse managers have been found to be unclear about what is expected of them in their leadership and management role; with this lack of clarity being compounded by time pressures, lack of resources and complicated lines of authority (RCN, 2009).

The NHS Leadership Academy's recently developed Healthcare Leadership Framework illustrates the complexity of the leadership role in health care. The aim of the model is to assist those who work in health and care to become improved leaders (NHS Leadership Academy, 2013). As such, this framework is a tool to illustrate the intricacy of the role and thus the importance of the development of nurse managers to be able to

undertake the leadership required to make their role effective. The Leadership Academy has identified nine 'leadership dimensions': 'leading with care, sharing the vision, engaging the team, influencing for results, evaluating information, inspiring shared purpose, connecting our service, holding to account and developing capability' (NHS Leadership Academy, 2013,p.3).

These dimensions have been refined from previous frameworks and are a result of the recent public enquiries, such as the Francis Enquiry (2013), into standards of care in the health service. Turnbull-James (2011,p.6) stated that 'the NHS needs people who think of themselves as leaders, not because they are exceptionally senior or inspirational to others but because they can see what needs doing and can work with others to do it'.

Some authors claim that nurse managers can have the biggest impact on morale and the quality of care provided in hospitals and that the health service needs to support these staff far more effectively than is currently the case (Middleton, 2012; Willcocks, 2012). The value of nurturing and developing the leadership skills of nurse managers to develop resilience, ensure good quality care and cultivate a skills base capable of undertaking the role in a complex health care world has been identified by Ashworth (2010), Gooch (2012) and Fenton and Phillips (2013).

Viewed in a historical continuum, current considerations of the role of the nurse manager need to reflect the fact that this role has been in existence since nurses started being considered to be an organised body of workers in the 19th century. For over a hundred years, the role of the nurse manager has been commented on, adapted, altered and changed through successive governments and by the actions of the nursing and midwifery professional and regulatory bodies. Therefore, it is useful to be able to review this historical continuum for significant events, so that the evolution of the role to its current state can be seen in context.

1.3 Historical context

It is generally accepted that the pivotal role of the nurse manager has been described since the start of what is called modern nursing in the 19th century. Reflecting more than a century of activity Table 1-1 illustrates

some of the key reports that have influenced the role of the nurse manager in the 19th, 20th and 21st centuries.

This demonstrates that there has been commentary on nurse manager leadership for well over 140 years. Throughout this period the key accountability of the role has remained constant: to provide leadership for a group of nurses who deliver direct patient care, whether in a hospital or community setting with the accountability extending to the nurse manager's practice and those of the nurses that they line-manage.

Despite this, the historical record shows change to the authority and span of control of the manager. With the exception of The Griffiths Report (1983), which influenced management in hospitals overall, all of the other key reports had a direct effect on the authority of the nurse manager role and in most cases eroded it.

For example, the Salmon report (1966) reduced the span of control of the manager quite significantly. However, perhaps not surprisingly, in 2001 it was recognised that this reform had gone too far. The role of the nurse manager needed strengthening and should resume its pivotal role in maintaining standards and effective care.

Year	**Report (R)or Publication (P)**	**The Effect on Nurse Manager Role**
1874	(P) Florence Lees (a nurse in the Franco-Prussian war)	'The nurse manager is a trainer who needs to demonstrate virtuous traits in herself but also aim to grow these qualities in those she presides over.' (Lees, 1874). She also said that all nursing care should be underpinned by a religious element, involving charity and love NB. At this time virtually all nurses were female, hence the use of the word 'herself'.
1877	(P) Williams and Fisher	The training of nurses should be done by the nurse manager with the moral background of Christian Charity.
1886	(P) Luckes	Identified that the personal traits of the nurse manager were the basis for good nursing.

1947	(R) Ministry of Health, Department of Health for Scotland, Ministry of Labour and National Service (1947 Wood report)	This Government report went as far as to say that a key function of nurse managers was to establish the tone in the hospital and this depended largely on the qualities of the individual nurse managers.
1949	(P) Pearce	A tutor at the Middlesex Hospital and author of a key textbook of the era comments that the nurse manager is the 'Captain of the team' (p.50).
1966	(R)The Salmon Report	A new structure for nursing as a whole and, in particular, its management structure. This included top, middle and front line management roles. This report had a significant effect in the role of the nurse manager, reducing its control and authority but at the same time not reducing its size and complexity. (Ministry of Health and Scottish Home and Health Department 1966)
1968	(P) The Dutton Study	Looked at nurse tutor recruitment and deduced that nurse managers did not want to become tutors as they wanted to stay in close contact with patients. It was viewed that the nurse manager could still continue to have ultimate control over patient care and standards and that they lost this when moving into a tutor role
1972	(R)The Briggs Report	Led to fundamental changes in nursing articulated in the Nurses, Midwives and Health Visitors Act. Briggs said that nurses instead of being 'ladies with the lamp' were becoming 'dictatorial automatrons'. The report also mentioned that 'The key figure in the ward team is, and will continue to be, the ward sister'. Responsibility for nurse training was moved into the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, UKCC (UKCC, 1986). It changed the policy, education and practice of nurses and was critical of the traditional work of nursing and linked nurses assuming too much power with failings in nursing.
1980	(P) Dr Sue Pembrey	The nurse manager role is important 'because she is the only person in the nursing structure who actually

		and symbolically represents continuity of care to the patient. She is also the only nurse who has direct managerial responsibilities for both patients and nurses' (Pembrey, 1980, p. 8).
1983	(R)The Griffiths Report	This resulted in a more corporate-orientated approach to health (Klein, 1995) and resulted in nurses not having to be managed by a member of their own profession. It led also to nurses being divided from the responsibility for standards of nursing care and practices. Prior to Griffiths the nurse manager managed all staff in their ward area, including catering and cleaning.
1991	(P) Department of Health (DH)	The introduction of primary nursing and team nursing (DH, 1991, Naish, 2009). These two systems essentially continued to devolve the accountability away from the nurse manager and instead transferred autonomy to individual nurses.
1992	(R)The Audit Commission	'The profound changes in nursing and hospital management of the past decade have exposed nurse managers to a great deal of uncertainty about the expectations of others above and below them in the hierarchy'. It continued, stressing that 'The ward sister holds the key to the ward: her management style determines the ethos and the direction of the ward and its response to change'.
1999	(P) Menzies–Lyth	Menzies–Lyth, a previous supporter of the changes to the role, admitted that the changes had swung too far and that instead of clear authority of the nurse manager there was a laissez faire attitude of staff and lack of firmness. Staff reported feeling unsupported and with lack of direction, they felt very insecure.
2001	(R)Department of Health	The Department of Health admitted that the role of the nurse manager needed strengthening and that they should resume their role of being the pivotal role in maintaining standards and effective care.
2003	(P) Sergeant	Found that nurse managers were very much occupied with administration and finance, which continued in the long term to be detrimental to the standards of patient

		care.
2006	(R)The Hay Group	Argued that 'great nurses do not always make great managers' and that the traits most associated with nurses such as empathy and caring were not always suited to being a manager.
2008	(P) Ann Keen, Minister of Health	Reiterated that the key to patient care is the nurse in charge of that ward (Harrison, 2008). This occurred at the same time as it was suggested that nurse managers have supernumerary status.
2009	(P) Royal College of Nursing	Found that nurse managers were highly motivated to be managers from a desire and passion for nursing but not necessarily a desire to be a manager in the fullest sense. Staff said they wished to retain the title nurse manager as they thought it helped identify them with patients and the general public rather than being identified as a manager.
2010	(R)Prime Minister's Commission on the Future of Nursing and Midwifery	The nurse manager should be the cornerstone of the patient experience and nursing standards.
2012	(R) Nursing and Quality Care Forum	Called for the role of the nurse manager to be strengthened.
2012	(R)Compassion in Practice	The Chief Nursing Officer's (CNO) vision and strategy for building a culture of compassionate care is based around six values and aims to raise nursing standards. This process has been called the 6Cs. (Department of Health, 2012)
2013	**(R)** Francis Enquiry. Report of the Mid Staffordshire Foundation Trust Public Enquiry.	Illustrated failures in nursing leadership and poor standards of nursing care.

Table 1-1 Nurse manager history.

The changes throughout the history of the nurse manager role shown in Table 1-1 go some way to explain why nurse managers at times feel confused by what is expected of them and what role they are really being asked to undertake. Some of these changes, particularly those connected with The Griffiths Report (1983), resulted in nurses not having to be managed by a member of their own profession and in addition, led to nurses being divided from the responsibility for standards of nursing care and practices (Bradshaw, 2010; Calkin, 2013).

It is interesting to note that prior to Griffiths the nurse manager managed all staff in their ward area, including catering and cleaning. It has been suggested that these changes radically altered and undermined the authority that the nurse manager had in their own area and rendered them almost powerless overnight (Black, 2005; Dimond, 2008; RCN, 2009). The concept of being managed by someone from outside your own profession was, at that time, also quite alien and again, arguably undermined the value of the role. Menzies-Lyth's (1988) survey of 200 nurse managers reported that they felt they lacked autonomy, authority and power; results echoed in East and Robertson's (1993) research.

In the 21st century, the role continues to be very complex and remains as pivotal to good quality patient care and the professional management of nurses today as it ever has been. It has been identified that nurse leaders need to be able to inspire staff with vision and motivation (RCN, 2009) and that comprehensive preparation and education are required for the leaders of tomorrow to succeed (Kitching, 1993).

Later in the decade, Lorentzon and Bryant (1997) wrote that they hoped for a more meritocratic style of nursing leadership in the 21st century compared to the hierarchical style used in the 20th century; it is not clear how they hoped or envisaged that would occur. Additionally, a leap of faith was required to assume that, with all the changes that had been imposed on the nurse manager role, there was an appetite for yet more change and responsibility (RCN, 2009), in turn, a demonstration of what happens to management and leadership when responsibility is increased but authority is reduced.

Currently nurse managers have lots of responsibility, needing to undertake their role in a manner delivering high-quality, low cost care (Fox, Fox and Wells, 1999; Currie, 2013) but, in many cases, with little authority to make changes. They continue to have responsibility for the standard of care in their area and are monitored by a wide variety of organisational and national audits, for example the Care Quality Commission, CQC (Middleton, 2012).

It has been suggested that nurses need to take a key role in the service redesign needed in the NHS (Ford, 2012) with the concomitant freedom to challenge and innovate, so they can transform services and improve patient care (Leah and Fenton, 2012). Effective leadership has been highlighted as vital for the development of junior nursing staff to reach their full potential (Haines, 2013). It is described as 'vital to high quality patient care and experience, resource management and interprofessional working' (Fenton and Phillips, 2013, p.12). The Francis Enquiry (2013) identified that wards that were 'well led' generally provided what were deemed acceptable standards of care. Wards where patients had 'terrible experiences' largely lacked 'strong, principled and caring leadership' (RCN, 2013, p.4), demonstrating the crucial link between leadership and quality of care.

This section has discussed the historical continuum for the role of the nurse manager in terms of leadership and management, including its current status. It has identified the great responsibility of the role, with the core responsibility for the quality of patient care undiminished at the same time as its authority has been eroded.

Development is necessary to help nurse managers undertake this difficult and challenging role. The first objective of this study was therefore developed in response to the requirement to fully understand these development needs and to identify how coaching has played a role.

The following section will discuss what development is currently in place for nurse managers.

1.4 Current development of nurse managers

The current development of nurse managers is an important area to review in order that the current context of how the nurse managers' skills and knowledge are fostered and grown can be fully understood.

It has been well documented that nurse managers feel inadequately prepared for their line manager role and that this hinders their ability to perform their roles effectively (McGibbon, 1997; Antrobus and Kitson, 1999; Mathena, 2002; Grindel, 2003). The importance of some preparation prior to a manager being appointed has been identified (Kennedy, 2008), so they can be better prepared to succeed in their new role. If this pre-preparation is in place it is suggested that managers can then better contextualise the learning they undertake once in post (Duffin, 2012).

The importance of contextual learning once a leader is in post has been recognised for many years by Dodwell and Lathlean (1987), Senge (1990), Schon (1991), Garrick and Clegg (2001) and Smith (2001). For nurse managers, however, lack of adequate preparation has persisted (Kennedy, 2008; RCN, 2009). Many nurse managers feel very inadequately prepared when they take on the role, then confused and unsupported in their development once in the role (Lipsey, 2009).

The importance of staff development and a distributed leadership model to empower clinical leaders, have been identified as key themes in what makes a top hospital by Robson and Tyndale–Biscoe (2013). Despite this, there is still no national programme for the development of nurse managers, although there are some programmes in place, such as those designed by the RCN, the professional union for nurses and midwives and the NHS Leadership Academy. The RCN's Clinical Leadership Programme provides a structure to develop the leadership and management skills and competence for nurse managers and is one of the longest running programmes of its type in the UK.

However, not all nurse managers have access to these programmes due to lack of funding from their employer, lack of release time from work or simply that it has not been suggested to them as a method of development (RCN,

2009; McNally and Cunningham, 2010). In addition, many NHS Trusts have designed their own nurse managers' development programmes and these are run 'in house' (Platt and Foster, 2008). Although these programmes may contain a range of topics such as 360-degree feedback, aptitude testing, understanding finance, human resources training, management and leadership, mentoring and coaching etc. there is no national benchmark for them to ensure parity, quality and content (Hay Group, 2006).

An RCN report (2009) did make an attempt to clarify the nurse manager role and contained a summary of good examples of development programmes from the RCN itself and a few NHS Trusts. There is, however, no national picture of what nurse manager development is being undertaken at NHS Trust level and how many nurse managers actually undertake leadership and management development. Without this national picture, organisations are unable to gauge their own effectiveness in providing training for nurse managers. This demonstrates the importance of research to determine the scope of development - objective two of the study.

There are a variety of development opportunities available for some nurse managers and health care senior managers, see Figure 1-2; within some training programmes, there is an opportunity for staff to receive coaching.

Figure 1-2 Illustration of the current nurse manager development available.

Reflecting my experience as a senior educational manager who has received coaching, a desire to build a greater understanding of what coaching is available to managers was required. Therefore, the following section will explore what coaching opportunities are currently available for managers.

1.5 Coaching of managers

Coaching is one of the key approaches through which leadership within organisations can be developed (West and Milan, 2001; Hawkins, 2012; NHS Leadership Academy, 2012; Coates, 2013). Effective coaching can be used by employers to retain key employees and helps to create a cohesive workforce, which will work effectively even when under pressure (Jarvis, Lane and Fillery-Travis, 2006; Hawkins, 2012; Field, 2013).

Coaching has undergone a major change and is now actively sought by employees rather than being seen as a remedial process for underperformance (Lane, 2010; McNally and Cuningham, 2010; Boersma, 2013). Coaching is also now seen as one of the most effective methods for managing talent and is seen as an opportunity for leaders to have insightful conversations and reflect on their performance (Hawkins and Smith, 2006; Joo Sushko and McLean, 2012; The Chartered Institute of Personnel and Development, 2013).

There are a variety of definitions of coaching. Bachkirova, Cox and Clutterbuck, (2010,p.1) state that it is ‘a human development process that involves structured, focused interaction and the use of appropriate strategies, tools and techniques to promote desirable and sustainable change for the benefit of the client and potentially for other stakeholders’. The definition from The Chartered Institute of Personnel and Development is that coaching is about ‘developing a person’s skills and knowledge so that their job performance improves [...] it lasts for a short (fixed) period and focuses on specific skills and goals’ (CIPD, 2013, p.3). The rationale behind coaching has also been described as developing greater understanding through discussion and reflective thought to enable any manager to become a more complete and authentic leader (Parsloe and Leedham, 2009; Cox, Bachkirova and Clutterbuck, 2010).

In health care, the importance of coaching for leadership development was identified by various authors e.g. Koloroutis (2008), Ponti (2009) and McNally and Cuningham (2010). In the public services, coaching has been offered to executive management and high potential level staff for a number of years but is still only just emerging as an option for middle managers and nurse managers (Herrin and Spears, 2007; Kowalski and Casper, 2007; Sparrow, 2007; Kombarakaran et al., 2008).

It has been suggested that for coaching to be effective it needs to be valued from the executive level right through to the clinical staff (McNally and Cuningham, 2010; Hawkins, 2012). Executives who have received coaching themselves are more likely to use coaching successfully for their managers (Haas, 1992).

There is evidence to suggest that if coaching has been undertaken competently and effectively then the employee will improve their performance (Jarvis, 2004; Laske, 2004; McNally and Cuningham, 2010; Moen and Federici, 2012). Coaching is valuable in helping a person to maximise their potential and enhance their performance and can be used for teambuilding, management of change and staff development (Jarvis, 2004; Fielden, 2005).

Locke (2008, p.106) concluded that 'the possibilities for development coaching in health care are limitless'. An evaluation of coaching in the NHS, undertaken by the Institute for Employment Studies (IES) (Sinclair et al., 2008), reported that the most significant benefits were at the behavioural level, including increased confidence, better management of teams, with beneficiaries having a more strategic and objective approach to their role.

The main feature of the literature on coaching for health care managers shows that it is usually offered to executive and very senior level staff in a health care organisation. It is offered to help them develop in their role, often to help them implement projects to meet targets to reduce funding for their organisation (Sinclair et al., 2008). Most studies report the value of coaching to high-level staff, however very few report the value of coaching to the nurse manager role (Law and Acquilina, 2013).

The studies that have explored the role of coaching for nurse manager development can be categorised in a number of themes. These are:
(1) Why coaching was initiated (Reid Ponte et al., 2006; Haycock, Kean and Baggaley, 2010; Bond and Naughton, 2011; Salman Taie, 2011);
(2) The relationship of the coach (Sparrow and Arnott, 2004; Kowalski and Casper, 2007);
(3) coaching versus mentoring (Houser-Carter, 1992; Fox, Fox and Wells, 1999; Fielden, Davidson and Sutherland, 2009; RCN, 2009);
(4) Outcomes of coaching (Reid Ponte et al., 2006; Kushnir, Ehrenfeld and Shalish, 2008; Medland and Steinhauer, 2009; Johnson, Sonson and Golden, 2010);
(5) Coaching as part of a leadership programme (Loo and Thorpe, 2003; Mackensie, 2007; Law and Aquilina, 2013).

This identification of some empirical evidence concerning the development of nurse managers gave rise to a desire to explore in more detail what the research was illustrating and to further analyse the gaps in the current knowledge base about coaching and its role in nurse manager development. This led to the development of objectives one, three and four of the study.

1.6 Focus for the study

Although coaching has been shown to be of benefit to executive level managers in health care there is still limited empirical evidence on its benefits to nurse managers. This study will contribute to and build on the limited empirical evidence already produced in the area of coaching for nurse manager development. This study should therefore be of value for the literature on the development of line managers; specifically the recognition of a highly responsible management role in situations concerned with human life.

First of all I wished to explore what development programmes were available to nurse managers and whether coaching played a part in this development. Because there is no national picture of nurse manager development, this study's insight into how nurse managers are developed across the four countries of the UK may be valuable. This insight was

gained through a national survey undertaken for the study, administered to health care organisations in all four UK countries.

Secondly, the focus for this study was to understand more fully the experiences of nurse managers who have actually received coaching while in role. This will allow their voice to contribute to the debate about coaching and their development.

These components of this study will be synthesised in order to advance the theoretical understanding of coaching in this context. It will make a contribution to the body of the knowledge and practice on the development and support of nurse managers and on coaching in this and similar contexts. It will discuss the implications for employers of coaching.

This understanding of the experiences of nurse managers was obtained through a methodology employing an analysis of data collected through interviews with nurse managers, directors of nursing and coaches.

1.7 Overview of the thesis

The introduction has explained my personal motivation for the study, has highlighted the importance of the nurse manager role in the current health care profession and the growing role of coaching for health care managers. It has reviewed some of the current media coverage of leadership in the health professions, illuminating the environmental context for this study. It has outlined some of the key themes to emerge in the empirical evidence available at present, for the role of coaching in nurse manager development.

Chapter 2 - Literature Review - evaluates the key empirical research that has been undertaken on the role of coaching for nurse managers and the empirical evidence available concerning their development in this role. It also reviews the evidence for coaching in respect of first line managers. Finally, it brings this evidence together to develop a conceptual framework to illustrate the context for this study and the contribution that it aims to make to the knowledge base of coaching and the development of nurse managers.

Chapter 3 - Methodology - presents the pragmatic constructivist assumptions that underpin the philosophy of this study and explains how the mixed methods methodology and thematic analysis was applied. It explains the process for the selection and recruitment of the nurse managers, directors of nursing and coaches and describes the quantitative and qualitative data collection methods employed, including a survey and semi structured interviews. Data management and data analysis of the survey and interviews are explained.

Chapter 4 – The National Overview - explores the results of the survey and sets out the landscape of the following three results chapters.

Chapter 5 – Why Coaching Occurred - examines why coaching occurred from the perspective of nurse managers, director of nursing and coaches. Three themes are explored: introduction to coaching, balancing transitions and self-confidence and self-efficacy.

Chapter 6 – The Experience of Coaching - explores the coaching experience of nurse managers from their own perspective and from the perspective of directors of nursing and coaches. It addresses the themes of: the value of relationships, the role of reflection, and the nurse managers' relationship to coaching, mentoring and clinical supervision.

Chapter 7 – Outcomes Following Coaching – builds on the preceding chapter, examining outcomes following coaching for nurse managers and for their organisations. It addresses themes of: organisational outcomes, return on investment and how the nurse managers have changed following coaching.

Chapter 8 - Conclusion - draws together the key findings and examines the implications for the practice and knowledge base of coaching and the development of nurse managers. A 'Coaching Impact Circle' framework, drawing together all of the key findings and contribution to knowledge and practice, has been designed and is presented. Limitations of this study are identified and recommendations for future research are suggested. Finally, reflections of the researcher's journey are shared.

Chapter 2 - Literature Review

2.1 Background and scope of the review

This review will examine not just the literature found directly addressing the research topic but also examples from business, education, psychology and psychotherapy, in order to develop a robust conceptual framework.

Section 2.3 focuses on the literature in the wider context of the development of the nurse manager role and will reflect on the development of first line managers. This sets the scene for section 2.4, which addresses how the role of coaching in nurse manager development is presently understood. A selection of the research on first line managers will also be included in section 2.3 and 2.4. This is a valuable source of comparison and insight given that this role, defined as 'the position representing the first level of management to whom non-managerial employees report' (Hales, 2007, p.473), is the function of nurse managers. In section 2.5 the use of coaching in the wider health care and business management sector will be analysed, to illustrate how coaching is being used at the senior management level.

2.2 Literature searching strategy

While a wide range of health care staff use coaching to support their patients, this review concentrates on how it is used to support the staff themselves, so excluding research studies on how coaching is used for patients.

Literature searches were undertaken using BNI, Cinahl, EBSCo, Medline, Business Source Complete and Emerald. The search strategy started with key word searches (nurse, nurse manager, ward sister, charge nurse, ward manager, community team leader and manager, development, coaching and mentoring) in the nursing literature.

Secondary searches widened this out to include search terms such as first line manager, new manager, health care and NHS. The search areas also included psychological, business and developmental literature.

Inclusion and exclusion criteria were set. The literature needed to be in English, primarily empirically research based and published within a 34-year timespan: 1980 to 2014. While this time span is longer than is normally used, it reflects the paucity of relevant research articles. Authors of recent relevant articles were also contacted where possible to gain further insights into their research.

The review strategy included reviewing both quantitative and qualitative studies, to further broaden the range of material for consideration. Figure 2-1 illustrates the review process.

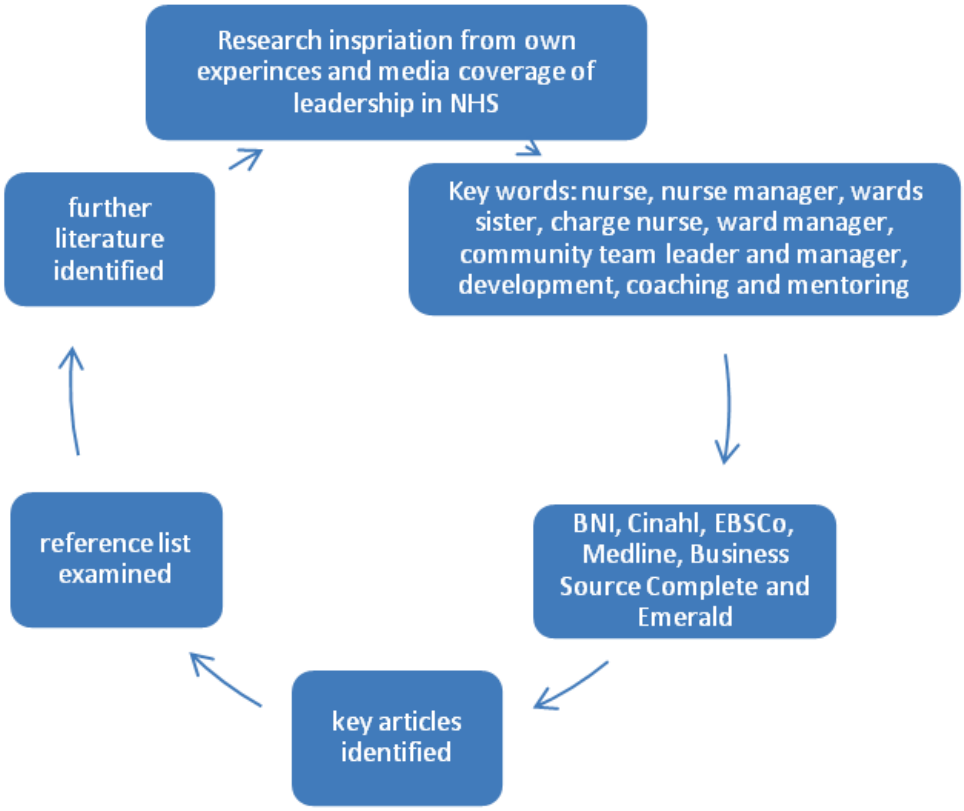


Figure 2-1 Literature search process.

This review starts by evaluating the literature directly related to nurse manager development.

2.3 Development of the role of the nurse manager

Historical and current research on the development of nurse managers is a valuable starting point as it sets the scene for how their development has evolved. For comparison, this section also includes relevant literature on the development of first line managers.

The key themes that emerged from reviewing current literature are: change in role of managers; change in expectations; development needs of first line and new managers; types of development programme; satisfaction in the nurse manager role, and finally clinical supervision. In the succeeding sections, each of these themes is reviewed, summarised in turn and conclusions drawn.

2.3.1 Change in role

Nurse managers and first line managers more generally are often appointed to this role as their first management post. As such, this formative change in role and the support needed to ensure its success is an important component of this research.

The needs of staff new to the role and requiring support, have been identified by Pembrey (1980), Ogier (1982), Lathlean (1986), McDermott (2001), Waters et al. (2003) and Hales (2005). Their research was undertaken using action research, surveys and a range of other methods, including interviews, observations and assessments. They identified that many managers are ill equipped for the role they are appointed to and have very little prior development – conclusions that accord with the author's own experience.

The important factors identified by this body of research were: the context in which the managers were functioning; the need for support in the management of change; role conflict and managing difficult staff situations; and that support comes from within the organisation and from external sources. Crucially the research identified that support was critical to the managers' ability to effectively develop themselves in their new role and to manage change.

In a Canadian based study drawing on publications from the UK and USA, McGillis-Hall and Donner (1997) undertook a literature review of the changing role of the nurse manager. The review covered skills and qualities, perceptions of the role compared with those of others, preparedness for the role, conflicting expectations and job satisfaction. They concluded that the role has evolved to be crucial for the effective functioning of hospitals. It was also evident that staff in nurse manager roles, require education and support if they are to be successful in managing change in the health care arena.

Recommendations for the development of leaders in management roles were made by Loo and Thorpe (2003), McKenna, Kenney and Bradley (2004) and Pitkanen et al. (2004). These studies used interviews to identify the importance of selecting leaders at an early stage. Taken together these studies demonstrate that the role of the manager is evolving in both size and complexity, in turn emphasising the importance of the ability to balance both personal and professional lives in order to be effective in the role. Additionally these studies identified a key deficit in the lack of development programmes for nurse managers, in contrast to those available for staff nurses to develop their clinical skills. Consequent key recommendations were the development of relevant programmes for nurse managers and for these to be designed by nurse educators.

Interestingly these studies, using research samples from Canada, Ireland and Finland, echo the outcomes of research undertaken in the UK on the importance of pre-selecting nurse leaders and then fully supporting them to become effective leaders (Royal College of Nursing (RCN), 2009; Vesterinen, Isola and Paasivaara, 2009; Chase, 2010). They demonstrate the ubiquity of the success of this approach, notwithstanding linguistic, cultural and health care provision differences.

The problems associated with the transition between the roles of nurse and manager, were examined in a case study research project conducted in Wales (Sambrook, 2006). Interviews were analysed thematically, then discourse analysis was used to investigate any links between participants, their professional identities and their discursive resources. Participants recalled the difficulty associated with the transformation of identity from

nurse to manager, the continuing paternalistic manner of many medical staff towards nurses, and the assumption that if you are a nurse you cannot be good at business.

The study stressed the importance of support and development during the transition from nurse to manager to ensure that a good nurse can become a good manager, recognising that being a good nurse does not automatically mean an individual will also be a good manager. This was echoed by McDermott (2001), McKay (2002), Gabarro and Kotter (2005) and Butterfield (2008) who identified an uneasy transition between friend and boss, with expectations not matching reality, a lack of understanding of a new culture and not making new relationships.

In summary, these studies all illustrate the importance of support and development as an organisational priority, when a manager is newly appointed and the consequences, including demoralisation and insecurity, when this does not occur. Given that new managerial appointments often coincide with, or are precipitated by, wider organisational change, the new managers' role in supporting their teams in change can be even more challenging when they themselves are not supported.

Despite the fact that this literature emphasises the importance of developing managers a relatively recent survey of 4000 managers showed that over a quarter felt unprepared to lead and over half of the managers did not receive management training (Hello et al., 2011).

2.3.2 How nurse managers manage changing expectations

Historical changes to the role of nurse manager, the vital link between senior managers and direct patient care, were described in the introduction to this study. Turning to the present and future most health care and business organisations are experiencing constant change with consequent changing expectations of the manager role (Watson and Harris, 1999; The Kings Fund, 2011). This section will look at how such change affects the manager role and how it adds to its complexity.

As well as managers undergoing change within their role, it has also been suggested that changes in an organisation can affect their role and the responsibilities they have for their own staff (Watson and Harris, 1999). The supervisory role of the manager was seen as key to managing the changing conditions in which they may manage their team. They were seen as a 'resilient but put upon survivor of organisational change' (Hales, 2005, p.502).

The nature of nursing management and the conflict that can be engendered from a corporate perspective, is described by Carnevale (1997). There is emerging recognition that nursing management is a practice, which needs to be mastered and that this requires more than development programmes focusing on finance and human resources (Chase, 2010). There is a concept that nursing management is a form of practical wisdom that requires the support of skilled mentors to develop skills. To enact this practically and to enable the development of nurse leaders requires a complete cultural change in attitudes of nurses and medical staff (Macleod-Clark, Maben and Jones, 1997; Antrobus and Kitson, 1999).

Sherman et al. (2003) identified the critical competencies needed to be a nurse manager. In establishing those competencies, the nurse managers' prime concern was their perception of having the most responsibility in their hospital, juxtaposed against their experience of very little leadership preparation for the role and its changing expectations.

This lack of preparation was echoed in Ireland in a study where the development of nurse managers was explored via a case study approach (Purcell and Milner, 2005). This showed that there was a wide divergence between the training and development that should be undertaken by nurse managers and what was actually undertaken. Most nurse managers reported a shortage of time to undertake development, a finding at odds with the recommendations of the Irish Report of the Commission on Nursing (Government of Ireland, 1998). This report stated that 'first line nursing and midwifery managers have to balance management skills with clinical credibility', this applying equally to hospital and community-based nurse managers (Government of Ireland, 1998, p.8).

The key conclusions of the research were that there was a considerable shortfall in nurse manager development, which needed to be rectified if the health care service in Ireland was to move forward. Although this research was a pilot study its outcomes concur with many of the studies found for this review.

In the UK, the RCN has undertaken investigations of the nurse manager role in order to ensure the role remains fit for purpose (RCN, 2009; RCN, 2010). Nurse managers reported having little training and education to prepare them for the role; 20% of those who responded had received no management or leadership training and a further 20% had not been on a training course in the previous year. All this despite the wide range of competence, knowledge and expertise required (Naish, 2009). Although not one of the specific recommendations of this study, many participants suggested that development programmes should be structured with coaching and one to one mentoring support.

A think tank convened by the Sawbridge and Hewison (2011) to respond to poor nursing care, concluded that nurse managers need to be developed and supported as leaders. This conclusion was reached after focus groups with leaders at a local and national level and a literature review of reports focusing on poor care. The importance of a strong nurse manager as a role model to students was identified and in particular, the need to set a culture where high standards of patient care can flourish. The lack of models of support for nurse managers was also identified.

This section demonstrates that there have been a number of reviews identifying how nurse managers should function within the changing needs of the health care sector but that many staff are still not supported through development programmes. Given this unsatisfactory position, and without change, it seems inevitable that this lack of development will hamper Governments' ability to change health care delivery as the leadership and management skills will not be present in the staff needed to most influence the change.

2.3.3 Types of development programme

Although the preceding section has evidenced the concern that not enough staff are able to undergo development programmes, it is useful nonetheless to review the research on the programmes that have been undertaken.

There have been a variety of tools developed to assess development programmes for first line managers (Skytt et al., 2008). These include the Leadership Practice Inventory (LPI), which has been used in two studies (Krugman and Smith, 2003; Tourangeau et al., 2003) and the Leadership Effectiveness and Adaptability Description (LEAD-Self and Other) instrument (Johnson and D'Argenio, 1991).

It has been suggested that development should be at a variety of levels and that this should employ training departments and training from executive level staff (Scheck-McAlearney, 2005). Building on this, a number of studies (Watson and Harris, 1999; McDermott, 2001; Scheck-McAlearney, 2005; Laff, 2006; Gumus et al., 2011) draw out the importance of clear support for leadership development. In addition, support for leaders is required and for this to be integral to organisational practice, not just a characteristic of the chief executive level.

The RCN undertook a multiple case study approach to evaluate their patient-centred clinical leadership programme (CLP) (Large et al., 2005) to improve patient care. One hundred and forty three qualitative interviews were used across sixteen case study sites along with a 360-degree leadership inventory to measure any changes in leadership capability during the programme. The main conclusion was that supporting nurses to develop leadership skills and in turn, develop their teams and enhance patient care at the same time is very challenging. The CLP enabled staff to develop a more patient-centred approach to care by better teamwork and, in an outcome relevant to this literature review, reported the value of mentorship for managers, providing strong leadership and good role modelling.

Lee and Cummings (2008) undertook a systematic review of nurse managers job satisfaction evaluating forty-eight articles from 1990 – 2006

to draw conclusions on the most effective manner to develop and support such staff. Weaknesses were identified in the twelve quantitative studies considered, spanning sampling, use of a theoretical framework and the analysis undertaken. However, the qualitative studies generally found the same results as the quantitative studies.

The finding most relevant to this study was that organisational support was found to be significantly and positively correlated to the job satisfaction of nurse managers. Highlighted in addition, was the importance of investing in the support given to nurse managers, to ensure maximisation of their job satisfaction and to allow them to undertake and direct their work more effectively. A similar emphasis on the importance of job satisfaction is to be found in the Johnson, Sonson and Golden (2010) study.

This section has identified a selection of the types of programme that have been used to develop managers and the value attached to their development. The following section will introduce clinical supervision and how this is used by and for nurse managers in their development.

2.3.4 Clinical supervision and mentoring

Within nursing, there is an expectation that staff undertake clinical supervision of others and participate in it themselves to improve their clinical skills and to maintain standards of care. All nurse managers will have been trained to be mentors of student nurses and in addition, may already mentor junior colleagues. As such they will be very familiar with mentoring and clinical supervision but not with the relationship of mentoring and clinical supervision to coaching. Therefore, although not a formal development programme in itself, clinical supervision is a significant type of development and as such is worthy of inclusion in this review.

One of the areas to emerge from the literature was the relationship between coaching, mentoring, clinical supervision and the manager as coach.

Factor	Manager as coach / Clinical supervision	Coaching	Mentoring
Coach/mentor	Learning and development Performance improvement Retention	Self-awareness Learning Behavioural change Performance improvement	Socialization Management development Understanding organizational politics
Coachee	Employees	Mostly executives and higher level managers	Lower level employees to high potential
Process	Less structured	Generally more structured in nature and meetings are scheduled on a regular basis	Mentoring revolves more around developing the mentee professionally and needs some advice, guidance or support
Focus	Partnership Communication Development of skills	Focus is generally on development / issues at work	Focus is on career and personal development
Duration	Ongoing	Relationship generally has a set duration	Ongoing relationship that can last for a long period of time

Table 2-1 Differences between coaching, mentoring and clinical supervision.

Both Jarvis (2004, p.20) and Joo, Sushko and McLean (2012, p.30) have usefully identified the relationships between the manager as coach, executive coaching and formal mentoring. Table 2-1 is a compilation of concepts from Jarvis (2004) and Joo, Sushko and McLean (2012) related to clinical supervision, coaching and mentoring.

Turning first to mentoring, it is used by organisations and individuals to develop staff and to enhance learning (Wanberg et al., 2003). It can be

used for the development of both skills and knowledge (Godshalk and Sosik, 2003) and is typically a long-term relationship (Joo, Sushko and McLean, 2012).

From this definition of mentoring, the different values placed on coaching and mentoring have been identified (Fielden, Davidson and Sutherland, 2009) in a study undertaken to examine the effect that coaching and mentoring had on leadership and career behaviours. This longitudinal study involved fifteen nurse managers, from six health care trusts, in the UK, the cohort being split into two groups, receiving either coaching or mentoring.

Both groups reported greater insight into the effectiveness of their performance and ability to negotiate. Self-esteem, self-confidence and improvements in the perception of their leadership skills rose for both groups, but was only significant in the mentored group. The coached group reported significantly more improvement in areas such as empowerment to achieve, organisational understanding and professional ambition.

The main conclusions to be drawn from this research are the value of both mentoring and coaching for nurse managers and the increased value of mentoring for junior managers as they start their role. The value of mentoring and coaching is significant given that all senior managers will have undergone training in being a mentor, as a requirement of being a senior registered nurse. However the paper does not state if any of the senior managers had undertaken coaching or been trained for coaching prior to study. This may have influenced the ability of the senior managers to coach the nurse managers.

This could be doubly significant given the fact there is some evidence to show that people do not know the difference between coaching and mentoring (Passmore, 2010; McNally and Cuningham, 2010). This needs to be borne in mind by those undertaking research into coaching, so that an understanding of the relationship between coaching and mentoring can be identified by participants. This potential knowledge gap must also be borne in mind when attempting to understand the national picture of nurse

manager development when identifying which organisations offer mentoring and/or coaching to their staff.

Confusion over terminology and concepts is further demonstrated through analysis of a number of articles published in the USA that describe using coaching in the same way that clinical supervision would be used in the UK. Houser-Carter (1992, p.111) illustrates the diversity of views about the role of coaching in the USA and states that it is 'not usually a formalised structured process' and occurs 'spontaneously in the work setting'. While this commentary seeks to advise readers on the work that is required in order to coach nurses, this description is more akin to the role of supervision in the UK and as such serves to identify how the nature of coaching is interpreted in different settings.

When considering clinical supervision within the UK, it is useful to observe that both the RCN (2004) and The Care Quality Commission (2013) have similar definitions of clinical supervision. In essence, it is an opportunity for staff to reflect on and improve their practice with a skilled colleague. More broadly, beyond health care, supervision is understood as a key role of first line managers, with 'performance-oriented supervision' being seen to sit alongside the numerous other management responsibilities of a manager (Hales 2005, p.501).

Use of a coaching style in supervision is discussed by Driscoll and Cooper (2005), Thornby and Pettry (2005) and Price (2009). As professional coaching is generally only provided to senior managers and executives in the NHS and clinical supervision is provided to many junior staff, the overlaps with a coaching technique in clinical supervision are notable.

In summary, since the 1980s much research has identified the need for comprehensive development programmes and support. However, repeated questions over the years to nurse managers reveal they are still not being invested in and do not have access to the very development required to undertake their role effectively.

The needs for support and development have been clearly identified but seemingly not fulfilled to the required degree. There is also a lack of clarity

on the national picture with regard to development programmes. This expectation – execution gap and lack of clarity emphasises the need for this study.

However, some organisations have identified the need for nurse manger development employing a variety of approaches. In addition, some studies have identified how mentoring and coaching can be part of this development either for managers to be coaches themselves or for them to be coached. The following section will examine this further through a review of the empirical evidence on how coaching is being used within nurse manager development.

2.4 Role that coaching has played in nurse manager development

Following on from the review of research looking at the development of nurse managers and first line managers, this section will focus on the role that coaching plays within their development. This will enable a clear view to be offered and assist in framing the context for the research being undertaken in this study.

In reviewing research articles for this section, it was found that there is minimal research on the value of coaching for nurse managers. Analysing the literature that does exist revealed a number of themes, used in turn to structure this section. These are: why coaching was initiated; the relationship of the coach and the common factors of coaching; outcomes of coaching; and coaching as part of a leadership programme.

2.4.1 Why coaching was initiated

The studies reviewed, both qualitative and quantitative, illuminate a variety of reasons for the provision of coaching. Many studies report that coaching had been initiated as part of a development programme while others that it was due to varied developmental reasons.

The use of coaching in a formalised manner was described in 1993 in the USA, identified by Patterson (1993) as being crucial to the development of nurse managers and assisting them in managing change. The reasons for seeking coaching were identified by Reid Ponte et al. (2006) and Byrne (2007) as: to gain help in thinking through a problem or relationship at work that was challenging; a potential career move; to address performance problems of staff in the workplace and to improve their leadership in this area; to maximise their skills and potential, and to enable them to become more effective leaders by helping them develop both personally and professionally.

The need for development into a new role as a nurse manager was identified in section 2.3.1. The value of coaching to help such a transition into a new leadership role as a first line manager, has been recognised by Charan, Drotter and Noel (2001), McDermott (2001) and Laff (2006). They identified the value of coaching as developing attitudes, abilities and values during leadership transition. The optimal time for this development to achieve advantage over competition was within the first 90-120 days of appointment according to Concelman and Burns (2006). They argued for the use of more experienced managers to undertake the coaching of juniors and for an in house cadre of coaches to reduce costs and enable a coaching culture to be developed and accepted.

However, as Bond and Naughton (2011) identified, there has been very little attempt made to evaluate the evidence for the benefit of using coaching as a development and support mechanism for transition into leadership roles. They also identified the lack of an agreed definition of a 'successful coaching outcome' (Bond and Naughton 2011, p.170). Taken together although these studies demonstrate some evidence for the use of coaching in role transition, it is not clear-cut, something this study aims to shed light upon.

The need for organisational support to prevent managers becoming ill due to stress and workload pressures is not new (Bright and Crockett, 2012). A post transition study (Haycock, Kean and Baggaley, 2010) found the emotional toll the role takes on managers along with feelings of lack of support, demonstrates the need for coaching to be undertaken before the

demands of the role make the leader ill. The main implications for practice were the need for managers to be supported more fully through coaching and mentoring. In addition, the importance of the need for a culture of better communication and support to ensure more effective leadership was identified (Haycock, Kean and Baggaley, 2010).

Coaching has been used in the arena of simulation to help nurses in their team develop life support skills for cardio-respiratory problems (Salman-Taie, 2011). The mixed methods research project assessed the effectiveness of training and coaching. Before training, nurse managers had very little insight into what coaching was and what skills were required. Following the test period, the nurse managers' knowledge of what coaching entails increased and the skills of the nurses who had been coached increased significantly, although no group was identified who had not received coaching, to act as a control. The key recommendations from this research were to conduct training for managers on how to be an effective coach, to introduce a coaching approach to training and to undertake further research on the effect of coaching nurses on the quality of patient care.

These studies have shown that there are a variety of reasons why coaching has been sought by nurse managers themselves or has been introduced by their employers. There is a consistent theme that coaching is seen as more beneficial when the organisation itself values nurse managers and their development. Thus, the support from their organisation appears important to nurse managers feeling valued, this support being a recurrent theme in many of the studies addressing coaching and nurse development programmes.

2.4.2 Relationship of the coach and common factors of coaching

A number of studies examined have established the importance of the nurse manager choosing the coach and of their relationship with the coach, both setting the scene for the success of the coaching. Alongside this, coach competence is important when one considers the type of coaching to be undertaken, which coaching model is to be used and the credentials of

the coach offering the service (Linley, 2006; Passmore, 2007). This section will address these areas.

There are a number of criteria used to identify a coach, usefully summarised in a study by Sparrow and Arnott (2004). These include personal style, cost, knowledge of the workplace, qualifications, and coaching experience. Of these the importance of the relationship, trust, and the expertise of the coach were judged as crucial to coaching effectiveness. However, the question of how to find the right coach for you is not an easy one for the uninitiated (Lane, 2010).

Reid Ponte et al. (2006, p.320) argue that the coaching literature identifies two competencies essential for the relationship to work: 'education and expertise in social behaviour sciences, and business expertise and knowledge within the client's working area'. The value of a non-judgemental and confidential coaching relationship allowing the manager to fully engage in the development process was also recognised. For example, Frisch (2001) and Wasylyshyn (2003) are among the authors to suggest that confidentiality is essential to the coaching relationship.

Recognising the importance of managers coaching junior staff, Kowalski and Casper (2007) discussed the importance of coach selection. They argued that it is important for a staff member not to be coached by their manager but by another senior manager so that the coachee does not feel intimidated. The study also addressed the use of reflection, disclosing the purpose of sessions and guidelines for a suggested action plan for each session. It concluded that coaching, although in its infancy for nurse managers, is valuable at all levels of nursing.

The common factors associated with coaching were those promoting effective methods for living, leadership and learning. To facilitate development, executive 'co–coaching' has been developed by Jumaa (2001, 2005) particularly from the work of Heron (2000). Rappe and Zwick (2006) used systemic consulting and neurolinguistic programming coaching techniques as part of a leadership programme. They found that managers who were newly appointed into leadership roles and who had received coaching to help their development demonstrated increased leadership

ability and competencies. They were also more able to act as effective role models and had improved interpersonal behaviour following the programme.

A Prosperity-Planning coaching model was used to develop nurse managers (Rivers et al., 2011). This mixed methods study used a transformational leadership approach to support nurses and to increase staff retention in critical care settings exhibiting compassion fatigue and where resilience needed to be increased. The findings showed significant changes in four areas: vulnerability to stress, satisfaction with family, satisfaction with life and reduced burnout. The interviews overwhelmingly reported that having a coach who was non-judgemental and consistent were the most important aspects of coaching.

From these studies, it appears that the coach–coachee relationship is fundamental for coaching to be effective. Staff need to be confident that the coaching they receive is confidential and to have confidence in the competence of the coach.

2.4.3 Outcomes from coaching

Positive coaching outcomes are valuable for employees and their organisations who invest time and money in their staff and want to see demonstrable benefits from this investment (Hawkins, 2012). Since coaching can be undertaken by anyone, research showing what outcomes result is a valuable addition to the literature. Despite this anticipated significance, this review has identified very little research examining the efficacy of coaching to enable organisational and personal change (CIPD, 2012).

Reid Ponte et al. (2006) and Kushnir, Ehrenfeld and Shalish (2008) have described the main benefits of coaching as: an effective way to change behaviours hampering performance in a role; consequent improvement in personal effectiveness and that of the organisation they worked within; training motivation; self-efficacy and skills acquisition.

Medland and Steinhauer (2009), DeCampli, Kirby and Baldwin (2010) report the value of coaching newly appointed nurse managers to help develop competency and capability in their role without the negative episodes associated with trial and error. This is echoed by Ponti (2009) where succession planning of nurse managers moving to executive level was carried out in a more formalised manner, with a key aspect of development being coaching, mentoring and providing opportunities for skill development.

Johnson, Sonson and Golden (2010) tested the usefulness of coaching in relation to a range of health care quality metrics, for example falls, acquired infections and patient satisfaction. The results showed that coached managers demonstrated quantifiable progress in knowledge and skills acquisition related to leadership, as well as improving metrics for quality. These metrics in turn were assessed in monetary terms: the reduction in falls saving $67k / £40k and reduced infection rates saving $115k / £69k. Although these represent considerable savings, the survey did not compare this with the amount spent on the coaching.

These studies show that coaching, as well as being beneficial to the coachee, is also beneficial to the organisation. This is an area that warrants the further investigation undertaken in the research component of this project, as it is one of the key determining points for organisations deciding whether to invest in coaching. This will be further discussed in section 2.5.2.

2.4.4 Coaching as part of a leadership programme

The development of employees to ensure their quality of work and their retention in the organisation has been identified as being key to a successful organisation (Joo, Sushko and McLean 2012). Consequently, many managers outside the health sector are introduced to coaching as part of a leadership programme where the value of coaching is seen as part of a bigger development programme (Watson and Harris, 1999; Loo and Thorpe, 2003; Yu at al., 2008). Given this, reviewing the literature in this area is useful to enable identification of how coaching is organised and woven into development programmes.

The importance of 'stepping off the treadmill' to review practice was identified through a phenomenological study undertaken with the aim of understanding the participants' experience of coaching, as part of the RCN clinical leadership programme (Mackenzie, 2007, p.2). These results indicated the need for managers to have a supportive work environment, sufficient resources, training and development, including mentoring and coaching for the role, and to be empowered to undertake the role.

Building on the concept of coaching within a leadership programme, the importance of coaching to enable new managers to make the links between what they are taught in the classroom on training programmes and how this is actualised in practice has been identified (Passmore, 2010; Bright and Crockett, 2012). In addition, coaching can enhance skills, develop awareness in new leaders, maximise their motivation to perform well in their new role and help them develop their confidence and self-worth in a new testing environment (Joo, Sushko and McLean, 2012). In their study of health care managers Yu et al. (2008, p.110) found that coaching was related to significantly improved 'proactivity, core performance, goal-attainment, self-insight, motivation, positive affect, and autonomy'.

Law and Aquilina (2013) researched the implementation of a nurse manager leadership programme. It included a comprehensive coaching component using a case study approach with an action research methodology. The coaching component was based on the GROW model (Whitmore, 2012). The managers reported enhanced self-awareness, ability to clarify personal strengths and enhanced professional and social skills. The results of the study were transformed into a health care leadership coaching model and illustrate the development of an authentic leadership style. The authors suggest that formal training programmes and individual and group coaching would improve managers' leadership skills. It was determined that individual coaching should form an integral part of any leadership programme. The value of 360-degree feedback was emphasised, working alongside the participants' own self-assessment and work with the coach.

This section has revealed that there are some empirical studies to support the role of coaching in nurse manager development. However, they are not

extensive and in some cases have been limited in scope and in their number of participants. Coaching appears to emerge within some training programmes but is also sometimes accessed independently of training. Whether the organisation offers support for nurse manager development and supports investment in coaching, appear to be important factors in determining whether nurse managers feel valued.

What appears to be important for an organisation is what outcomes are attributable to coaching. The literature reviewed here shows beneficial outcomes fall into two categories: the personal development of the coachee and secondly the ability of the coachee to undertake their role more effectively with consequent indirect improvements in patient care. These components of benefit are important themes for this study and will be further investigated in the qualitative interviews. As described in section 2.4.2 the identification of the coach - whether this is a line manager or someone remote from the organisation – is significant when coaching is available within an organisation's development programme. Again, this requires further investigation.

This review has examined evidence for coaching nurse managers and will now review coaching for more senior managers and its utility for this study.

2.5 Coaching senior managers

Senior managers have received coaching in both health care and business organisations for a number of years in the UK (Grant and Cavanagh, 2007; Lane, 2010), making the assessment of studies in this area a valuable addition to this literature review. Furthermore, senior managers are the very staff who make decisions about funding for first line manager coaching and their experiences will, no doubt, play a part in the availability and success of coaching for their subordinates.

Reviewing the small but growing body of empirical research on coaching for senior managers (Boyatzis, Smith and Blaize, 2006; Hawkins, 2008; Joo, Sushko and McLean, 2012), reveals a number of common themes: senior managers perceptions of coaching, outcomes of coaching and the

competence of coaches. These will be reviewed and analysed, so illustrating the extent of coaching already in existence.

2.5.1 The perception of coaching and coaches, by senior managers

How managers are developed in the health service is crucial to developing a modern and efficient patient-centred service (Sambrook, 2006). Hence it is important for this study to understand how coaching is perceived by them and is used within their practice, particularly as both coaching and mentoring are perceived to be popular with a number of executives and leaders (CIPD, 2012).

Sambrook (2006) and Locke (2008, p.106) have shown that senior managers see coaching junior managers as one of their roles and that 'the possibilities for development coaching in health care are limitless'. They reported that the informal learning that can occur during coaching might help alleviate problems associated with staff not being able to be released for whole days to attend formal training sessions. However, questions remain about the training managers receive to undertake this coaching role (CIPD, 2012).

Coaching has been seen to build resilience, reduce depression and increase workplace wellbeing in the public health sector (Grant et al., 2009). Aimed at enhancing leadership capability, their leadership programme consisted of 360-degree feedback, a workshop and four individual coaching sessions. Their key recommendations were for coaching to be in place for managers and for it to be available over a longer time periods.

The important role that senior managers have to play in supporting and developing junior managers is emphasised by Locke (2008). Coaching has been used to develop new managers' understanding of their own approach with staff and to gain insights into how to develop this to be most effective.
It has also been proposed that training on its own is not enough to maintain market competiveness and that developmental coaching could be key to bridging the gap between the training of management skills and the

practice in the work setting (Joo, Sushko and McLean, 2012). The importance of transition into a new management role is also echoed by Bossert (2005, p.18) who postulates that 'transition coaching helps a new leader immediately offer positive economic value to the company while preventing mistakes'.

The Institute for Employment Studies (IES) evaluated coaching in the NHS (Sinclair et al., 2008) using a twofold approach: developing the coaching skills of senior managers in the NHS as well as offering coaching to executive level staff. The broad objectives to emerge from the coachees were organisational change, difficult relationships, new roles, influencing staff and profile raising.

Interestingly there were no business objectives at the outset of the coaching. This is in contrast to the benefits that emerged from the coaching which were business-focused, including reduced staff costs and more profitable services development. The bigger benefits however were behavioural, including increased confidence, better management of teams, and having a more strategic and objective approach to their role. One coachee reported that 'I wish that everybody could have the experience that I had. I can put my hand on my heart and say that I had a superb experience which I would have been prepared to pay for' (Sinclair et al., 2008, p.dix).

Coaches reported that the main goals of their coachees were working through transition periods, deciding on priorities and managing relationships. Interestingly these findings echo those in nurse manager coaching research (Medland and Stern, 2009) indicating a commonality of benefit regardless of seniority.

Coached executives placed value on space to think and to test out new ideas with a person of similar experience. Learning at the organisational level was identified as the build-up of a valuable resource of senior staff who could coach and facilitate external coaches for executive level staff. Although benefits were apparent for both staff and their organisation, participants identified a challenge in how to realise the benefits against a background of time and funding constraints.

Having identified that some senior staff act as coaches, it is interesting to note that the competence of such individuals, both in business and health care management, has not been widely reported (Carter and Sinclair, 2011). An NHS development programme evaluated coaching competence using a self-review approach (Law and Ireland, 2006). It found that personal competence was a predictor of coaching/mentoring competence and that this increased with life experience and age. There was a correlation between personal and social and social and cross-cultural competences, reflected in a recommendation to include a cross-cultural dimension within a core coaching competence.

These studies indicate that while there is support for coaching by senior managers and that they receive coaching themselves; there is little evidence for how widespread this is within organisations.

2.5.2 Outcomes of coaching

Organisations are always interested in the return on investment for any activity (Hawkins, 2008), with chief executives increasingly looking to see that investment in coaching is giving tangible benefits to the organisation (Hawkins, 2008) not just contributing to the development of an individual. However, it has been suggested that coaching for new leaders has given variable results as measured by two approaches: return on investment and Goal Attainment Scaling, indicating benefits tests are best designed and agreed before leaders are appointed (Carter , 2006; Spence, 2007).

The NHS Institute has been using an evidence based coaching evaluation methodology since 2010 (Institute for Employment Studies, 2012), evaluating thirty-one top leaders in the NHS, pre- and post-coaching, using survey questionnaires and return on investment interviews. The majority of the leaders (72%) rated coaching most useful for making transformative changes rather than smaller incremental ones. 93% of leaders would recommend their coach to other staff desiring coaching. 79.3% reported that their coaching had benefitted the NHS by facilitating better positive outcomes and quantifiable benefits for patients.

Despite the findings acknowledging that some of the improvements may not all be attributable to the coaching itself, with other factors in play, the key benefits to the NHS were seen as increased organisational effectiveness and efficiency followed by staff engagement and retention. One leader reported that 'our approach in the organisation is all about (patient) benefit'. The tone is set from the top and the 'coaching helped me to set the tone' (Institute for Employment Studies, 2012, p.4). The main reasons for commencing coaching were recorded as being to increase self-awareness and self-confidence, considerations of how to manage complex and politically sensitive situations, relationships with other organisations and managing change.

Coaches were asked to provide feedback reporting that their clients made improvements in their readiness to change and in their understanding of their own and organisational development needs. They also felt that resilience, self-awareness and self-confidence of the leaders they were coaching had all improved.

A final stage evaluation of the National Leadership Council's (NLC) Emerging Leader Workstream Executive Coaching Skills Programme (Carter and Sinclair, 2011) gives more detail on the effectiveness of the coaching programme offered by the National Leadership Council. The key recommendations drawn from the evaluation were to promote the benefits of coaching more widely to overcome some resistance found; to promote coaching to emerging leaders and not just executive level staff; to ensure that coaches take up supervision for themselves; and to put in place regional evaluation of return on investment.

There were also useful conclusions drawn for future coaching programmes in the NHS. These included: that there could be a choice of coach; consideration of whether the coach is too near to the staff member and a more distant senior manager may be required; and whether there is potential for conflict of interest if the coach is from a part of the organisation that is affected by what is being disclosed by the client. Conclusions were also reached on the background of the coach and the need for the coach to be credible; the importance of the venue being away from the client's workplace; and for more senior level backing for coaching.

Return on investment was measured in this evaluation, presented as a series of case studies. Each case study was able to articulate that the money spent on coaching enabled the client to either manage projects more effectively or deliver a service change that was more effective than expected. The clients directly attributed their ability to undertake these tasks to the coaching they received. The coaches interviewed for this report were all from the NHS and reported that the benefit they found from coaching staff included adopting a more coaching style of management towards their own direct reports.

The NHS has explored the use of coaching to support team working by using a case study approach (Woodhead, 2011). The research took a social constructionist perspective using a qualitative methodology to observe and question managers in one NHS Trust Department. The data collected was analysed using an interpretative phenomenological technique.

It was suggested that the coaching enabled staff to work more productively to break down barriers, develop better interpersonal skills and get to know each other much better. This in turn led to more effective planning and strategy development for the department and a realisation, somewhat surprisingly for some staff, that they all wanted the same goals.

This research evidence has shown that coaching is used for executive and very senior level managers in business and health care. It has been shown to have an impact on the performance and the ability of senior managers to achieve goals and outcomes. What does not appear so clearly is whether in turn these positive experiences lead to coaching being supported for more junior staff, including nurse managers.

2.6 Focus for the research

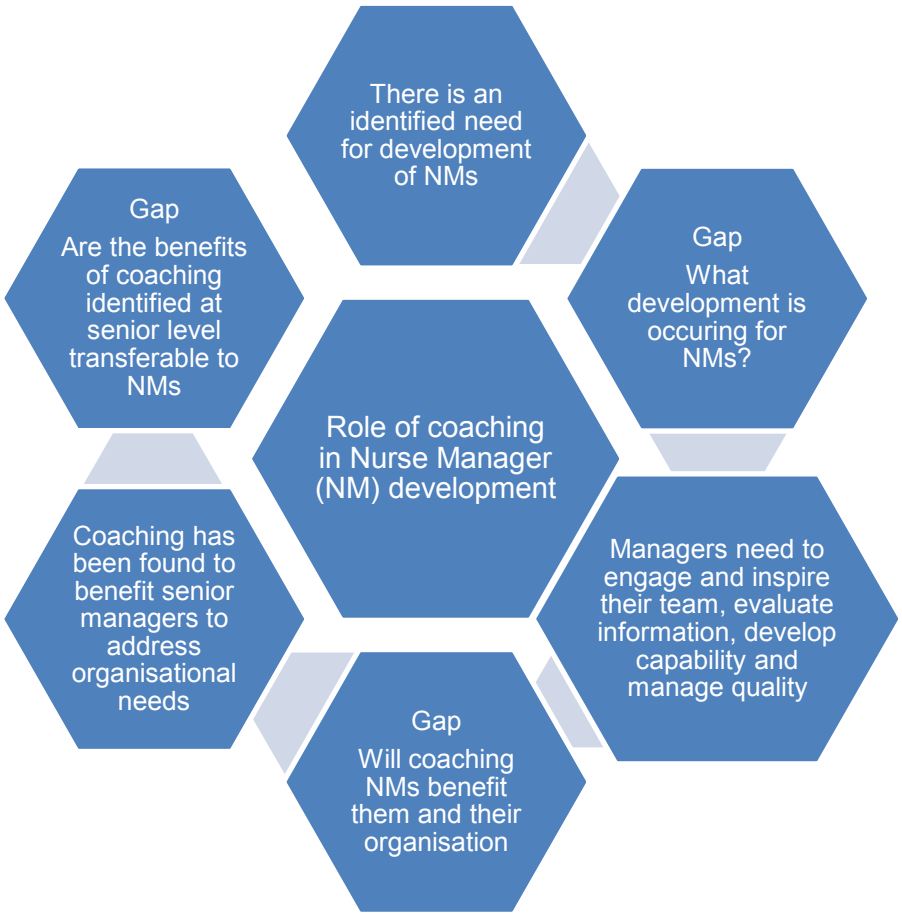
This review has shown there is some understanding of how coaching may play a part in the development of nurse and first line managers but that this is an area that is under-developed with a sometimes confusing overlap with clinical supervision and mentoring.

Much of the previous empirical research has been undertaken on nurse manager development and on executive level coaching in the health arena. However, little empirical research has been identified in the specific area of coaching and nurse manager development, despite there being a need for increased development for this group of staff. This research therefore seeks to investigate this area.

Taken overall the key themes to emerge from the review are:

1. The perceived need for the development of nurse managers but the lack of such development identified in many studies.
2. The lack of a national picture of nurse manager development.
3. The perceived value of coaching for senior managers in the business and health sectors but the paucity of empirical evidence of coaching value for first line managers in business and health
4. Coaching benefits have been identified as influencing the coachee personally, their management and leadership skills and to benefit the organisation.

Figure 2-2 Conceptual framework.



From these themes the gaps that emerge in the literature are:

1. How and when coaching should play a part in nurse manager development and whether coaching this group of staff will benefit them and their organisation?
2. What development nationally is occurring for nurse managers?
3. Whether the reported value of coaching executive level staff in the health sector, is transferable to the nurse manager level?

For over thirty years, there has been a clearly identified need for more effective development of nurse managers. However, if such development does occur, what does it currently comprise and what role does coaching play? These questions have led to this study developing a conceptual framework; see Figure 2-2 to inform its empirical methodology.

This study will research these gaps by ascertaining the national picture of nurse manager development, the role that coaching is currently playing in nurse manager development and the experiences of staff who have had coaching. It is hoped that the results of this study will contribute to discussions on the role that coaching may play in the future support and development of nurse managers and lead to recommendations for practice and policy makers.

The following Chapter 3 will explore the philosophical standpoint for this study and articulate the journey taken to arrive at this methodology.

Chapter 3 - Methodology

3.1 Introduction

This chapter will explore the philosophical foundations for this study and articulate the journey taken to arrive at its methodology. It will describe how the survey and interview components of the study were undertaken, including information on sample selection, data collection and analysis. The key issues that arose and the links between these and ethics and reflexivity will be discussed, along with the application of appropriate quality measures.

3.2 Philosophical foundations

My research journey has found that there are a variety of paradigms, methodologies and strategies that can be used in research. The requirement in any research project is to decide which paradigm and therefore, which methodology is best suited to the research in question (Morgan, 2007). Reflecting that Weaver and Olson (2006) suggest that no one paradigm is superior to any other, I set about trying to determine my own paradigm. Table 3-1, based on Crotty's (1998) framework and adapted from Morgan and Smircich (1980) and Welford, Murphy and Casey (2011), was devised to help identify my position in this study. My perspectives are identified in bold in Table 3-1.

Taking each component of Table 3-1 in turn there seem to be two opposing paradigms, positivist and constructionist, in relation to which Sandelowski (2001) says that no blurring between the two beliefs is possible. However, I believe that both are compatible, depending on the type of research being undertaken and discounting one or the other does not enable the inclusive standpoint that I have worked with in my health care career (Green and Thorogood, 2013).

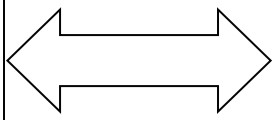
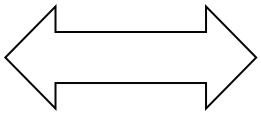
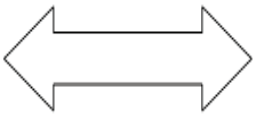
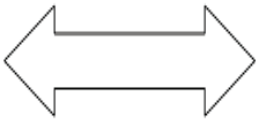
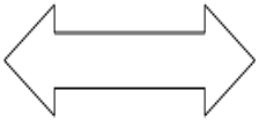
Axiology – ethics (right and good)	Subjectivist Phenomenology Interpretive alternative **Constructionist**		Objectivist Positivist
Paradigm	Qualitative Phenomenological Humanistic Interpretivist **Pragmatist**		Quantitative Scientific Experimentalist Traditionalist Functionalist, Empiricist
Ontology	Reality as a projection of human imagination Nominalism, Idealism Relativism, **subtle realism**		Reality as a concrete structure, Realism Materialism
Epistemology	Anti-positivism Constructionism Social constructionism Interpretivism, hermeneutics	 **Pragmatism**	Positivism
Methodology	Grounded Theory Case Study Phenomenology, Ethnography Ideographic **Thematic analysis** **Mixed methods**		Experimental Manipulative Scientific verification of hypotheses Nomothetic
Research implications	Interaction **Value laden** No cause and effect No Hypothetico-deductive reasoning No Operationalisation No reductionism		Independence Value freedom Causality Hypothetico-deductive Operationalisation Reductionism Generalisation

Table 3-1 Table to illustrate philosophical approaches.

(Adapted from Morgan and Smircich (1980); Crotty (1998); Welford, Murphy and Casey (2011).

My own paradigm is a mixture of positivist and constructionist, which may sound like a paradox. However, I believe that some elements of a positivist perspective, e.g. 'knowing about the world is an end in itself and is intrinsically valuable', is equally as valuable as a constructionist perspective of 'knowing as a means of social emancipation which as an end in itself is intrinsically valuable' (Lincoln and Guba, 2000, p.172).

Axiology is relevant to qualitative research as it has a direct bearing on the ethical perspective of research (Given, 2008). It is often considered alongside ethics as it represents what is valuable in the world with regard to knowledge and where the researcher stands from the moral viewpoint in terms of what is right and wrong. My own morals have developed during more than three decades of working in health care and are deeply embedded in codes of health care ethics from regulatory bodies and my own inner belief to do the right thing. Therefore, consideration of axiology allowed me to reflect more fully on the nature of the research required and the questions asked.

Ontology is related to one's beliefs about the nature of the world and what is said to exist in it. Wand and Weber (1993, p.220) discuss ontology as 'a branch of philosophy concerned with articulating the nature and structure of the world'. In understanding my own ontological view, there appears to be three philosophical perspectives - those of realism, materialism and idealism - and a newly emerged perspective of subtle realism Lincoln and Guba (2000).

The subtle realism perspective seems to be most aligned to my own view as it accepts the view that social phenomena exist independently of peoples' depiction of them and suggests that gaining an understanding of these views is best gained through obtaining individuals' perspectives (Mays and Pope, 2000). I accept that people's view of the world is socially constructed but I also recognise that some aspects of social phenomena also occur independently of peoples' depiction of them.

Epistemology asks the researcher to question their relationship to what they know and what can be known and how that is differentiated it from our own views and opinions. According to Hirschheim, Klein and Lyytinen

(1995, p.20) the word epistemology denotes 'the nature of human knowledge and understanding that can possibly be acquired through different types of inquiry and alternative methods of investigation'. Having read health research during my career I can appreciate the importance of quantitative studies, for example in determining new drugs or gene therapy, as well as constructionist research, for example gaining a full understanding from a patient perspective of what it is like taking a new drug or how gene therapy may affect them psychologically.

Therefore, I prefer the view that there is a continuum between qualitative research and quantitative research and that quantitative research is at the positivist end of the spectrum whereas the qualitative research is at the social constructionist end (Green and Thorogood, 2013). Both lead to enquiry and can coexist as they both require consideration of what research question is to be answered at the outset (Gabor, Unrau and Grinnell, 1998).

From these deliberations, I came to understand and embrace the concept of pragmatism as 'pragmatism is not committed to any one system or philosophy and reality' (Cresswell, 2003, p.12). Pragmatism admits the value of both quantitative and qualitative research. It reasons that there is no better or worse way to develop knowledge and no reason to suppose that quantitative and qualitative methods have to be in opposition to each other (Houghton, Hunter and Meskell, 2012).

The Fishman (1999, p.83) analogy is useful - likening the pragmatic approach to using different pairs of glasses each selected according to which pair 'is most useful in meeting our particular, practical goals in that situation'. This also resonates with Cherryholmes (1992, p.16) view that 'pragmatists also believe that we would be better off if we stopped asking questions about laws of nature and what is really "real" and devoted more attention to the ways of life we are choosing and living when we ask the questions we ask'.

Viewing the world from a pragmatic perspective, I set about understanding which methodology would be most appropriate for my research question.

3.3 The path taken to the methodology

Methodology asks how researchers can go about finding out what they wish to know, in this case how coaching is being used in the development of nurse managers. A variety of approaches were considered (see Figure 3-1) including pure quantitative measurement using a variety of tools, such as pre- and post-coaching resilience measurement.

However, a pure quantitative approach would have precluded gaining insights into the experiences of nurse managers who had received coaching and if those experiences corresponded with my own. This desire either to assess the applicability of pre-existing knowledge and/or to gain new insight led to a more social constructionist stance, to determine the lived experiences of these staff and what had, or had not, made a difference to them. Therefore, a variety of routes were explored while the methodology was being determined that would be best suited to the study questions. These included action research, case study, grounded theory etc., see Figure 3-1.

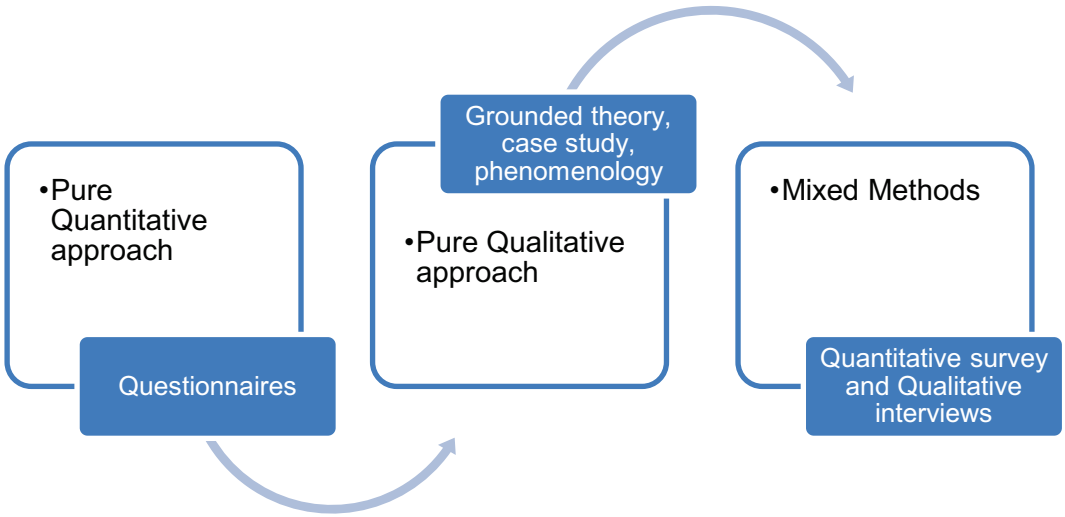


Figure 3-1 Illustration of methodological decision-making.

There was concern that with a purely phenomenological approach, the data collected would have produced very rich narratives of individuals but it

would not deliver a broad view of coaching in the development of nurse managers in the UK and from the desired range of perspectives.

The use of a mixed methods methodology was then considered, utilising a variety of approaches in respect to two objectives of the study: creating a wider contextual overview of the situation and evaluating a first person perspective from nurse managers themselves. Robson (2002) and Tashakkori and Cresswell (2007) summed up the choice of methodology by commenting that the research strategy and the methods used must be appropriate for the questions you want to answer. Therefore, the methodology should be inevitable and be able to integrate the findings from both qualitative and quantitative approaches in a single study. These deliberations led to Objective no 2: to explore empirically how coaching is used in nurse manager development on a national scale, requiring a quantitative approach and Objective No 3: to explore empirically the experiences of nurse managers who have received coaching, requiring a qualitative approach.

However, from the philosophical position of subtle realism we can only know reality from our own perspective. Therefore, even quantitative data in the mixed methods approach cannot be seen as 'hard data' reflecting the objective reality. These data was being used to describe the context for qualitative data, while describing the experiences of nurse managers in line with my view on the nature of knowledge. Accordingly, the decision was made not to engage in a full-scale statistical analysis for Objective 2, which would be more suitable for a positivist position on knowledge development, but to use quantitative data only for illustrative purposes.

Further investigation of the literature on mixed methods studies was undertaken to support the decision to use mixed methods. It is suggested that mixed methods research enables questions to be answered that could not have been answered by one approach alone (Tashakkori and Cresswell, 2007; Teddlie and Tashakkori, 2009). Additionally Sale, Lohfield and Brazil (2002) argue that a combined approach is useful in areas such as nursing where the phenomenon is complex and in which a wider range of perspectives is needed.

The explanation of findings can be enhanced by, for example, using a qualitative approach to follow up findings from a quantitative survey. Bryman (2007, p.11) suggests this is akin to 'putting meat on the bones' of a dry quantitative study. Hypotheses can also be more fully tested by using this follow up approach, for example, using a qualitative approach to determine questions that can be used in a quantitative survey.

Although the concept of mixed methods and the language used to describe it, is comparatively new (Doyle, Brady and Byrne, 2009), it was a useful methodology. It bridged both strategies, giving flexibility and allowed development of recommendations for future research and implications on future practice. Doyle, Brady and Byrne (2009) expanded on the five reasons for undertaking mixed methods research designs: triangulation, complementarity, development, initiation and expansion - the latter having been derived by Greene, Caracelli and Graham (1989).

Cresswell and Piano-Clark (2007) advocate that there are three main decisions that need to be made before choosing the type of mixed methods design:

1. Whether the qualitative and quantitative components will be undertaken sequentially or concurrently.
2. Whether both methods are given equal weighting.
3. Whether there will be mixing of the qualitative and quantitative components.

The four designs from Cresswell and Piano-Clark (2007) are the triangulation method, the embedded design, the explanatory design and the exploratory design. This is in contrast to the two phases of partially mixed methods and fully mixed methods from Leech and Onwuegbuzie (2007).

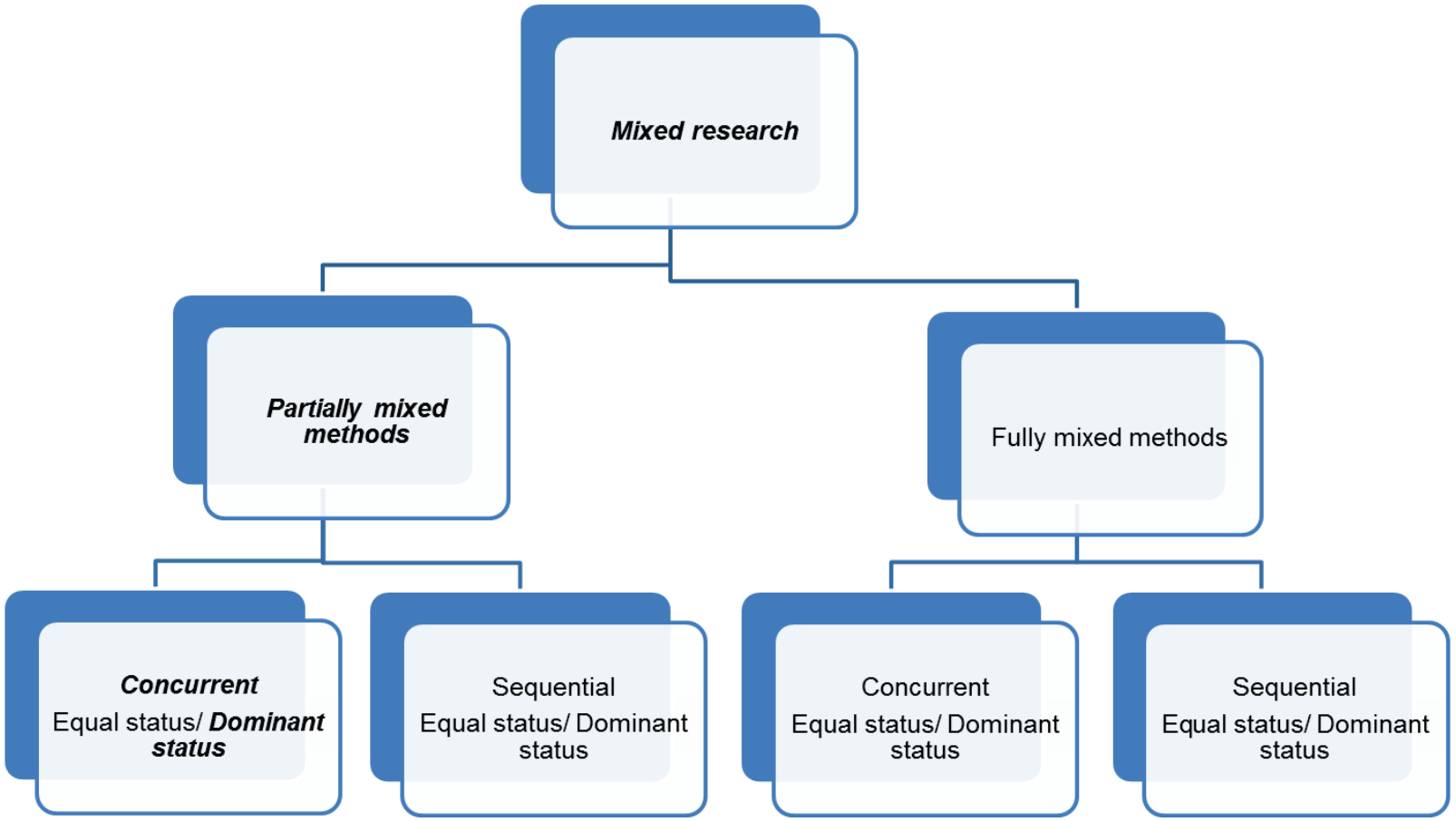


Figure 3-2 Adapted from Leech and Onwuegbuzie (2007, p. 269).

For this study, a hybrid of the embedded design from Cresswell and Piano-Clark (2007) was chosen, similar to the partially mixed methods concurrent design with dominant status of Leech and Onwuegbuzie (2007). The two types of mixed methods approaches were reviewed and it was determined that the approach to be used in this study fitted very well with the 'concurrent travelled but dominant pathway'. The bold italic letters in Figure 3-2, adapted from Leech and Onwuegbuzie's typology of mixed research (2007, p.269), identify this pathway.

The triangulation design allowed also for both qualitative and quantitative components to be given equal weighting - very similar to the fully mixed methods design of Leech and Onwuegbuzie (2007). The embedded design was judged most suitable because it is typified by having one more dominant method with the other data set providing a supportive role.

Two embedded designs exist, these being experimental and correlational (Cresswell et al., 2003). The experimental design has been used for quantitative studies with a qualitative section embedded within them. In this study, a different approach is planned using a qualitative method with a quantitative survey embedded within this. This embedded design can be described as a variant on the standard embedded approach being very similar to Leech and Onwuegbuzie's (2007) partially mixed methods approach using concurrent data collection with one data set being more dominant than the other.

Thematic analysis was used to draw out themes common to all interviewees, along with a quantitative survey to gain a national perspective on nurse manager development. Once it had been determined that the mixed methods approach, using thematic analysis, was most suitable to the research question, it was identified that a quantitative survey approach was most suitable to ascertain the quantitative components of objective two, to explore empirically how coaching is used in nurse manager development on a national scale. Likewise, methodological research indicated the use of a qualitative study to examine objective three, to explore empirically the experiences of nurse managers who have received coaching.

3.3.1 Research plan

The study design was in two stages, undertaken in parallel. Stage one, the survey, was determined by objective two and involved the design and administration of a survey. Stage two, the interviews, were qualitative interviews and were determined by objective three.

Each stage will now be explained in detail.

3.3.1.1 The survey

There is no national picture of nurse manager development or the role that coaching is playing in this development, across the four countries of the UK. Therefore, the main goal for the survey was to gain a national picture of the development in place currently for nurse managers, what this development comprises and what role, if any, coaching plays in it. The survey was designed using an iterative approach, by defining the aim of the survey, drafting questions and piloting these to identify their value and relevance before finally determining the survey structure (Crabtree and Miller, 1999; Clifford, 2013).

The following comparisons addressed the aims of objective two.

- The number of nurse managers with access to a development programme.
- The range of development and support offered to the nurse manager compared to number of nurse managers.
- Whether there is a link between development and coaching being offered.
- The type of organisations who offer a development programme.
- What type of organisation offers coaching as part of development.

The choice of using an online survey was determined by several factors. The value of online surveys has been shown by Evans and Mathur (2005). If undertaken correctly they are quick and efficient to administer, a key advantage over other formats such as postal surveys. Walker (2013) identified that online surveys have the advantage of speed and that a link to a survey via an email can elicit responses more quickly than by post. However, even in 2001 Sheenan (2001) identified that online survey response rates had started to drop and this is possibly due to the high

traffic in spam emails (Waters 2009, p.1) 'where more than 97% of all e-mails sent over the net are unwanted'. An added benefit to online surveys is that they can be quickly and anonymously circulated to the most relevant person when sent to an organisation. Following completion, the results can be collated quickly and transferred into secure databases without the concern of transcription errors.

The questions were arranged in a logical manner and were derived by reference to the insights gained from the literature review – see Table 3-2.

Survey Question	Relevant literature
Is a development programme offered	Loo and Thorpe (2003); McKenna, Kenney and Bradley (2004) and Pitkanen et al. (2004); Royal College of Nursing (RCN), (2009); Chase (2010),
Is the programme offered prior to becoming and nurse manager	Purcell and Milner (2005); Spence (2007)
What support is available on appointment	Pembrey (1980); Ogier (1982); Lathlean (1986)
Is coaching available for nurse managers	Reid Ponte et al. (2006) ; Byrne (2007); Bond and Naughton (2011); Law and Aquilina (2013)
Who are the coaches and are they	Concelman and Burns (2006)
Is the coaching evaluated	Sinclair et al., (2008) ; Medland and Stern (2009)

Table 3-2 Derivation of survey questions.

The survey was accompanied by an explanation of what it was designed to cover (see Appendix 4 for the survey). The first part allowed data on the size of organisation, the number of staff employed and the number of nurse managers employed, to be collected.

3.3.1.1.1 Survey pilot

Neale (2009) talks of the value of piloting a survey and asking the pilot group to comment on how easily questions are understood, whether the content is suitable, and whether it is presented in an easy to use manner. Neale (2009) also states that if, following the pilot, there are numerous changes then the survey should be piloted again.

The ten people chosen for the pilot group reflected a range of expertise, including directors of nursing, academics with survey expertise and practice colleagues. From the ten approached, seven responded, including the South Central Strategic Health Authority Leadership Team, who funded the survey tool. The comments were incorporated into the final version of the survey.

Gaining an understanding of whether the questions were clear or not and whether the survey appeared too long or too short was crucial. The colleagues asked to complete the survey, are all very busy senior nurses and a long survey would take up a great deal of their valuable time and so may be off putting. As well as addressing survey clarity and length the pilot group were asked whether there were any other questions that should have been asked and also if there were any other comments they wished to make.

All understood the content of the questions. There was advice about rewording a few questions in case they appeared ambiguous, for example the terminology for nurse manager. This response chimed with the ambiguity previously discussed in the literature review (Chapter 2) and echoes the transition of ward sisters to nurse managers in the last 15 years (Bradshaw 2010). So, when designing the survey, for clarity the phrase nurse manager was explained as meaning ward sister, charge nurses and community team leaders.

3.3.1.2 The interviews

Stage two, the interviews, was run in parallel with the survey and comprised qualitative interviews with, initially, just nurse managers. The interviewees were then broadened out to include directors of nursing and coaches of nurse managers to fully embrace the phenomenon of coaching of nurse managers.

The interviews were based around semi-structured questions (Crabtree and Miller, 1999). The questions were determined following the identification of the conceptual framework, which identified the gap in knowledge about the coaching population. Table 3-3 illustrates examples of the literature used to guide the formation of the questions, which were piloted before being used on the first interviewee.

The semi-structured approach was used to allow for further questioning on any aspect and to allow the interviewees to give free flowing answers (Harding, 2013). By contrast, an unstructured approach was not deemed as useful as I wished to examine consistently a variety of themes within the interviews and an unstructured interview would have been inhibited with this approach.

	Question	**Author**
2	**Before coaching started**	
A	What led to you receiving coaching in your role?	Condman and Burn (2006); Reid Ponte et al. (2006); Carter and Sinclair (2011)
B	Did you have a chance to choose your coach and how did you chose him/her?	Carter and Sinclair (2011)
C	What did you know about coaching before you started working with a coach?	Savage (2001)
D	What were you expecting of coaching and what were you expecting of your coach?	Medland and Stern (2009)
3	**The process of coaching**	
A	What type of coaching did you receive? E.g. was it in a group, or one to one, did you have tasks to complete, how many sessions did you have and over what period of time?	Medland and Stern (2009)
B	Examples of issues you brought to your coaching sessions.	Reid Ponte et al. (2006)
C	Examples of how your coaching and coaching relationship developed.	Sparrow and Arnott (2004)
D	What was easy and what was difficult during coaching?	Kowalski and Casper (2007)
E	What have you noticed about your role during coaching?	Kushnir and De Campli (2008); Carter and Sinclair (2011)
4	**After coaching**	
A	What changes you may have noticed in your nurse manager role following your coaching.	Kushnir and De Campli (2008); Carter and Sinclair (2011)
B	Have these changes impacted the organisation? If you had a chance to have coaching again, what issues would you take to work on with your coach?	Sinclair et al. (2008); Carter and Sinclair (2011)
C	What are your views on the role of coaching in nurse management development in your organisation?	Reid Ponte et al. (2006)

D	Do you know of other staff who have had coaching?	Lee and Cummings (2008)
E	Have you undertaken any other development programme as a nurse manager?	McKenna (2004); Gumus et al. (2011)

Table 3-3 Derivation of semi-structured interview questions.

3.4 Sample and recruitment

This section will describe how interviewees were recruited and illustrate some of the issues faced in the recruitment of nurse managers, coaches and directors of nursing to be interviewed and of recruiting directors of nursing to undertake the quantitative survey.

Four groups of people were used on which to base the study. These were directors of nursing for the survey and for the interviews nurse managers, coaches and directors of nursing. Bryman (2007, p.416) suggests to 'sample in terms of what is relevant to and meaningful' for the study. Applying this advice meant it was therefore key that the nurse manager interviewees had experienced coaching and that the coaches had coached nurse managers (Morse, 2007) so they could share their own experiences and also to be part of the rich data gathered on the phenomena. Directors of nursing were chosen to both receive the survey and also to be interviewed, as they are the lead nurse in an organisation, possessing an overall understating of the nurse manager role and development needs.

A probability, stratified sampling approach was used to recruit directors of nursing to the survey (Crabtree and Miller, 1999). This was undertaken by using databases of email addresses of directors of nursing from across the United Kingdom. Directors of nursing were emailed initially to request their participation in the survey and then followed up twice. Personal introductions were used within the emails following support for the research from South Central Strategic Health Authority, Leadership Foundation, the Welsh Department of Health, the Royal College of Nursing and senior nurses in Scotland.

There are approximately 200 NHS Trusts. However, gaining access to contact emails for the directors of nursing for all of them proved problematic and so a total of one hundred directors of nursing were approached across

the UK as being representative of each region and country. Thirty-three undertook the survey.

For the qualitative interviews, a 'non-probability approach' to sampling was used. Sampling was purposeful with an element of snowballing and convenience sampling methods (Robson 2002, p.264). Interviewees were either recruited through adverts placed at key nursing conferences, a research blog in the Nursing Times, personal links, through information received in the survey and by word of mouth and Twitter (see Figure 3-3). The criteria for participation were that nurse managers were nurses who had received coaching whilst being a nurse manager and who were willing to share their experiences. The criteria for recruiting directors of nursing were that they were willing to share their views on nurse manager development. Coaches were recruited who had directly coached nurse managers.

Figure 3-3 Recruitment of interviewees for the interviews.

Following the recruitment techniques above, individuals approached me to participate. All interested interviewees received an information sheet about the study and a consent form so that they could make an informed choice as to whether or not to be a participate in the study (Clifford, 2013), (See Appendices 1 and 2).

A total of eleven interviewees, who had received coaching whilst being a nurse manager, were recruited and followed through to interview. During

the interview process it became clear that gaining the perspective of a number of coaches and also of directors of nursing about the role of coaching for nurse managers would enrich the data and fulfil the criteria for case study research more fully. Therefore, further recruitment was undertaken that produced five interviewees who had coached nurse managers and five interviewees who held the post of directors of nursing.

3.5 Background data on the interviewees

The nurse manager group comprised staff who had been nurse managers for between two and five years when they received coaching. The group comprised ten women and one man and they worked in health care organisations in England, Scotland and Wales (see Table 3-4). Although the lack of male interviewees could have been a concern, the responses of the male interviewee were similar to all the female interviewees and so I did not view the absence of more male interviewees as a negative feature.

All the coaches and directors of nursing interviewees were female. The majority of interviewees being female reflect the gender spread within nursing, with approximately 90% being female and 10% male (NMC, 2008a). The coaches worked in England, Scotland and Wales and the directors of nursing worked in England and Scotland. No volunteers came from Northern Ireland.

All interviewees have been given pseudonyms for the purposes of relaying their responses in the research findings, with some pseudonyms being applicable to male or female so that the one male interviewee cannot be easily identified (see Tables 3-4 and 3-5 for pseudonyms). Where there is a name that can be male or female in the results chapters the word they and their has been used instated of he or she.

Pseudonym	**Length of time as an nurse manager**	**Age range**	**Type of health care organisation**
Jane	5 years	20-30	Acute Trust
Alexis	10 years	50-60	Community
Lesley	8 years	30-40	Acute
Julie	5 years	30-40	Mixed acute and community

Pauline	3 years	20-30	Acute
Val	4 years	20-30	Acute
Sandy	2 years	30-40	Mixed acute and community
Dale	3 years	30-40	Acute
Chris	4 years	30-40	Acute
Jo	4 years	30-40	Acute
Fran (pilot)	5 years	30-40	Mixed acute and community

Table 3-4 Background information about the nurse managers.

Coaches	Emma, Jadyn, Jess, Pam, Paula. Mixture of NHS employed and independent coaches.
Directors of Nursing	Beth, Denise, Helen, Kayla, Marie. Mixture of acute and community NHS Trusts.

Table 3-5 Pseudonyms of the coaches and directors of nursing.

Interviews were undertaken by phone or face to face. The advantage of phone interviews became clear when it allowed the cohort to include respondents from England, Scotland and Wales when traveling long distances was not possible.

Three of the directors of nursing and one of the coaches were known to me and this could have led to a potential limitation. However, review of the transcripts showed that the interviews were conducted - and views expressed - in the same professional manner as the interviews with people I did not know.

The sampling strategies used to recruit interviewees proved to be valuable. However, there was a concern that only nurse managers who had received a positive outcome from coaching would have been recruited. This proved to not be the case with some interviewees being sceptical about the role of coaching.

3.6 Data collection

3.6.1 Data collection for stage 1

The survey was administered using Survey Monkey. The Survey Monkey tool was only accessible to me so ensuring that only I was able to insert questions and view answers thus maintaining confidentiality (Clifford, 2013).

3.6.2 Data collection for the interviews

Interviews have been found to be a reliable way to try to appreciate people and are amongst the oldest methods of collecting data (Holloway, 2008; Al-Yateem, 2012; Clifford, 2013). The interviews were undertaken either at a location suitable to the interviewee or on the phone and were digitally recorded. They were undertaken in line with best practice ensuring confidentiality, ease for interviewees as much as possible and a professional approach (Green and Thorogood, 2013).

A pilot interview was undertaken (Fontana and Frey, 2003) enabling the questions to be trialled and alterations made. It also showed the importance of making sure that the equipment was working properly as the recording machine broke in the pilot interview. To ensure that the interview data recording was not entirely reliant on technology, bullet point notes were also recorded while undertaking the interviews. An example of the utility of the semi-structured approach was the value of enquiring in more detail about potential examples of 'return on investment' that became obvious in one interview and then was enquired about in all subsequent interviews after this.

The importance of trust and of building a quick rapport with the interviewee was vital to ensuring open answers to questions (Zinkin, 2008). My background in nursing and as a coach was useful in this respect and my many years' experience of being able to put patients or coachees at ease very quickly proved very useful. Techniques advocated by Al-Yateem (2012) were used: arriving early for the interview; having equipment that was fully functioning but as inconspicuous as possible; explaining everything as clearly as possible; and selecting an appropriate setting.

The interview questions were semi-structured in the following sections:

a) Introduction
b) Before coaching started
c) The process of coaching
d) After coaching
e) Summary and end of interview

As with many interview processes much of the rich data was collected near the end of the interview with the interviewee being very relaxed and wishing to share many of their experiences.

3.7 Ethics

This study adhered to the three dimensions identified for ethics in research; procedural, ethics in practice and professional codes (Guillemin and Gillam, 2004, p.263). The professional code applied in this study, being a registered nurse governed by the Nursing and Midwifery Council Code of Conduct (2008) was to act with integrity and honesty. Additionally, this code has been applied in this research to all aspects of the data collection process. Within a health care context, there was also a responsibility should any safeguarding issues have been mentioned.

From the procedural perspective, both the survey and interview components of the research were approved by Oxford Brookes University Research Ethics Committee.

The survey component of the research, although anonymously completed, could have led directors of nursing to be concerned as to what would happen to the data and perhaps to have concerns on full disclosure about their own organisational development. This was mitigated by designing very factual, non-threatening questions, which primarily elicited data without asking for details identifying the organisation. No staff member that was contacted replied to say they were uncomfortable about completing the survey and apart from two follow up emails to seek interviewees there were no other methods used to unduly influence respondents.

One to one interviews can present ethical issues and these need to be recognised in ‘ethics in practice’. Because the questions were relating to the person’s own experiences they could have been seen as intrusive and

also could have potentially breached health care worker's ethical codes of confidentiality. To mitigate this, the interviewees were advised that if they wished at any point not to answer a question or to retract anything they had said, this was acceptable. If names and organisations were mentioned during the interview recording, they were removed from the transcript, so that the interviews of each transcript did not breach confidentiality.

When asking for examples of issues taken to coaching or that coaching helped staff deal with, interviewees were advised to not disclose any confidential information relating to individuals or organisation. Again, if any names were mentioned these were removed from transcripts. All interviews were saved using pseudonyms and these same pseudonyms have been used throughout the findings presented.

3.8 Reflexivity

Having been a reflective practitioner for my entire nursing career I now find myself utilising this process in an effective way through reflexivity. With this relationship between reflection and reflexivity still under discussion (Etherington, 2004) I recognised that I needed to 'be aware of our personal responses and to be able to make choices about how to use them' (Etherington, 2004, p.19). However, even with self-insight, one can still be susceptible to misrepresentation (Dunning, 2006) and so the importance of demonstrating reflexivity cannot be underestimated.

Firstly, I was aware that my research choice has been framed by my own experiences. Secondly, that during the study there was a great deal of coverage in the media about leadership in nursing and the perceived lack of leadership. These key drivers affected the context of the study and if anything made it more pertinent. At the same time, as a qualitative researcher I could not and did not, wish to ignore my past as it is this very personal experience that led me to undertake this research.

Due to my passion for the research subject, I was aware that I could create a strong effect on the data collected through, as with any researcher, the manner and the way I communicated. My own experience of being a nurse manager and of receiving coaching, gave me a unique perspective, which probably influenced how I asked the questions and how I listened to and interpreted the answers. I mitigated this by allowing the interviewee to

have full control of their answers. Therefore, although I recognised the interactive factors that may be affected, such as transference and counter transference, I could remove myself from the research whilst continuing to give recognition to my perspective at all times.

3.10 Data management

This section will describe how the data from the survey and the interviews were managed.

3.10.1 Post survey data collection

The initial request to undertake the survey elicited a number of replies to ask clarifying questions such as whether the survey request be sent to colleagues. The survey site was viewed on a daily basis and follow up emails were sent out at 1 month and 2 months to elicit more respondents. Once it became clear that no further responses would be gained for the survey the data was downloaded and examined. The survey findings are shown in Chapter 4.

3.10.2 Post interview data collection

Following each interview, additional notes were made on the key points that had become apparent while listening to the responses. All interviews were transcribed using a confidential transcription service; each transcript was checked for accuracy and assessed for confidentiality with all reference to names or organisations being removed before storing them in electronic files.

The analysis was undertaken using thematic analysis. This method is widely used for the identification, analysis and reporting of themes within qualitative data and can be used with a variety of methods (Braun and Clarke, 2006). Thematic analysis involves reviewing coded or summarised data and relating elements to produce categories that identify the conceptual differences in the data (Ritchie et al., 2013).

Thematic analysis is not linked to a specific theoretical perspective and so can be used with a range of paradigms. By combining thematic analysis, a range of data can be used to identify and trace the patterns that emerge.

Joffe (2012) recommends verbal interviews as being the most suited data for thematic analysis. The process of thematic analysis allows for codes to be developed both from the data gained through interviews - called inductive codes - and also codes that are theoretically derived from previous research - called deductive codes (Joffe, 2012).

3.10.3 Development of themes

Thematic analysis was undertaken with the following phases as suggested by Braun and Clarke (2006) and Harper and Thompson (2013) and my own thematic analysis process (see Figure 3-4).

1. Familiarity with the data
   The audio data was listened to a number of times and then read and reread following transcription.
2. Generation of initial codes
   Each group was read individually at first and themes were compiled into a table. Initial codes were identified in the nurse manager, directors of nursing and coaching interviews separately, see example in Appendix 5.
3. Exploration of themes.
   All three tables were then reviewed for patterns and to see how cross cutting themes emerged. The cross cutting themes were compiled into the table in Appendix 6.
4. Reviewing themes
   Once all interviews had been analysed for each group, they were cross-referenced across groups with many cross-cutting themes emerging (see Appendix 6). These were organised under the headings of self-development, clinical supervision and mentoring, organisational issues and benefits of coaching.
5. Classifying and naming themes
   Once the cross-cutting themes were identified, the interviews were re-analysed, using pattern coding, to identify how each group viewed these and what patterns had emerged. The use of pattern coding has been documented as a reliable method of analysis when using mixed methods data (Saldana, 2012).

The cross cutting themes from Appendix 6 were then further refined and were then enumerated under the headings for the three results chapters, as can be seen in Appendix 7.

6. Production of the results

All of the qualitative interviews were read repeatedly and the initial codes derived from the data can be seen for example in Appendix 5 for nurse managers.

The results of the data analysis are shared in Chapters 5, 6 and 7.

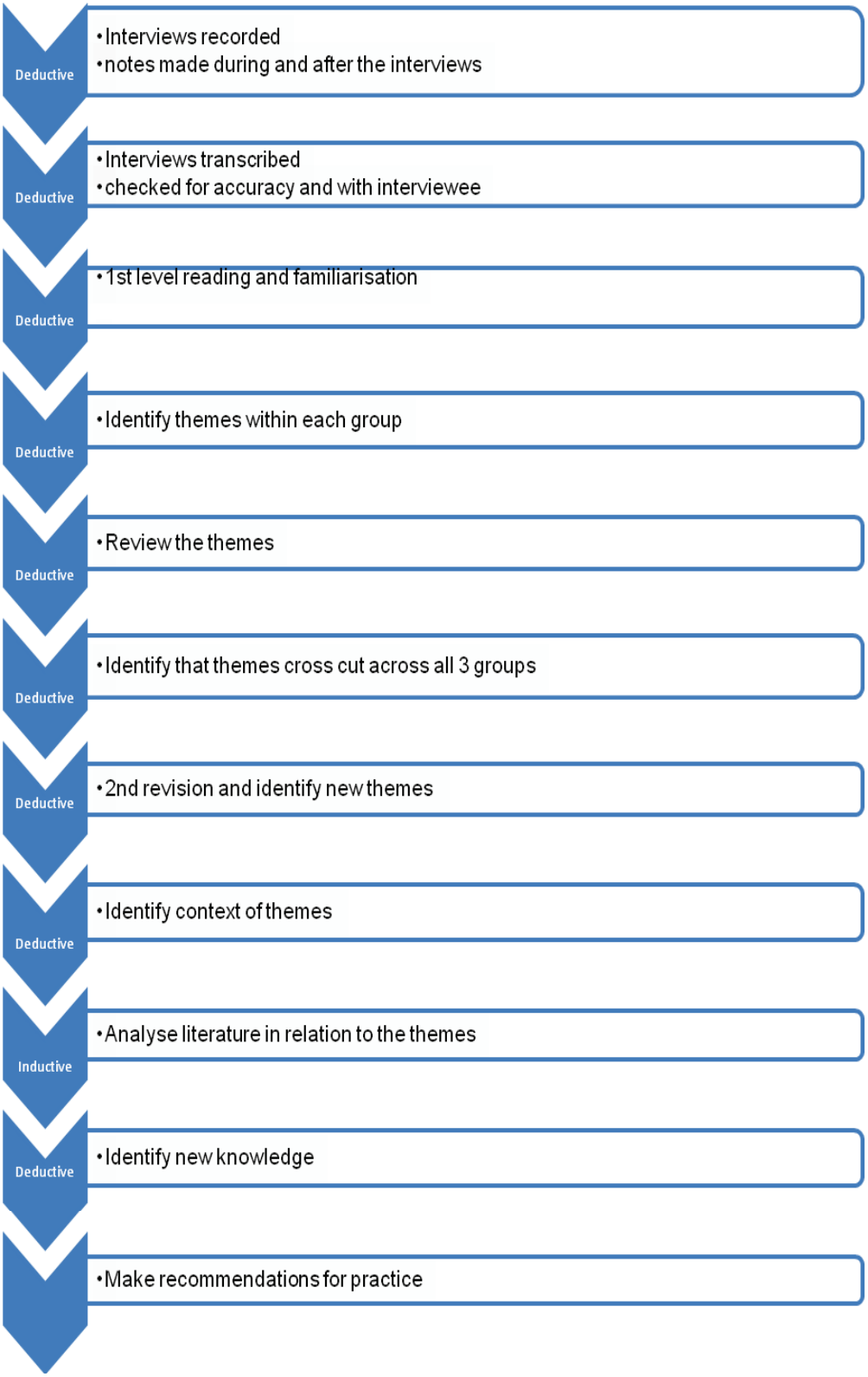


Figure 3-4 Process of analysis.

3.11 Quality measures applied

The eight criteria illustrated by Tracy (2010) were used to demonstrate the quality, reliability and validity of both data sets, examining the key points that need to be noted by qualitative and quantitative research.

The topic has been shown to be **worthy** in that, it is very significant for the health sector at this time with the development and support of nurse managers remaining sporadic. **Rich data** has been collected from the qualitative interviews, shared in the following chapters. The survey has data to illuminate a cross section of what is occurring in the NHS and private sector across the four UK countries. **Reflexivity** has been shared in section 3.7.

Credibility was demonstrated through triangulation and respondent validation. Using mixed methods as a method of triangulation to help to verify data is supported by Green and Thorogood (2013). In this case, the survey complemented the findings in the interviews.

However, with qualitative research the aim was not to gain a consistent version of the subject but to contribute to a new understanding (Denzin, 2009). Thus, the aim of validity in respect of these interviews was to balance the weaknesses of the method used and challenge any biases that came from the interviews.

All transcripts were returned to the respondents to ensure they were an accurate record. During the interviews if there were points being made by the interviewees that I was unsure of, follow up questions were asked to clarify their meaning. Comparisons of each data set were undertaken to ensure that data interpretation was undertaken consistently (Green and Thorogood, 2013).

Survey validity was ensured as much as possible by undertaking a pilot and also seeking views from a range of experienced researchers or practitioners. As only comparative analysis was intended to be applied to the data there was no need for validity of the questions to be more rigorously interrogated.

Resonance has been addressed by ensuring the study flowed freely and that there is a desire on the part of the reader to want to read and understand the concepts behind the study. **Significant contribution** will be illustrated by how the results will contribute to knowledge and what impact there will be on the future support and development of nurse managers. **Ethical** considerations have been addressed in section 3.7. Finally, meaningful coherence has been attained by following through a clear aim and objectives throughout the study, the use of appropriate methods, the linking of research questions to the literature, findings and the results and conclusions.

This chapter has summarised the methodology used for this study: a pragmatist paradigm using a mixed methods methodology and thematic analysis for data analysis. The following four chapters will explore and discuss the findings. Chapter 4 will explore and analyse the results of the survey and introduce the results of the interviews. Chapter 5 will share why coaching occurred. The experiences of nurse managers during coaching will be explored in Chapter 6 and the outcomes following coaching will be explored in Chapter 7.

Chapter 4 - The National Overview

This chapter will discuss the results of the survey, including details on the backgrounds of the survey respondents and how these results are further developed in the following three chapters. At the end of this chapter, the overview of all findings is presented with a brief description of what is covered in each of the subsequent chapters. In this chapter and in Chapters 5, 6 and 7 the term nurse manager is abbreviated to NM and Director(s) of Nursing to DN.

4.1 The survey results

The survey was administered to a minimum of 100 DN, senior leaders in NHS and private sector health care organisations across the UK. It may have been received by more than one hundred recipients, as a number of email responses received indicated that staff had passed the survey on to colleagues, who they thought would be keen to contribute the completion of the survey within their organisation or from other health care organisations. There are approximately 200 NHS Trusts with a DN but access to contact details was problematic, despite contacting regional Local Education Training Boards to ask for help. The one hundred targeted were from across the four countries in the UK and reflected a representative spread across the English health care regions.

Responses were gained from 33 organisations, approximately a 33% response rate and this was achieved by sending reminder emails, a recognised boosting technique (Nulty, 2008). This response rate falls in the mid-range of that reported in the literature: 20-47% (Nulty, 2008). The decision not to use full statistical analysis, is explained in the methodology chapter in order to stay consistent with the main epistemological position of the study. The data will therefore be used for illustrative purposes to position this study in the national context.

As can be seen in Figure 4-1 responses were received from Scotland, Wales and Northern Ireland and from seven of the nine identified regional health areas in England. 18% of the responses were received from Scotland, 3% from Wales and 9% from Northern Ireland.

It was useful to receive responses from all four UK countries as England and Northern Ireland, Wales and Scotland all have their own health policies under the umbrella of the NHS. Therefore, although they are part of a standard NHS they can all act in a different way with regard to developing their own policies relating to, for example, development of staff.

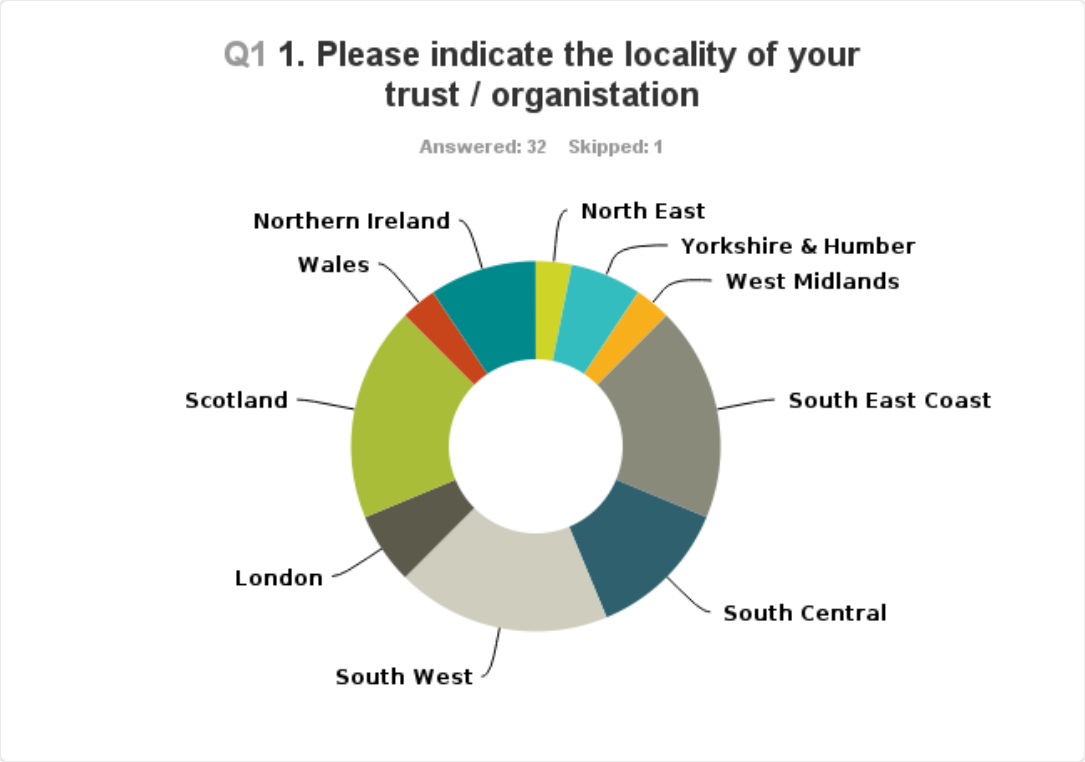


Figure 4-1 Areas of responses.

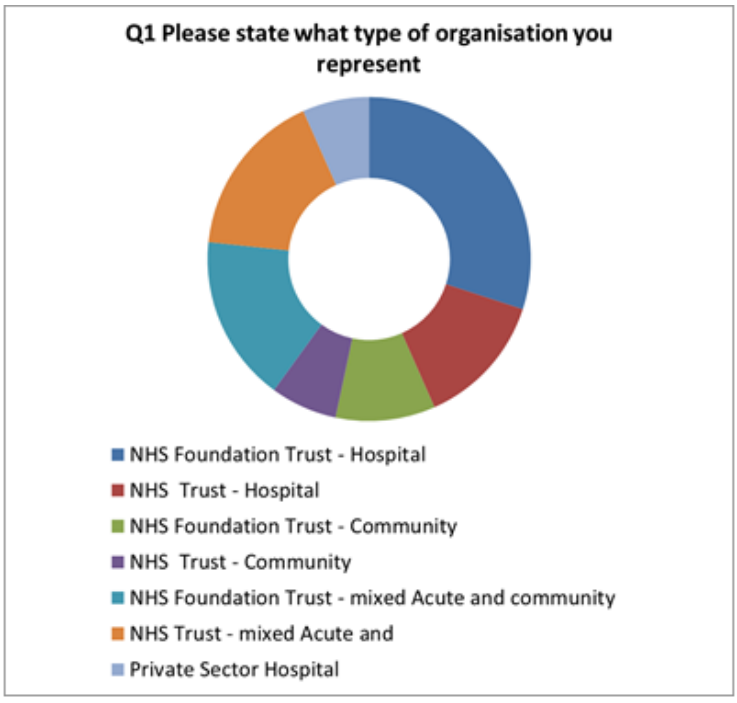


Figure 4-2 Types of organisation.

All types of organisation were represented, including NHS foundation and non-foundation trusts, community trusts and the independent sector (Figure 4-2).

Responses showed that the number of NMs working in their organisations ranged between less than 20 NMs to more than 50 NMs. 50% of respondents had over 50 NMs in their organisation and 28% had less than 20 NMs. 68.8% had a development programme for NMs with 31% of organisations not doing so.

4.1.1 Types of development programme

Of those who responded, 50% had a voluntary programme with a varied uptake rate ranging between less than 25% to more than 70%. Of these voluntary programmes, only 40% of them had an uptake of over 50% of staff. 36% of respondents had a mixture of mandatory and voluntary schemes with only 18% having a mandatory system. This equates to only four respondents ensuring that all their NMs attend a development programme. The length of programmes varied between less than 5 days to over 21 days. These results appear to indicate a wide disparity of development programme provision, which may lead, in some cases, to insufficient opportunity for NMs to develop in their role.

The survey indicated that a development programme was offered to NMs within 6 months of appointment in only 50% of the organisations. Additionally, 74% of responses confirmed that a programme was not offered to staff before they became NMs. These results suggest two themes: the timely and pertinent availability of development opportunities after appointment to a NM role and the dearth of development programmes for potential NMs.

The needs of staff new to the role and needing support have been identified over the last thirty years by Pembrey (1980), Ogier (1982), Lathlean (1986) McDermott (2001), Waters et al. (2003) and Hales (2005). However, it appears from this survey data that development is still not widespread and mandatory.

The respondents that did offer development programmes appeared to offer a wide range of leadership development opportunities to meet NMs'

development needs. Some development programmes had been based on particular reports or recommendations such as: Delivering Better Care Through Leadership (NHS Scotland, 2010); Aston Team Effectiveness Principles (Borrill et al., 2000); Free to Lead Free to Care (Welsh Assembly Government, 2008).

The in-house and nationally available courses included a variety of training and skills. These included: recruitment and retention, managing performance, leadership development, management issues, coaching, managing people - covering all aspects of managing staff, performance management and appraisals and coaching. The programmes often focused on the organisation's values and strategy and the development of the NM role. Mandatory training included a range of health and safety, recruitment and selection, equality and diversity, and essential training for specific roles, which included managing people & teams, finance and budgets, etc.

A number of questions were then posed to further interrogate the data. First: does organisation type influence the provision of development and coaching programmes? As 4-3 shows while no NHS Community Trust survey respondents appeared to have a NM development programme, 100% of NHS Foundation Community Trusts did.

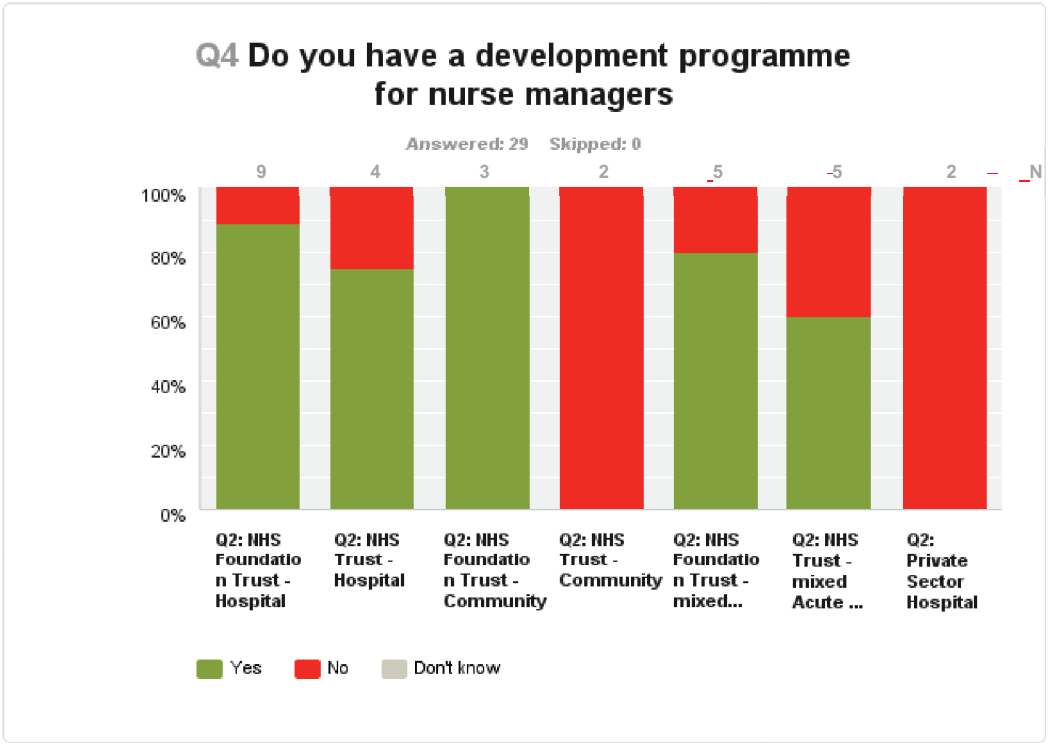


Figure 4-3 Span of development programmes.

With the exception of NHS Community Trust respondents, all NHS organisations appear to have an NM development programme but no private sector hospitals appeared to. Although caution must be applied as this was a small sample the situation is worthy of future investigation.

Survey responses suggest that in NHS Hospital Trusts more than 50% of programmes are undertaken within a certain period of time (Figure 4.4). Elsewhere programmes are undertaken within a certain period less than 30% of the time and in the case of NHS Foundation Trust / community and NHS Trust – mixed acute, there is no time limit.

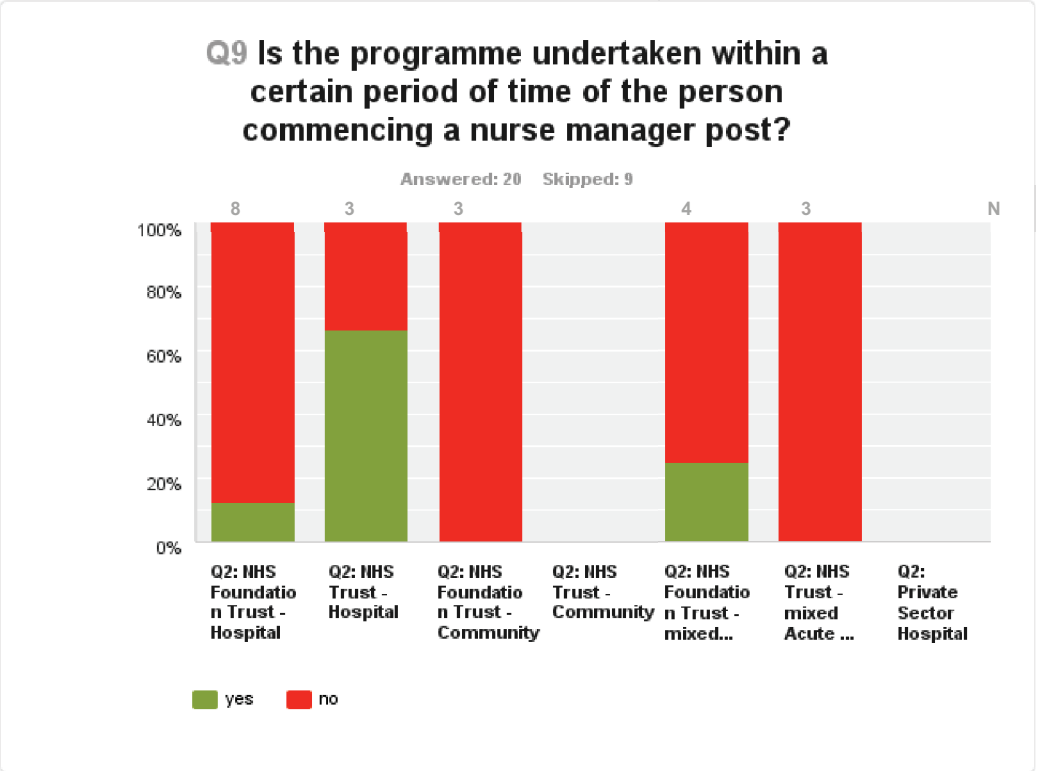


Figure 4-4 Time period of development programme.

4.1.2 Provision of coaching

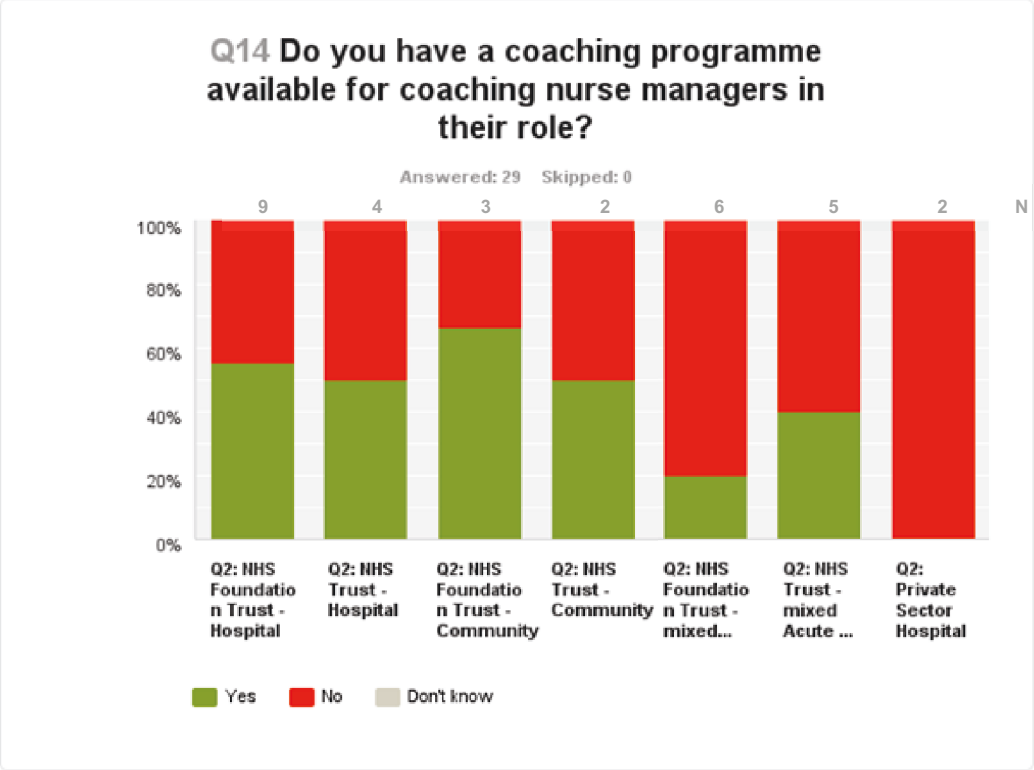


Figure 4-5 Coaching programmes.

Turning to coaching provision (Figure 4-5) the data available illustrated that NHS Foundation Trusts - Community had the highest percentage of coaching programmes availability of any organisation type. This reinforces their 100% provision of NM development programmes. By contrast, in the survey sample there was no coaching available to NMs in the private sector matching the lack of provision of development programmes for NMs.

These results indicate a need for further, larger, sampling surveys to establish whether the strong positive link between organisation type and coaching and development provision observed here is maintained.

Figure 4-6 Context of coaches.

The survey shows (Figure 4-6) that every organisation that has coaching, uses coaches from within its own organisation. This is not to say that there are no NMs who access coaches from outside their organisation but this appears to not be known by the organisation. There were two respondents that solely used coaches from within and no external coaches. Although it was not clear if these were staff who were employed as coaches or were staff in other roles e.g. management or human resources, who also acted as coaches.

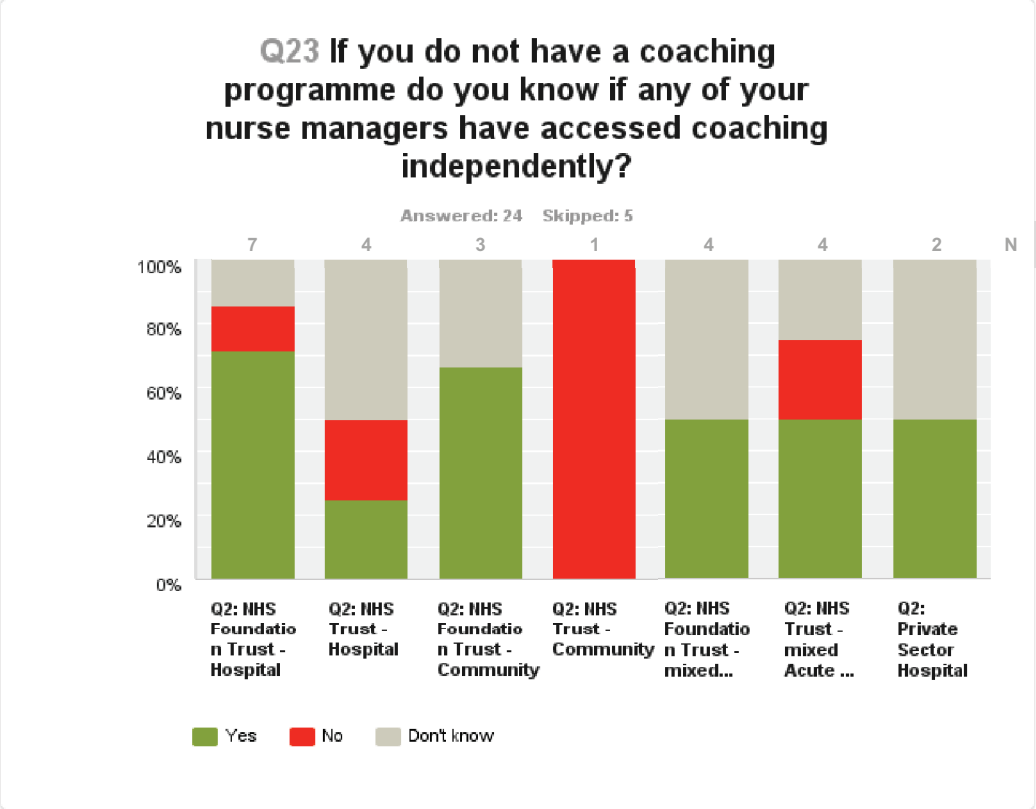


Figure 4-7 Access to independent coaching.

The survey also revealed that a lot of independent coaching is being used (Figure 4-7), the exception being NHS Trust community organisations, where it was reported that there was no knowledge of independent coaching. This concurred with their 100% score for using coaches from within their organisation. Although, as mentioned previously the respondents may not be aware of any NM who is accessing coaching and paying for it privately.

4.1.3 Role of location

The second theme investigated in this chapter is whether organisation location, including different parts of the UK, is a factor in development and coaching provision for NMs

.

The survey suggest that all locations have NM development programmes of which five locations reported 100% having programmes (Figure 4-8). Only the West Midlands respondents appear to have 100% of programmes completed in a certain period, posing the question of whether this is a local policy (Figure 4-9).

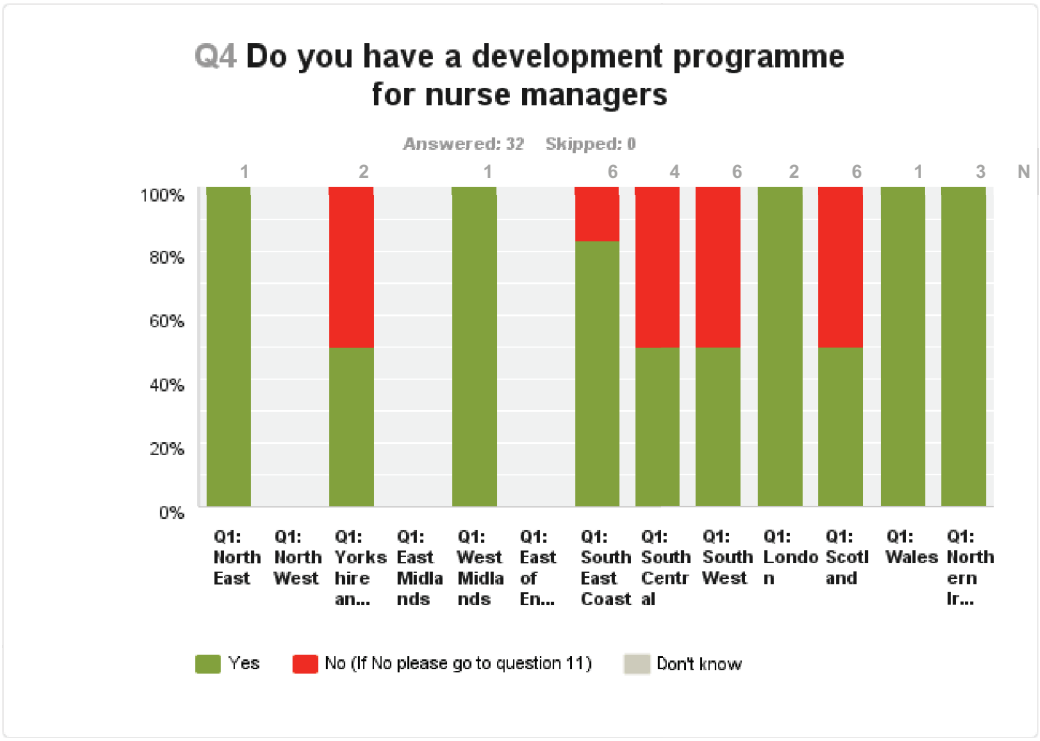


Figure 4-8 Development programmes.

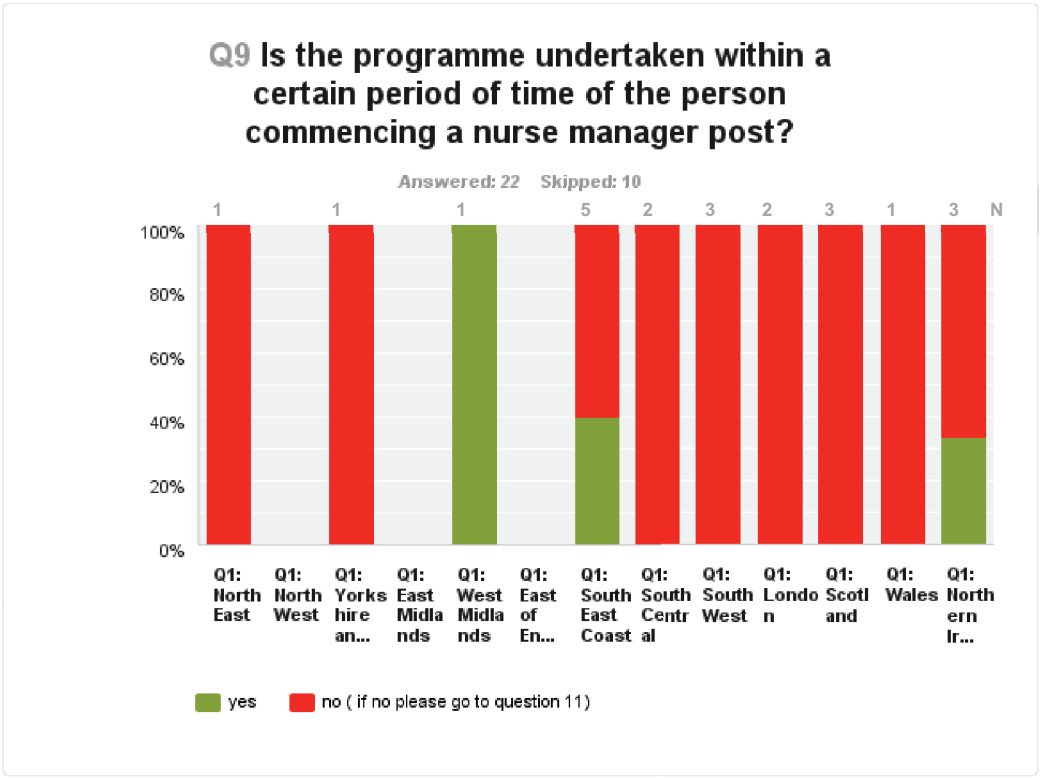


Figure 4-9 Time period for development.

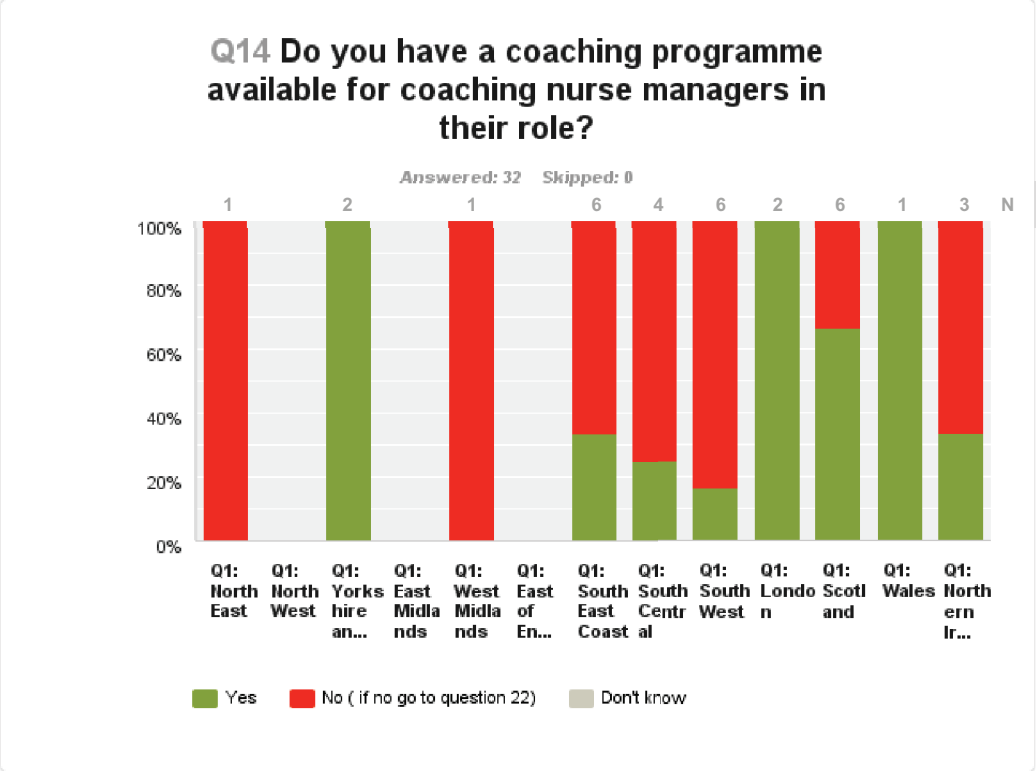


Figure 4-10 Location of coaching programme.

From the data available, access to coaching appears to be quite location dependent (Figure 4-10) and possibly more location dependent than organisation dependent, see Figure 4-5 above: only in 3 locations is it 100%, for 2 locations it's zero, and for 4 locations it is less than 40%.

With the exception of SW England all locations use coaches from within their organisations (Figure 4-11) and eight locations reported NMs accessing coaching independently (Figure 4-12).

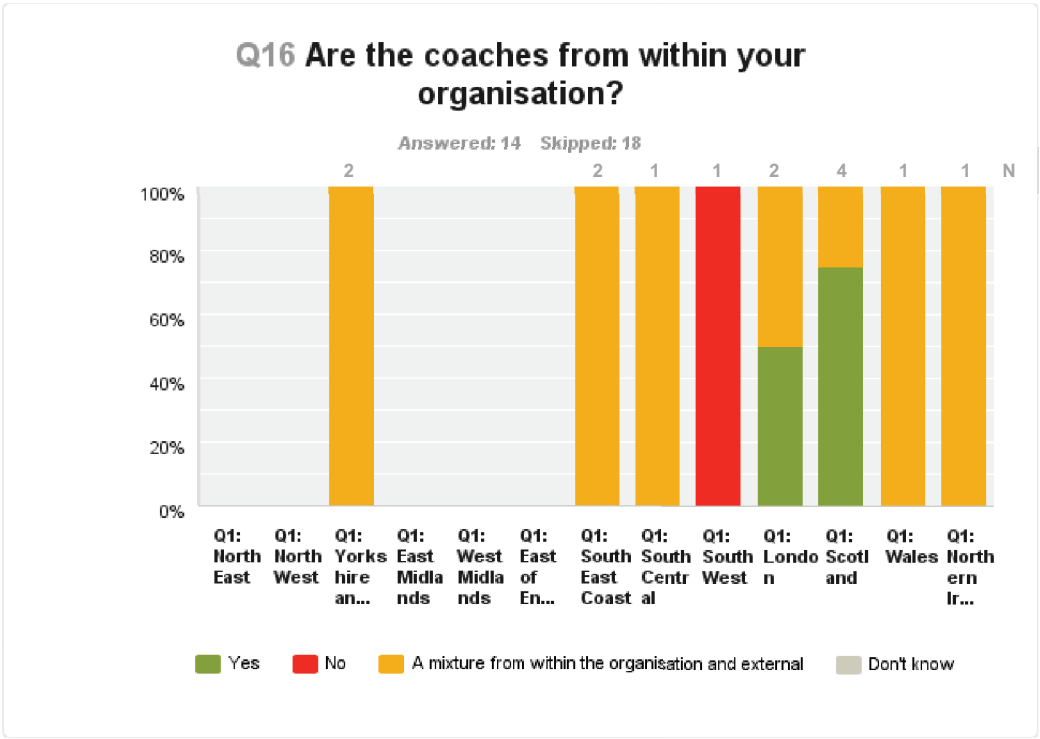


Figure 4-11 Context of coaches.

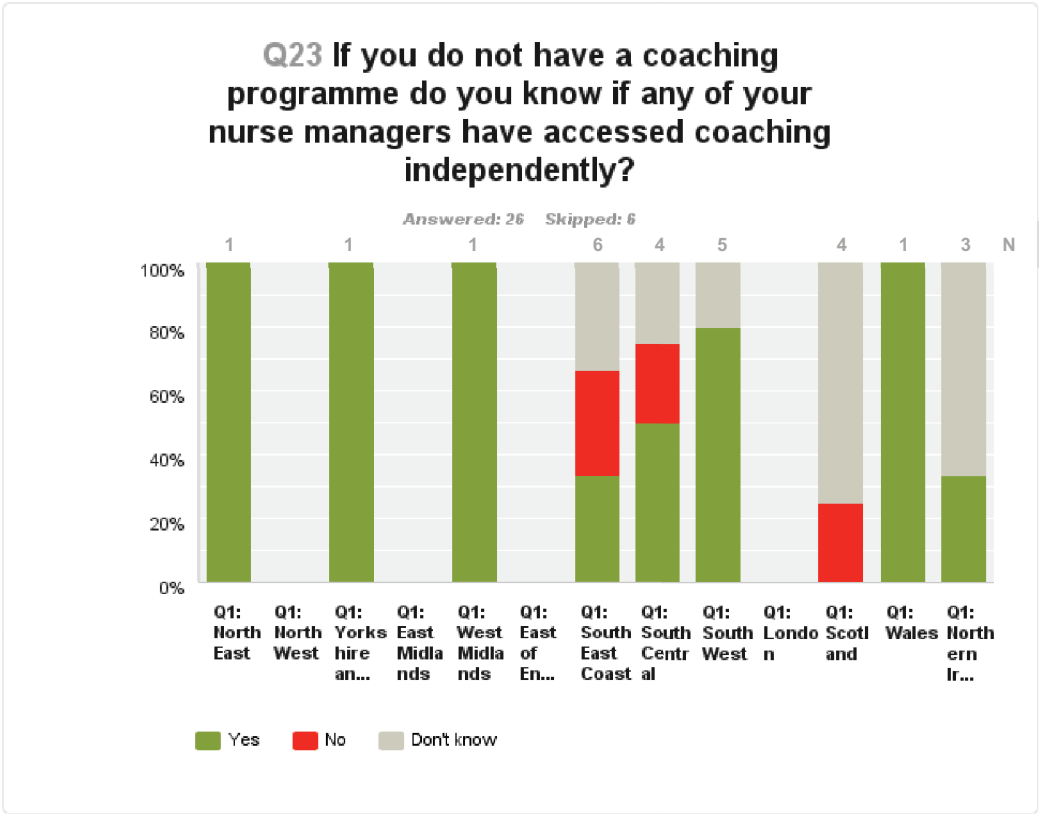


Figure 4-12 Geographical independent location.

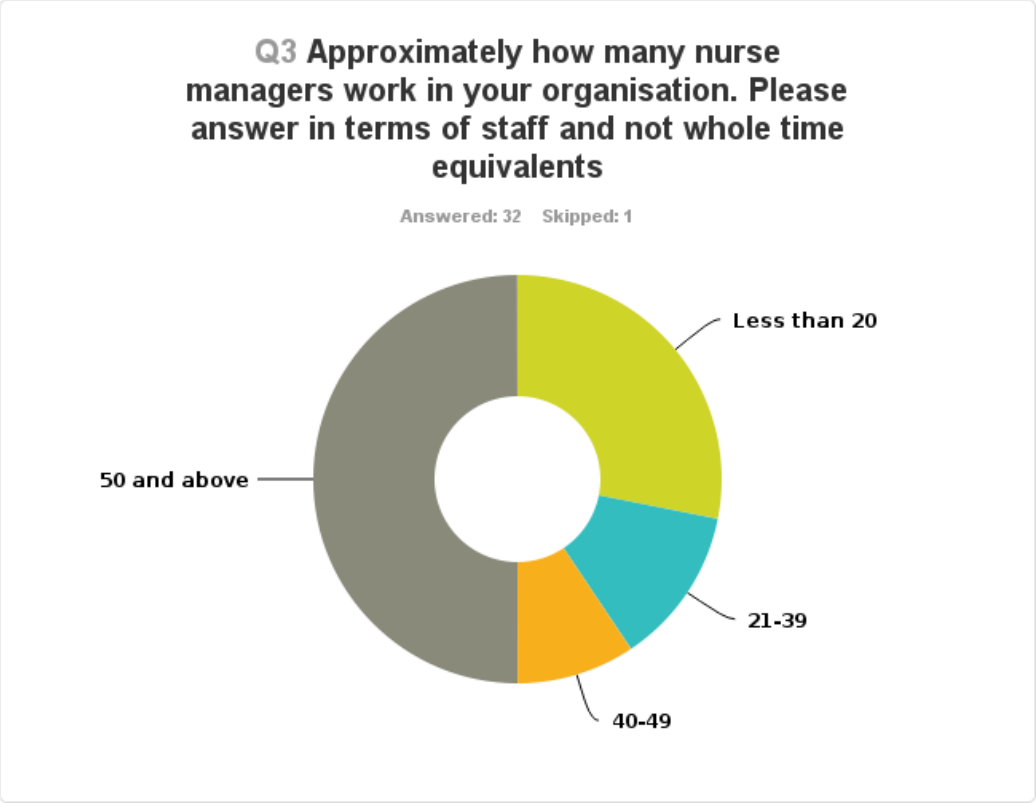


Figure 4-13 Organisational size.

4.1.4 Organisational size

The third theme addressed in this chapter is the influence of organisational size and therefore resource volume on NM development and coaching provision. The survey (Figure 4-13) suggested a preponderance of large organisations (50%). However, nearly a third of respondents worked in organisations with less than 20 managers – outstripping those with 40-49 and 21-39 NMs combined.

The data was examined to see if size influenced development programmes and coaching. Figure 4-14 shows quite a good relationship with the percentage of organisations having a NM development programme being a function of organisation size. While this might not be unexpected, there was however, an indication of a negative relationship of organisation size and whether development programmes are completed in a certain period of time e.g. Figure 4-15. However, this only holds true if one discounts the results for organisations with fewer than 20 NMs, given their very small sample size. Further research could test this relationship and with it the hypothesis that there is less emphasis focused on the individual and so less organisational impetus to complete a development programme in a certain time period, in ever larger organisations.

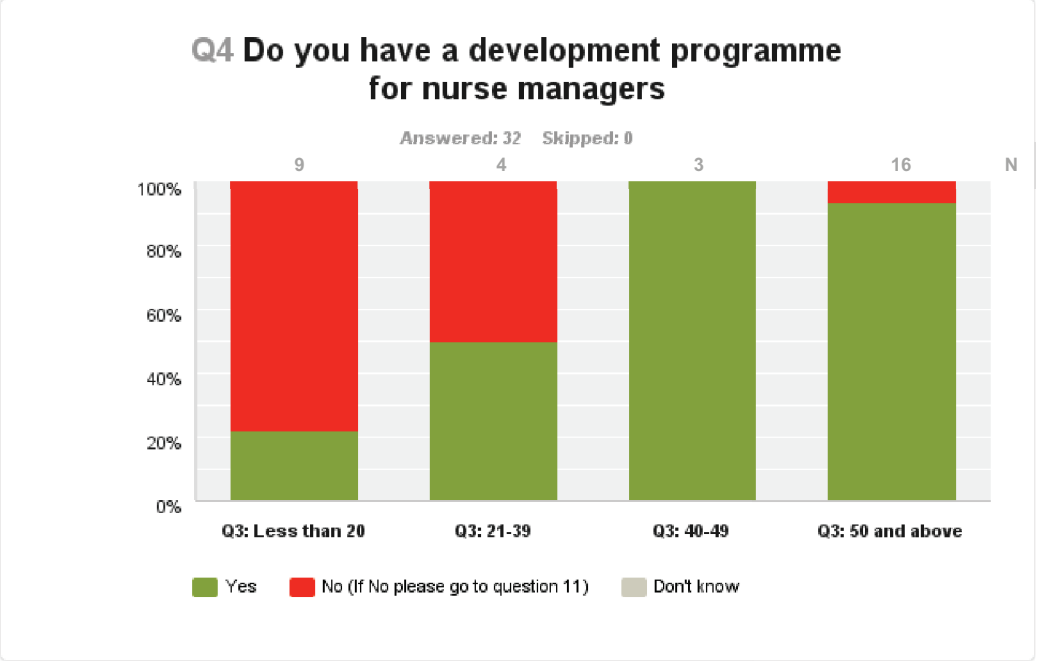


Figure 4-14 Size related to programme.

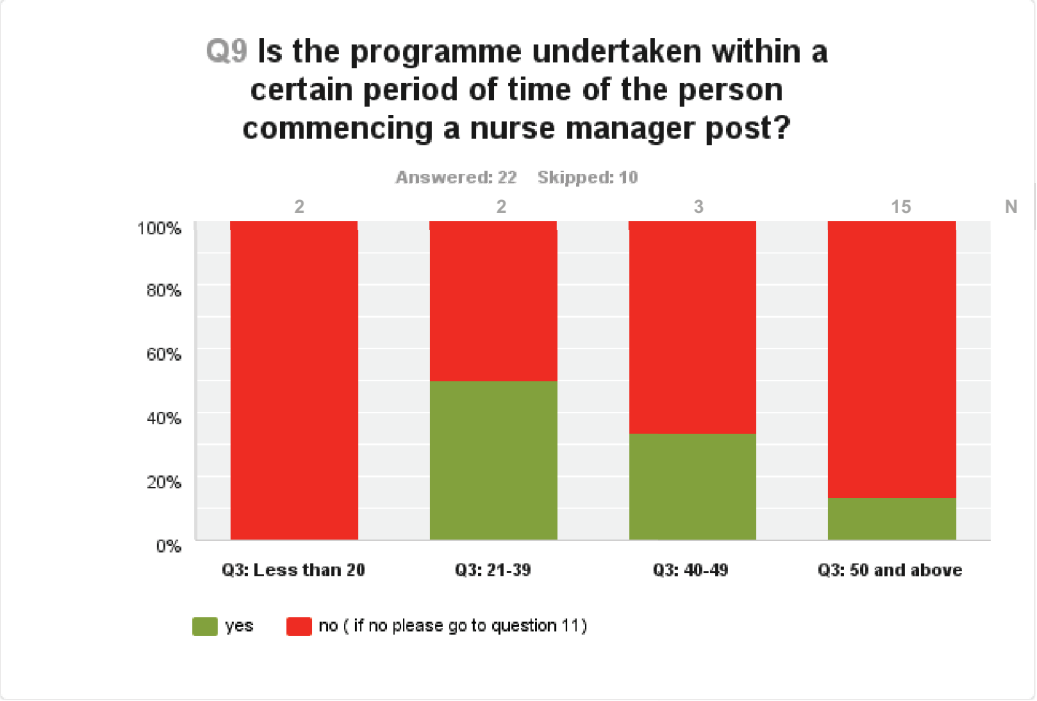


Figure 4-15 Size in relation to development.

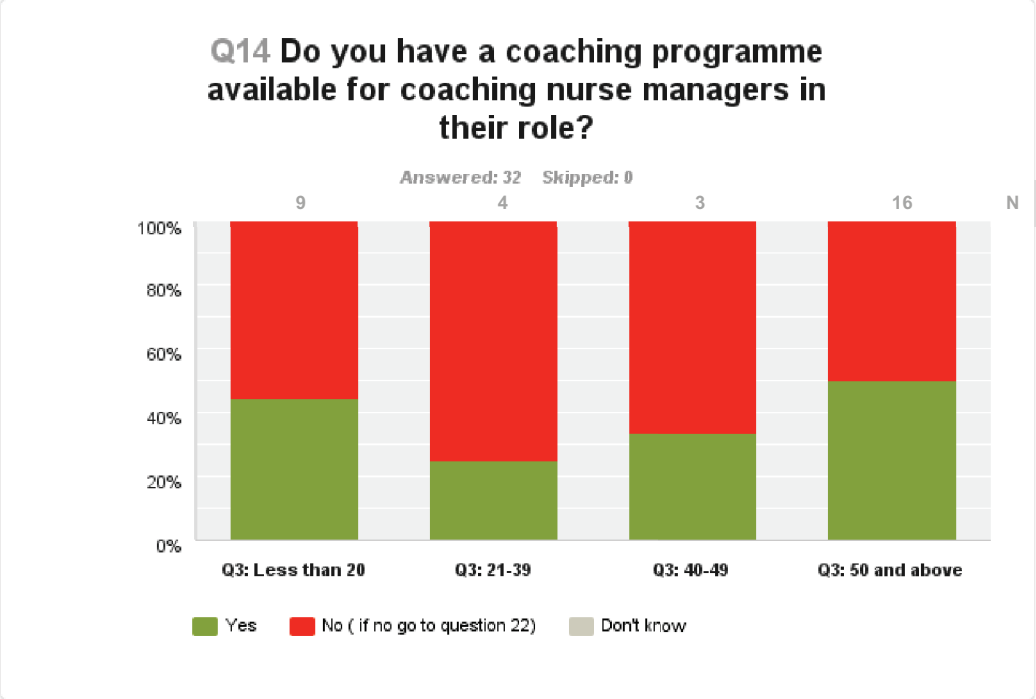


Figure 4-16 Size in relation to coaching.

Figure 4-16 suggests that, for this survey sample, the existence of a coaching programme is not a function of organisation size, which appears to be unlike the provision of NM development programmes. Again this disparity would be worthy of further research as it appears to indicate a discontinuity in the provision of these two vital functions. This is of particular note as many managers are introduced to coaching as part of a leadership programme where the value of coaching is seen as part of a bigger development programme (Watson and Harris, 1999; Loo and Thorpe, 2003; Yu at al., 2008).

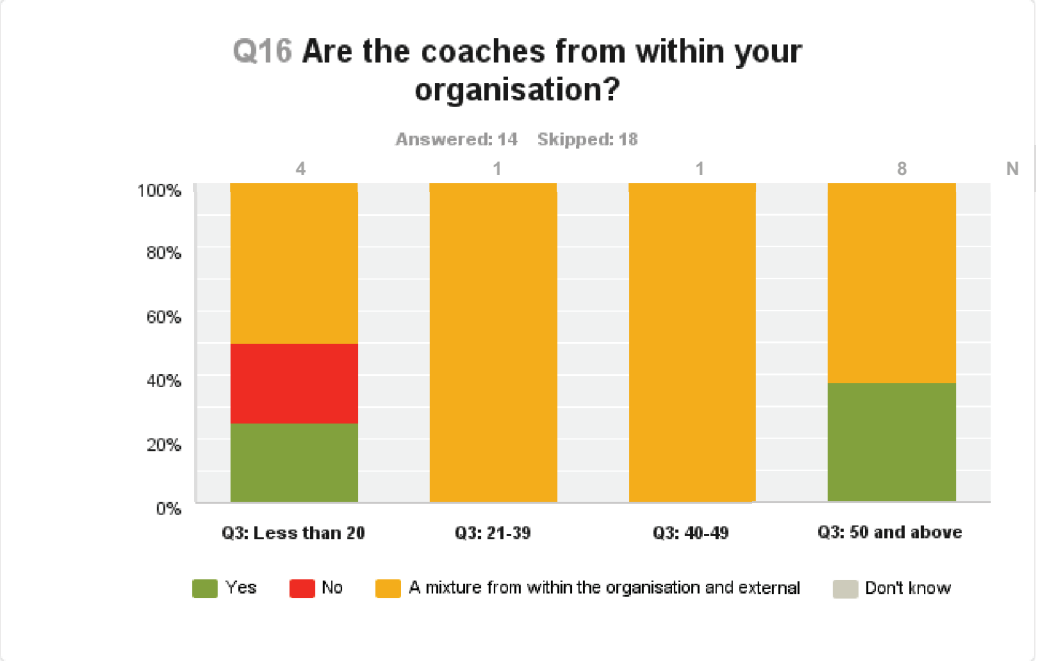


Figure 4-17 Size in relation to source of coaches.

From Figure 4-17, it appears that in organisations with more than 50 NMs there is a critical mass that potentially allows an organisation to rely on coaches from within the organisation.

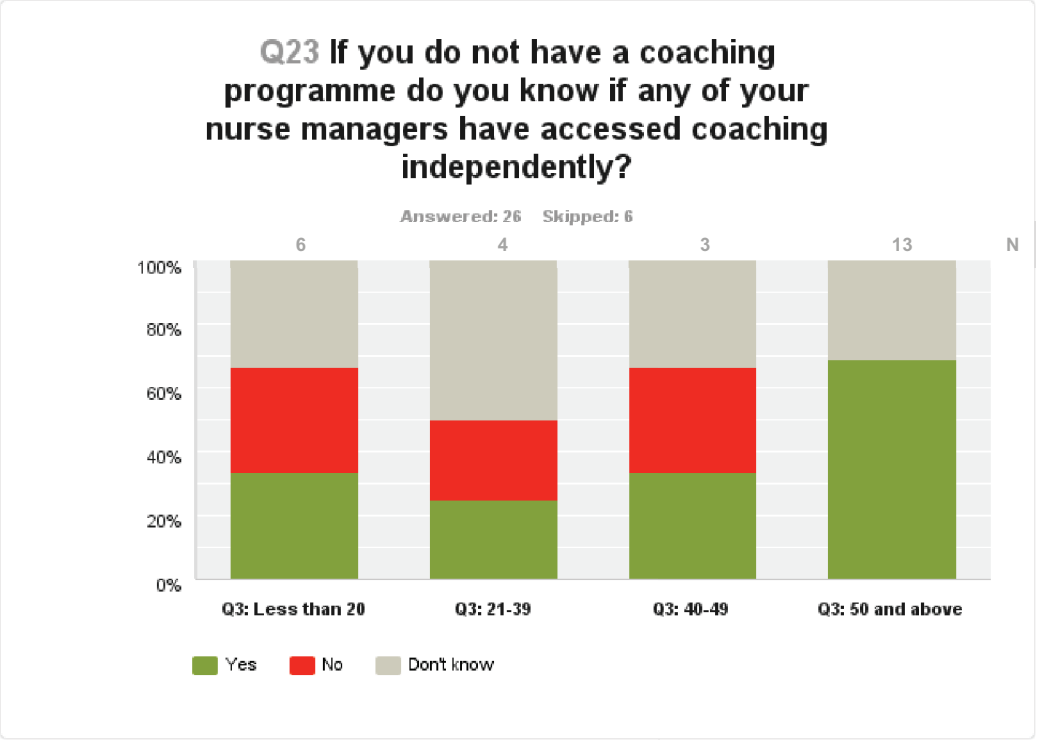


Figure 4-18 Size in relation to independent coaching access.

Lastly the survey showed that there were a significant number of 'don't knows' (30 to 50%) at all organisation sizes, even the smallest, about independent access to coaches (Figure 4.18) with reasonably constant knowledge about independent coaching across all organisation sizes.

In summary, all types of organisation were represented in the survey, including NHS foundation and non-foundation trusts, community trusts and the private, voluntary and independent sector (PVI). 50% of respondents had over 50 NMs in their organisation, however it appears that only four respondents ensured that all their NMs attend a development programme.

The survey appeared to suggest that a development programme was offered to NMs within 6 months of appointment in only 50% of the organisations. This appears to suggest from this sample that development is still not widespread and mandatory. Additionally, it appeared that with 74% of responses that a programme was not offered to staff before they became NMs.

With regard to coaching provision, it appears that community trusts had the highest percentage of coaching programmes availability of any organisation type. This also reinforced their 100% provision of NM development programmes. By contrast, in the survey sample it appears there was no coaching were reported as being available to NMs in the private sector. This is coupled with what appears to be a lack of provision of development programmes for NMs in the private sector.

Access to coaching seems to be quite location dependent and arguably more location dependent than organisation dependent, with most access being given in the West Midlands. The results suggest that the existence of a coaching programme is not a function of organisation size, which appeared to be different to the provision of NM development programmes. This disparity would be worthy of further research as it might indicate a discontinuity in the provision of these two vital functions.

4.2 Organisation of the following chapters with the results of interviews

The data gathered in the qualitative interviews were extensive and this, along with the survey, has created many areas that are worthy of attention. As Harding (2013, p.176) says 'there is no correct way of writing about results that is better than all others […] but that the key findings accurately expresses the views, ideas and experiences of the respondents'. Therefore, the research aims and the pragmatic paradigm have been used as a steer to prioritise the presentation of the results. Pragmatic choices have been made to ensure the most useful aspects for the development of nurse managers (NM) and the knowledge base of coaching have been incorporated into the results.

Thematic analysis was used for data analysis of the qualitative interviews, as Braun and Clarke (2006) suggest thematic analysis has the potential to identify unexpected insights, which may be useful for practical application and future recommendations for policy development. Therefore, themes from the literature were looked for following the initial coding and new insights gained from the data analysis were also investigated.

During the secondary analysis of the interviews, a number of themes emerged that clearly fell into three main groups. Therefore, the results from the interviews will be organised into three chapters. The results of the interviews with the NMs, coaches and DN are integrated within the relevant themes rather than in separate chapters to illustrate and discuss the findings as a whole.

The first group of themes was about why coaching occurred. The themes it consisted of were introduction to coaching, balancing transitions and self-confidence and self-efficacy. All of these areas are explored in Chapter 5 and the interviewees' responses are shared along with related links and analysis of the relevant literature. Chapter 5 is therefore called 'Why Coaching Occurred.'

The second group of themes to emerge was about the experiences of the NMs undergoing coaching. The sub themes to emerge were related to the value of relationships; the role of reflection, and the NM relationship to

coaching, mentoring and clinical supervision. Chapter 6 is therefore called 'The Experience of Coaching.'

The third group of themes was about the outcomes following coaching for the NM and the organisation. The sub themes identified were related to the organisational outcomes, return on investment and how the NMs have changed following coaching. Chapter 7 is therefore called 'Outcomes Following Coaching'.

Chapter 5 - Why Coaching Occurred

In this chapter, the themes that emerged from the data are described in three sections:
5.1 Introduction to coaching;
5.2 Balancing transitions;
5.3 Self-confidence and self-efficacy.

Each section describes the analysis of findings illustrating these using the actual words of the interviewees and considering these in the light of the literature. The researcher's voice, in section 5.4, is used to share the holistic interpretation of the data. Existing literature is used to interpret findings and additional literature is introduced, in light of the data analysis, with new insights being drawn from the data and literature in this section.

5.1 Introduction to coaching

NMs had come to coaching through a variety of routes. The majority of nurse managers (NM) and directors of nursing (DN) had received coaching as part of a leadership and management development programme and this, in many cases, had been their first exposure to coaching. The development programmes had usually included sessions on human resources, finance, governance etc. and in addition to these sessions, coaching had been offered. The coaching was often part of a package, including, for example, a 360-degree feedback process and a Myers Briggs type evaluation. The coaching was offered to NMs following some type of pre-assessment, with the results of these assessments used by the coach as a base for the structure of the coaching sessions. This is expressed by NM – Julie:

> *I had to learn more about myself before I could be coached. So that was the interesting part for me … to do my Myers Briggs and my Belbin ... and find how do I work.* NM – Julie.

The value of the coaching had been identified by the DN, as some had started their own coaching journey when they had been an NM and had continued to access coaching in each subsequent role. Receiving coaching as part of a manager development programme was also how

three of the coaches had been introduced to coaching and they had then continued with it as a career.

Many NMs reported not knowing what coaching entailed and what they were 'letting themselves in for'. NM Sandy illustrates this by talking of how fortunate they felt to have been given coaching as part of their leadership programme.

> *It was once a month for twelve months, which was the duration of the leadership programme. I feel like I was very fortunate to have that and I knew, even though I didn't actually really know what coaching was going to entail,... after the first session, I realised that actually this was something special, that I was really lucky to be being paid for.* NM – Sandy.

The 360-degree feedback process and the Myers Briggs type assessment, received as part of their development programme, was generally felt to have been valuable in helping the NMs identify what to raise in their first coaching sessions. NMs Pauline and Jo illustrate this.

> *The coaching came as part of an optional 'add on' for a course that I was doing. So the Trust started a course called, 'Leading for Improvement'. And part of that was doing a 360 degree, as well as Myers Briggs. And you could take the opportunity to do coaching if you wanted it. So once, at the end of that course, is when I asked if I could take the coaching as well, and was offered six sessions and the 360 fed into the coaching.* NM – Pauline.

> *…we did a 360-degree appraisal before we started the course and then once we were finished, so that we could identify our requirements for improvement and where we were going to focus the coaching on. Mine was around using the handbrake and thinking before I speak and taking more balcony moments.* NM – Jo.

However, not all NMs thought the 360-degree was a valuable tool to use as a basis for the coaching sessions – with some feeling that it did not address what they really wanted to work on. NM Lesley recalls this problem leading to not getting as much out of the first session as they had wished:

> *It was quite interesting actually because I came out with being very assertive, and right at the top end of the scale. And so the coach was saying, … in what sort of scenarios would you need to tone that down a little bit? But I didn't actually recognise myself from the questionnaire, so I found that quite interesting… I didn't actually agree with the questionnaire or the coach, so I couldn't really answer her question very well.* NM – Lesley.

Most NMs reported that, in their opinion, there is a great need for development programmes to ensure they understand finance, human resource issues, how to work together and in teams and the scope of the NM role. However, they felt there was a need for coaching to be available coincident with a development programme, as illustrated by Jane.

> *…but I think it has to be alongside some developmental workshops.* NM – Jane.

Coach Paula saw this from the coaching perspective and agrees with the value of coaching being offered as part of, or following, a development programme.

> *Yes, I started working with managers and ... that was very useful because they had come to me as a result of going on the leadership development programmes. One of the programmes that we ran, offered the people on the programme the opportunity to have a coach working with them, to help them implement some of the ideas and things that they'd learnt on the leadership development programme.* Coach - Paula.

NM Val comments that development does not have to take place solely through a dedicated programme, although a development programme can occur alongside individual training from a line manager. However, if a development programme is not offered, the NM may not receive coaching and so may miss the opportunity to be introduced to it through this route:

> *I think a lot of that training can probably come from your immediate line manager or from your HR or employer relations teams within the organisation, which is what we've got here. As well as this we've got quite robust training programmes for each of those things.* NM – Val.

The value of employers investing in development programmes was identified by all NMs and DN. However, what appeared to be the case was that the support for NMs to undertake management and leadership programmes was very variable. Some employers had had good programmes in place and had then allowed them to lapse; this resulted in the staff not feeling supported. Other organisations were in the process of designing new programmes. This variable investment in development programmes was also illustrated in the survey results with 31% of respondents not having a development programme for NMs to access. Investment in the development of NMs is covered in more detail in Chapter 7 section 7.1.

Interviewees in all three groups identified that it was generally the staff who were the most motivated who attended development programmes, whereas those who, perhaps, really needed development did not take up opportunities.

The NMs who had been coached as part of a programme had found it a very good introduction and they recommended that if NMs had not undertaken coaching before, that it always be offered as an introduction as part of a development programme. NM Pauline speaks of the importance of having coaching and the way it has changed her ability to perform her role. What appears to emerge is the value of having a whole package of development, e.g. a development programme as well as coaching, as this combination is of great benefit.

> *So the tools are there, I mean it all helps in the development of leadership and management. Certainly, now that I've benefitted from it, then I'd probably be a different manager today than before I started but it was the whole package.*
> NM – Pauline.

This section has explored how NMs arrive at coaching and the value they attach to having it as part of a development programme. The next section will address their responses to how coaching can help with role and career transitions.

5.2 Balancing transitions

A number of NMs had sought coaching as part of a new role or job or when thinking about taking on a new role, or if they were dissatisfied with the role they were undertaking. From the coaching perspective, Paula and Emma summed this up from their experience of coaching NMs. They illustrate the value of coaching prior to gaining a new post as well as preparing for moving out of a post.

> *I've labelled some of my coaching as entry strategies to new jobs, or exit strategies from organisations. I've worked with people that are actually considering leaving the job … how you can bring closure to that in a positive way and prepare them for the next job, so that they end that chapter of their career ready to move on to the next one. So that would be the exit strategy coaching that I got involved in.* Coach - Paula.

> *Some work around kind of how to progress and move forward within their careers, when people are sort of not quite sure what to do and where to go. And helping people kind of get that straighter in their mind, or at least get some ideas of how to move forward. Somebody who's been in a job for a long, long time and just has got really stuck, so quite a lot of un-sticking.* Coach – Emma.

5.2.1 Developing 360-degree manager skills

Many interviewees discussed the importance of learning effective line management skills. All NMs had been appointed into the NM role from being a nurse in a team, with some encountering immense differences as they transitioned from a team player to a manager. Having coaching and learning coaching techniques to help with line management when new to a role, was illustrated by NM Jane.

> *If the Trust were going to develop a nurse manager course then coaching needs to be in that for starters I think. Because I think that's very beneficial for both ways, for them as individuals getting it in their new role, but also to be able to provide it to their staff in supporting them in the new role that they've taken on.* NM – Jane.

A number of NMs and coaches talked about the importance of 'coaching upwards'. They described this learning in terms of how to best work with their own line manager and to get the best out of this relationship. This need to manage upwards in their line management structures was seen as equally important as managing downwards. This was illustrated by NM Lesley.

> *I've continued to use those skills in my every day work, particularly, not just coaching my staff, but also coaching up, and I've found it particularly useful in coaching up.* NM – Lesley.

However many of the NMs had not thought of this concept until they started coaching. A number of NMs had undertaken coaching because they had difficulties with a line manager but had not appreciated that they needed to manage this relationship. NM Val voiced the views of many of the NMs and coaches interviewed.

> *Yes, it is interesting managing your managers. It's a real skill I think as well and something that you need to learn how to do.* NM – Val.

5.2.2 Words used to describe the role

The types of words and metaphors that interviewees used to describe their feelings when taking on the NM role, or with problems within the NM role, can be seen in Table 5-1. These words ranged from challenging, conflict, toxic and out of depth to frustrated, incompetent and victim.

Table 5-1 paints a picture of a group of staff who at times feel very pressurised and vulnerable in their role. They also illustrate the need for staff to feel that they can take control of their own direction, as illustrated by NM Jane.

> *So the coaching side of it actually helps in lots of different ways, through change management and implementation strategies. So they all interlink I find.* NM – Jane.

This was also illustrated from the coaching perspective by coach Paula.

> *I think a lot of people came to coaching because they were tired, they'd run out of energy and they wanted to make a new start. It may be that they've got this new job or they've gone somewhere else or they're working in a new team or whatever. This was the opportunity to start afresh and enjoy nursing again.* Coach – Paula.

Needs identified by the NM		
Executive support *Peer support* *Time commitment – personal and organisational* *Valued by the Trust*		
Negative feelings of NM role	**Positive feelings following coaching**	**Outcomes of coaching**
Alien Barriers, Battle, Bullying Challenging, Conflict Confrontational, Controversial, Cry Difficult situations, Disillusioned Failing, Fear, Fire-fighting, Frightened Frustrated, Groaning, Horrible, Hurt Incompetent Lack of time, Lack of executive support Moaning, Not feel valued by the Trust, Out of depth Paternalistic, Politics, Suspicion Time commitment – personal and organisational Toxic, Truth,, Unaware, Unhappy Victim, Vulnerable, Waste of time	Affirming, Aware Be in a good place, Best thing Challenging, Competent, Confident Courage Emotional intelligence Empowering, Energised, Energising, Engenders Foster, Healing, Influence Mindful, Motivational Ownership Resilience, Restorative Safe, Success Think strategically, Trust Understand myself, Unsticking Vision, Winner	Change behaviour, Coaching works Congruence Deal with politics, De-escalate Develop as a leader Fix Patient advocate, Positive actions Proactive, Productive Significant difference, Success Techniques, Toolkits, Tools Transformational, Try things differently
Metaphors identified pre coaching, following coaching and as outcomes of coaching		
Horse to water *Didn't know what didn't know* *Been through the mill*		

Rained on my parade	*Go the extra mile*	*Loosened from glue*
Gone nuclear		*Using the*
handbrake		
Too close to see the wood from the trees		*Make a new star*

Table 5-1 Key words and metaphors

5.2.3 New roles

Some NMs reported having coaching specifically because they were unhappy in their job and wished to find a new post. The examples below from Fran and Pauline illustrate this.

> *We had a bad quality review and I had problems with my team and I thought maybe a new job would help.* NM – Fran.

> *I was just finishing the leadership course, so I was doing two courses and working full time. And I was unhappy in my job, so the reason I wanted coaching was to find a way out of it, so I went in wanting to do a CV, work out how to build up good contacts and find another job.* NM – Pauline.

A number of interviewees talked about the loneliness of being a manager and how they had to build up new support networks when they had been appointed in a new NM role. The problems they faced when taking on a new role were exemplified by phrases such as *'little support'*, *'learn by your mistakes'*, *'you've just got to do it'*.

It appears that many staff either sink or swim when they start their new role and that the staff that sink could have been shown how to swim with a little support and development. In these conditions, coaching was identified by NMs as playing a crucial part.

Surviving and thriving in this transition is even more difficult if you do not have a good manager to help you, as illustrated by NM Pauline.

> *It is hard, a hard transition. I do think you need to have somebody more experienced and with tools to actually help you sort of sift your way through it all, particularly if you didn't have a good manager.* NM – Pauline

This does not however mean that coaching is the panacea to all problems. From the coaching perspective, coach Emma makes a valuable point that losing some staff may, in the end, be the best for the staff member and the organisation.

> *I think there is always a risk for an organisation when you give people coaching, that some of them you will lose. I think you would*

have to trust that equally, there are others who will progress in other ways. Actually, the ones that you lose, maybe that in itself is good, is the right thing for the person and possibly for the organisation. So, you know, you can maybe take a positive in a roundabout way from that as well. Coach – Emma.

This section has shared the responses about coaching and the needs of NMs in their role and the words to describe their feelings before and after coaching. The next section will explore the needs of NMs for self-confidence and self-efficacy.

5.3 Self-confidence and self-efficacy

Many changes are occurring in health care, both at a national level and at individual NHS Trust and private health care sector level. Amongst all these changes, all interviewees felt that the role of the NM itself had changed considerably and this was an ongoing process within all organisations. The words some of the interviewees used to describe (see Table 5-1) included: alien, battle, bullying, challenging, conflict, confrontational, controversial, difficult situations, disillusioned, failing, fear, firefighting, frightened and frustrated.

NM Alexis and, from the coaching perspective, coach Paula commented on the way the role has altered over the years.

In the Seventies, I remember some very frightening ward sisters, and ... you know, back in the day, the training was completely different to what it is now. So my training had a massive impact on who I wanted to be. I did aspire to be a ward sister and, you know, have that authority, respect. I don't think it is there now. NM – Alexis.

A lot of people in those days got quite disillusioned with themselves and questioned their ability to do the job that they'd been appointed to. There were a lot of changes going on within the NHS that meant that management roles were assigned to clinicians. A lot of the clinicians found it very, very difficult to work within the new structure. Coach – Paula.

However, the perspective from DN Beth is of a role that is being enhanced again with increasing authority to control the quality and standard of care. She illustrates the reality and vision of the NM role developing in the future.

I think it's the accountability that is so pivotal. We see the Ward Sister as the pivot, almost the key determinant of the quality of

care…. So the real difference is, the accountability and responsibility, but also they have some opportunity for creativity. The other area we're working quite hard on, is to make sure that that role is supervisory, in terms of time. I want the Ward Sister role to influence the care of every patient on their ward. DN – Beth.

5.3.1 Increased workload

NMs reported having a greater workload year on year with higher performance expectations, often with less authority but with increased responsibility. NMs Val and Fran illustrate this frustration.

If they didn't agree with something, then they just wouldn't do it. It meant that … the area that I was jointly accountable for was failing. And not necessarily down to me not wanting to do things well or not putting the effort in, but because I was working alongside of another person. It didn't really negate away from the fact that, at the end of it, I was worried about patient care, patient experience, staff safety, staff experience. NM – Val.

We have so many demands now ... audits, quality visits, mandatory training for staff and it all falls on me. NM – Fran.

In addition, DN described how organisational change had affected the NM role and how they, in particular, had to manage more workload with fewer financial resources. These changes were also being covered in, at times, adverse media coverage. Some NMs talked of the constant 'fights' they thought they had to get things done. This feeling of being in a battle was explicit in a number of interviews, illustrated by NM Alexis.

You have to fight. I have to fight with Estates, I have to fight, fight is probably the wrong word, it's negotiate and be very strong minded and not buckle under pressure. NM – Alexis.

Given these challenging environments, NM Lesley talks of the value of having safe space to be able to receive coaching and how self-affirming it was to be able to talk to someone.

I suppose, if I get right down to the root of it, it was somebody asking me how I felt and how I coped and what issues were worrying me, spending three quarters of an hour actually talking to me on a one to one basis, without interruptions and in a private place. And probably, that had been the first time that had happened for a few years. So it was affirming, was actually somebody valuing me as a person, giving me the time and the space in a safe environment. NM – Lesley.

5.3.2 Developing resilience

Coach Paula introduces the notion of NMs needing resilience to be able to undertake the role. She also talks of the coach being able to assist with building self-confidence to help the manager.

> *A lot of my work was involved in developing self-efficacy, self-confidence, building resilience, introducing more creative methods to their working practices, and just helping individuals who had gone into nursing for very altruistic reasons, work with an environment that was very, very different now.* Coach– Paula.

NM Jo and DN Beth mention resilience and how this has increased following coaching.

> *I mean my ability to be heavily challenged, I have much more resilience.* NM – Jo.

> *In fact, I don't think I would have been as resilient through organisational change without that coach relationship. I could not have got through because I would have said something or done something that might have been far more career limiting than what I did say or do.* DN – Beth.

In summary, the areas to emerge from the interviews were the importance of having development programmes within which NMs are introduced to coaching. The perceived value to the NMs of coaching for balancing the needs of the role and their own career development emerged. In addition to this, a number of words were identified in the interviews, which illustrated the feelings of the NMs before and after coaching. These appeared to show the value of coaching to the NM in helping them overcome problems they had with challenging situations where they may have felt out of their depth and how coaching helped with their resilience in dealing with these situations and their role in general.

5.4 The researcher's voice

The three areas above illustrate how and why coaching has occurred from the interviewees' perspective. This will now be analysed in more detail. The views are a collation of the NM, DN and coach interviewees and

incorporate relevant findings from the survey. Figure 5-1 illustrates, from an overall perspective, how and why coaching occurred.

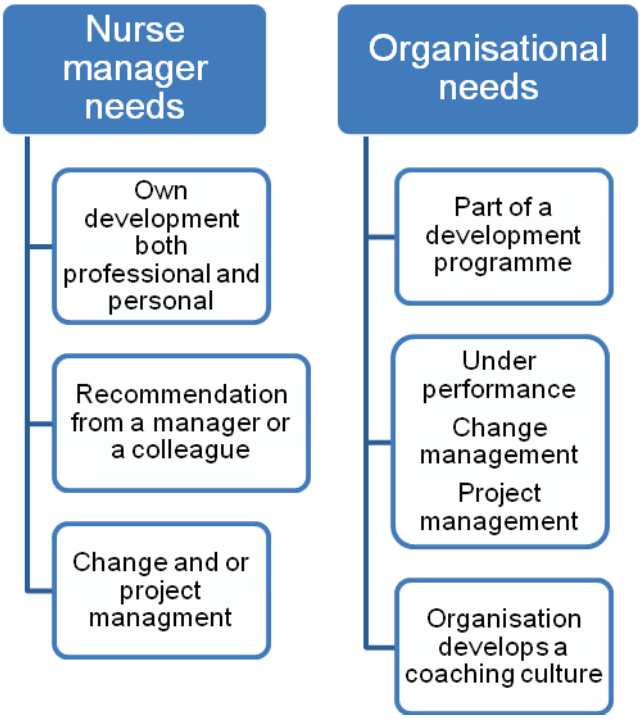


Figure 5-1 Why coaching occurred.

What appears to emerge from the interview data is the concept of a duality of understanding: what NMs, DN and coaches understand of the value of coaching and what is hidden. Building from this, the concept of NMs not knowing what they need to develop but also not knowing what is available for their development will be explored by using the Johari Window. This structure, developed in 1955 by Luft and Ingham (1955), was further enhanced by Handy (2000). The four rooms described by Handy (2000) are:

1. Known to me and others,
2. Known to others but not to me,
3. Known to me only,
4. Not known by anyone.

These four rooms have been adapted and reworded in this study, to interpret the role of the NM. They have been used to illustrate the understanding of NM development needs and how coaching can be embedded into this. In this formulation the term 'others' refers to colleagues that work with NMs, including their managers, the multi-

disciplinary team, administrative staff, coaches and family members and friends.

What the NM and others see	What others see of the NM
What only the NM knows	What no one sees

Figure 5-2 Interpretation of the Johari Window.

5.4.1 What the NMs and others see

It appears that meeting the need for development by NMs is crucial for their ability to undertake and to gain satisfaction from their role (RCN, 2009). The development has to be multifaceted, including areas such as finance, human resources etc. Introducing coaching during a development programme appears, from the data collected, to be an effective method to enable staff to gain insights into how coaching can help them.

The lack of and the inconsistency of, access to development opportunities was apparent from the survey, with only 68% of respondents having a formalised development programme and with only 12% of those respondents ensuring that their staff attend a programme. Contrast this with repeated recommendations for the development of leaders in management roles; for example Thorpe and Loo (2003), McKenna, Kenney and Bradley (2004) and Pitkanen et al. (2004). However, the lack of development is still being identified (Hello et al., 2011) as causing failures in creating an effective work environment (Whiley, 2001; Doran, 2004). It appears though that, even with the evidence that has been shown, mandatory development of NMs still not being undertaken. .

In addition to the lack of commitment by some organisations to invest in the development of their NMs, the NMs also face changes in their role. Most health care and business organisations are going through constant change and as such, there are changing expectations of the manager role (Watson and Harris, 1999). All three groups of interviewees talked of the increased expectations of the NM role. This increase in expectation leads to increased stress and has also been shown to decrease NMs effectiveness as line managers (Doran et al., 2004).

The value of coaching to help with difficult line management decisions and to demonstrate leadership was identified by all three groups interviewed.

This was particularly noticeable in relation to how the NM develops line management skills and leadership and how NMs deal with difficult situations. A number of NMs and coaches said the reason they had sought coaching was either to deal with difficult staff that they managed, or their own line manager (illustrated in Table 5-1).

There is evidence that the organisations that are most effective, have managers that demonstrate transformational leadership behaviours (Block, 2003; Doran et al., 2004). If NMs are able to adopt a leadership style that has a positive impact on their practice area, it has been shown that it will directly increase satisfaction and quality of patient care (Doran et al., 2004; Casida, 2007). Coaching therefore needs to be a clear goal for NMs and their organisations and will ultimately, benefit the organisation more than a pure development programme will.

5.4.2 What others see of the NM

The new insight gained from the interviewees in this study was the value the NMs ascribed to having been introduced to coaching as part of a leadership programme. Many NMs would not have thought of accessing coaching had it not been part of a programme. Therefore, the investment in development that includes a coaching component seems to be a key route to enable NMs to access a support mechanism that many would not have considered.

There have been debates in the literature for a number of years as to the value, or need for, nurses to be developed in their management roles and indeed whether they are suited to management at all (Macleod-Clark , Maben and Jones, 1997). One idea put forward by Reedy and Learmonth (2000) is that nurses are being asked to leave behind their identity as being a caring worker and take on a manager identity. It is postulated that this has to occur before the nurse can fully take on the requirements of being a manager.

There are two opposing camps in the discussion with some authors thinking that nurses should not take on management values as they usurp the values of caring (Traynor, 1994). Others, though, believe that proper management training is essential for nurses to be able to progress in their careers (Macleod-Clark , Maben and Jones, 1997). It may be, perhaps,

that there is still a view that nurse managers are just enhanced clinical staff and as such do not need the development that a manager in a business context, for example, would demand.

The NMs interviewed appeared very willing to take on and become expert at the management and leadership required for their role, viewing coaching as an integral part of this. The value of coaching was seen by many, as being able to unpick the differences between being a caring nurse and a manager. Coaching also helped to show that the skills required for each are not incompatible. The view held by some authors that NMs were not suited to becoming managers could be revised in light of this study.

Many of the interviewees talked of undertaking personality tests either during a management programme or when coaches used them as part of an evaluation of a new client. The use of personality tests in business is well documented (CIPD, 2012). They should be seen as non-punitive and as an aid to help discussion rather than an end in themselves.

Personality tests were used by many NMs and as well as telling them about the way they work, they were also seen as a useful tool to help think about the personality of the staff they line manage and their own manager. This concept was described in terms of managing upwards and downwards by interviewees. However, while some of the NMs found the use of 360-degree and MBTI helpful, others did not. I wonder if the ones who found it unhelpful, though, did not have an opportunity to explore why this was the case with their coaches. Sometimes one does not wish to explore areas that are seen as not as positive unless this is undertaken in a supportive manner.

The value of these tools, for exploration with a coach, is that they give some guidance on what others think of the NM, which the NM may not appreciate themselves. However, these tools should be seen as tools for discovery and not as tools for making judgements (CIPD, 2012). Being judged was an area the NMs felt did not occur with most coaches and maybe, for the staff that did not have such a good experience, it was perceived that an element of judgement was present.

The problems associated with managing upwards were often due to the NM not having considered the importance of managing the relationship with their own line manager. This was an area that was unknown to them as they were generally concentrating on managing their own staff and so the relationship with their own manager had not entered into their thinking. This is an area where coaching can demonstrate much benefit, enabling the NM to feel empowered to manage their relationships more effectively than being driven by them. This ability to manage relationships was mentioned by some interviewees, e.g. Lesley, Jane and Val. They were able to identify who had received coaching and who had not, purely by the person's ability to effectively manage their communications with senior staff in meetings.

5.4.3 What only the NM knows

It seems clear that a problem that some NMs have faced, when undertaking development programmes, is that they seem a world away from their own practice as a nurse (Reedy and Learmonth, 2000). This period of transition between being a wholly clinical nurse and the nurse manager is a problem identified by the interviewees and is documented by (Sambrook, 2006). This is also echoed by McDermott (2001) when considering the short length of time that managers are in an organisation now before they are promoted, which adds to their lack of experience and maturity as a manager.

One way that this conundrum can be helped is helping NMs to make the link between their development programme and their own practice. This linkage can be facilitated and enhanced by coaching (Passmore, 2010; Bright and Crockett, 2012). The need for, in particular, new managers to remain clinically focused is a problem in the new world of audits, quality measures and increased paperwork. Therefore, the importance of NMs being able to lead their clinical staff effectively, while still balancing the needs of the quality machine is a complex task. This is one area where coaching can play a part in terms of prioritising, delegation and time management skill development.

The need to develop resilience and self-efficacy in their role was also identified as a key reason to seek coaching. A number of NMs reported

feeling overwhelmed by the role whether new in post or having been in the role for a while, reflecting the fact that first line managers have been seen as a 'resilient but put upon survivor of organisational change' (Hales, 2005, p.502). While the importance of the coaching relationship is explored in more detail in Chapter 6, the key factor the NMs recalled, in being able to divulge their concerns and worries, was the confidential nature of the coaching relationship.

Some NMs would not have undertaken coaching if it had been with a person in a line management capacity with respect to their role. They expressed their concerns about their own discussions not being kept confidential in this type of relationship and how this may have put them off coaching if it was the only option offered. This understanding of self and the need to feel secure was illustrated by NM Lesley and leads one to conclude that some NMs feel very insecure in the lack of confidential relationships they have with their line managers. Table 5-1 illustrates this through words such as: barriers, bullying, challenging, conflict, difficult situations, fear, fire-fighting, frightened, frustrated, lack of executive support, not feel valued by the trust, and politics.

Coaching is about 'establishing beneficial relationships, and coaching aims to establish relationships based on mutuality' (Moen and Federici, 2012, p.12). The value that coaching with an independent person can bring can therefore not be underestimated in enabling a safe environment for reflection and support.

5.4.4 What no one sees

The value of developing the NM, to demonstrate leadership capability, has been identified by Large et al. (2005). However, being able to demonstrate leadership is more difficult if the NM is unable to perform even basic components of the role, such as financial and human management (Lee and Cummings, 2008). This lack of effectiveness was expressed by the NMs in terms of 'incompetent, failing, out of depth and didn't know what we didn't know', (see Table 5-1). All of these terms suggest that these are a group of staff who operate under immense amounts of pressure, often with little support for undertaking such a complex role. On top of this, they have a fear of failure, which is now exacerbated by the fallout from the Francis

Enquiry (2013) and their own regulatory body requirements to undertake their role effectively (NMC, 2013).

The need for NMs to build resilience, so that they can manage this most complex and pressured of roles, is also entwined with self-efficacy. The constructs of resilience and self-efficacy are interlinked, with the ability to realise self-efficacy being to some extent dependent on resilience. Bandura (1977, p.3), the developer of the Self Efficacy Theory, says that self-efficacy refers to 'beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments'. This has been further explored by Davis et al. (2007, p.206) suggesting that 'self-efficacy beliefs have been important predictors of behaviours related to physical and mental health'.

According to Davis et al. (2007) the ability to persist, in the face of challenges, is dependent on thinking positively and creating a positive environment. This is problematic in the health sector as there are many factors that will lead to a less than positive environment, for example cutbacks in finance and staffing, as well as the acuity of the patients. It can be argued that coaching can bring resilience to the NM role to enable them to manage this adversity more effectively. Adversity can be defined as 'any negative, stressful, traumatic, or difficult situation or episode of hardship that is encountered in the occupational setting' (Jackson, Firtko and Edenborough, 2007, p.3). Reflecting back on the interviewees' words in Table 5-1 to describe the NM role, one can see that words used to describe adversity are evident.

When the person's own workplace is in such a state of adversity and turmoil the ability of the NMs to create their own internal positive environment, through developing resilience, may be more effective in helping them to attain self-efficacy. The need to be resilient in the face of organisational pressure and change is identified by Sherlock-Storey, Moss and Timson (2013). When a person increases their resilience, they are more likely to be open to changes in the organisation and be more proactive in the way they manage their team (Avey, Luthans and Jensen, 2009; Lawton-Smith, 2013). This building of resilience is key to NMs being able to lead and manage in their role rather than just survive in it.

As will be discussed in Chapter 6 the NMs did not set out to have a better self-understanding but found that this was one of the by-products of coaching. This understanding of self is shown to be significant in resilience research, contributing to self-efficacy, high esteem and emotional regulation (Reivich and Shatté, 2002). Self-efficacy is linked to a number of behavioural outcomes and by investing in a leader's ability to improve their resilience their self-efficacy will be also improved (Lawton-Smith, 2013).

The NMs faced many problems, which led them to seek coaching. They used many negative words to describe how they felt in their roles prior to coaching (see Table 5-1). How they coped with the problems in their role prior to coaching can be viewed from two angles. Firstly there is 'problem focused coping' where the person takes the initiative to tackle the problem; secondly there is 'emotion focused coping' where the problem cannot be managed other than through an emotional reaction by trying to 'reduce the negative emotional responses associated with stress such as embarrassment, fear, anxiety, depression, excitement and frustration' (McLeod, 2010, p.1).

What is clear is that many of the words used by NMs to describe their role prior to coaching are akin to the words used in emotion focused coping, whereas the words they use afterwards are more akin to problem focused coping (see Table 5-1). Coaching seemed to be able to enable NMs to engage in an active process that is described by Giordano (1997, p.1032) as 'a shifting balance between vulnerability and resilience'.

Some empirical studies already show that coaching can enhance skills, develop awareness in new leaders, maximise their motivation to perform well in their new role and help them develop their confidence and self-worth in a new testing environment (Rappe and Zwick, 2006; Medland and Steinhauer, 2009; Joo, Sushko and McLean, 2012). Coaching is usually seen as a process that allows an increase in the coachee's self-awareness of their role and potential and what they can do to improve their performance (Moen and Federici, 2012). Significantly, NMs did not anticipate this development of self-awareness before they undertook coaching.

The Johari window has been used to summarise the researcher's voice.

1. What the NM and others see	**2.What others see of the NM**
Need for development but inconsistency of this Coaching helps with difficult decision making and 360-degree line management	Coaching being introduced as part of a development programme NMs' desire to be excellent managers
3.What only the NM knows	**4. What no one sees**
Difficult transition to NM role Developing resilience and self-efficacy	How coaching can help in a shift to problem focused coping How coaching can help with moving from vulnerability to resilience

This chapter has shown how NMs have been introduced to coaching and how for some it was a way to balance transitions and the demands of the role, while for others it was a way to develop self-confidence and self-efficacy. It has been seen that there are some areas known only to NMs, such as their own needs in the role and other areas not known to them, such as what development and coaching can offer them in their role.

Accessing coaching appeared to be predominantly through a development programme; however although this is not the only access route it appeared to be a key way to introduce NMs to the value of something they knew little about. The following Chapter 6 will explore what happens during the coaching process and the experience of coaching for NMs.

Chapter 6 - The Experience of Coaching

Chapter 5 explored how and why nurse managers (NM) access coaching. Following that analysis this chapter will explore the actual experience of coaching for NMs, with the themes that emerged from the data discussed in three sections:

6.1 Value of Relationships

6.2 The role of reflection

6.3 The NM relationship to coaching, mentoring and clinical supervision.

In section 6.4, the focus will be on the researcher's voice and the holistic interpretation of the data. Findings are interpreted using existing literature and additional literature is introduced to draw new insights from both the data and literature.

6.1 Relationships

6.1.1 Relationship between the coach and the NM

All interviewees identified the relationship between NMs and their coaches as crucial. The importance of utmost confidentiality led many interviewees to state that they would not like their line manager or anyone in their direct manager hierarchy to coach them. Most NMs either felt they could not trust their line manager not to disclose what their session had contained or could not trust someone in a position within their organisation that could feedback to their line manager. This element of mistrust, from the coaching perspective, of some senior staff in an organisation is summed up by coach Jadyn.

> *Because I've realised ... how very isolated and vulnerable they are, although they don't thank you for saying it or acknowledging it. … some of them would dearly love to do it but they don't feel, I think there's something about safety, I think there's something about people worry. I don't think this is unique to … I think this is the same in the NHS family by and large. And it pains me to say it, I don't think they feel their confidentiality will be safe. I have to say that of the NHS is awful because if anybody should be able to ensure that, it should be people that work in the NHS.* Coach – Jadyn.

Even when NMs did report good support from their line manager, although this was outweighed by the NMs who did not feel this way, they did not

want their line manager as their coach. In another perspective, having a coach from the same organisation was seen as having someone who perhaps had already developed some learned helplessness and as such would not be able to shed new light on a subject. This is illustrated by NM Lesley.

> *All I can say, in my own experience, I found it more useful when it was someone who could stand right back and be completely out of the political situation within the Trust. Rather than someone, who was already, maybe had some sort of learned helplessness or was already constrained by things going on politically or strategically within the Trust. So that's my personal feeling.* NM – Lesley.

This lack of trust of managers was expressed through a variety of words, including fear, disillusionment, suspicion and being caught up in the 'political situation' within a trust (see Chapter 5, Table 5-1).

6.1.2 Venue for coaching

Both NMs and coaches described the importance of the coaching session occurring away from the workplace, not necessarily on another site but just not in the work area. Some NMs however did talk of the value of being completely physically away from their organisation when coaching took place. This physical separation seemed to help them to be more objective about their work.

A few NMs and coaches called the experience affirming. It helped them to understand what was true, sometimes in a world where they were not sure what was authentic. From a coaching perspective coach Paula sums this up.

> *It resulted in affirmation that what they thought was right was right and was true. That is the real, that is you, you know, you are OK about this and that sort of thing. And I think it was refreshing.* Coach – Paula.

Building on the theme of affirmation a number of NMs were keen for the coach to acknowledge what was going on in the life of the NM. Coaches also recognised this but both they and the NMs did not want the coaching to become a 'moaning session'. They also felt that it was important to raise any issues at the outset that would impinge on the coaching, for example family bereavement etc. Therefore, it was felt there was a balance to be

found between offloading problems and trying to remedy the problem. NM Jane sums this up.

> *Whereas, you don't want it to become a moaning session about individuals or situations, but you actually are trying to remedy a problem which was quite difficult when we first started, which is quite bizarre really.* NM – Jane.

6.1.3 Self-affirmation

One of the strongest areas to be shared was the realisation that the problems facing NMs were not their fault. This came over powerfully and was an epiphany moment for many NMs who, until they had coaching, presumed that all the problems they faced were their fault. NM Jane sets this in context.

> *So through coaching ... it was actually quite beneficial realising that actually, it wasn't my fault, it was just circumstances. … that actually I had put things in place to be able to carry on. … just other processes out of my control were slowing things down. So, therefore, through the coaching you realise, it wasn't actually your fault and actually you are able to benefit from having those, giving you the inner confidence to actually say to your staff, these are the things I've actually proactively managed and this is what I've done about it.* NM – Jane.

This theme of self-affirmation came over as well in terms of the value placed on the personal time with a coach. Many NMs felt guilty to begin with about taking time out for themselves. However, once they saw the value of the coaching and how they could improve their effectiveness in their role, they saw it as a good investment of their time. This is illustrated by NM – Julie.

> *No, I think it's essential, I think all nurses should have it, myself, which I was saying to the Chief Nurse. It's absolutely essential because you can see in teams that have been coached, and when I put coaches into my team after I'd done it, because I didn't feel that I could coach them and I wanted them to, our team was very successful. Because I think you learn all kinds of other skills, even if you aren't directly coaching somebody, just the whole concept of knowing who you are, how they all fit, who's the best person to do it in this room and not making everybody be the same, was beneficial. So no, I think it should be built in more.* NM – Julie.

The importance of a NM being able to feel good about themselves and how this links into the NM mental wellbeing is also echoed from the coaching perspective by coach Paula.

> *I think that if you have people who want to do the best they can, who are getting the opportunity to have the benefits of coaching, which it is about is thinking about things in different ways and playing out how things might unravel, that they actually can go home at the end of a day, or at least at the end of the week, and feel that they're accomplishing what they're there to do. And that they're doing it to the best of their ability and they actually have opportunities to feel good about themselves. Then I think their overall mental health certainly, is far more robust.* Coach- Paula

6.1.4 Shared values

The importance of values and standards comes across from a variety of NMs and coaches. In reflecting those values and standards the NMs felt the need to have a coach who intrinsically had the same ethics and values as themselves, whilst recognising this needed to sit alongside the perceived need for an external outlook. This enabled the NMs to relate to the coaches more effectively and helped cement the relationship. NM Val sums this up.

> *I have a very good personal and professional working relationship with my coach and we […] have a lot of the same values and standards of how things should be. So yes, I've found it enormously beneficial.* NM – Val.

The importance for the organisation of NM/coach shared values and ethics was also mentioned by DN Helen as a factor when choosing either a coaching company or internal coaches.

Coaching's role in understanding themselves and how they function was an additional point made by NMs. Many interviewees talked of the value of coaching to enable them to better understand their own personality and ways of working. This had at times involved understanding their own life and upbringing better, though this could overlap with the need for counselling, as opposed to coaching. The understanding of what they thought were the boundaries between coaching and counselling was expressed by coach Emma.

> *I always had to remind myself that I was coaching and not counselling. But I think that sort of tips over into the actual learning I was telling you about as well, because in many respects, that was*

> *almost like coaching. And you weren't trying to give somebody the answer but, you know, helping them to see the answer for themselves. They are different, and I think we always had to keep alert to make sure we didn't tip over one into the other.* Coach - Emma.

All coaches reported that they would refer an NM to a counsellor if they thought their client required these specific skills. However this boundary between coaching and counselling was seen differently by the NMs. Reflecting the value they placed in the relationship with their coach they were happy with an element of counselling as it saved them going to see another professional and making a new relationship.

The interviewees had varied opinions as to whether the coach needs to understand the health sector or the client's employer. Some felt that knowledge of the pressures associated with being an NM may be useful in understanding the context of their workplace. This is summed up by NM Lesley.

> *I imagine actually, that you would need some knowledge of what the constraints and national problems are likely to be. But, on the other hand, I suppose if you're encouraging someone to come to their own conclusion, perhaps that isn't necessary.* NM – Lesley

However, others felt that if they had a skilled coach then it did not matter where they worked. This view seemed to be more pervasive in NMs and DN who had received coaching for a number of years. When NMs first started coaching, they had more of a need for someone who understood their role and health care context. Once they were more confident in the coaching process, they could see the value of having someone who could help them think outside the organisation and outside healthcare. This is illustrated by NM Dale.

> *Strategic thinking, it was never, well it still isn't now, one of my great strengths. And to help me think strategically and that's where somebody outside of the NHS was very helpful and very powerful, some of the questions they asked me.* NM – Dale.

6.2 The value of reflection

The NMs reported a variety of methods used by coaches in the coaching process. Some NMs did not attach a name to their type of coaching just reporting whether they felt it worked or not.

Most interviewees valued the brainstorming of ideas and the value of the coach reflecting back what had been discussed with the coach encouraging the NM to reflect themselves on issues they had brought. While nurses are familiar with using reflection to enhance their practice, the value of engaging in this in a structured process and with a skilled facilitator was reported by all groups including DN.

The utility of reflection is expressed by NM Lesley.

> *I became a better delegator and I became better at reflecting things back to staff. I was aware of the tools and techniques that I'd learnt. So, I suppose the delegation skills and probably time management skills probably improved. That lesson has stood me in good stead right the way through now.* NM – Lesley.

Jadyn reported that when she learnt to be a coach the programme had ensured that the participants had reflective skills, both in terms of being able to reflect themselves and being able to reflect back to others.

> *…they sort of checked that everybody had some sort of reflective skills, so that you were able to reflect back to people, which was the most important thing. Actually reflecting back, had you understood what someone was saying? And sometimes, reflecting back, people hear it for the first time.* Coach – Jadyn.

Both NMs Lesley and Dale also commented that sometimes when a coach reflects something back to the coachee it might enable the coachee to see something in a completely new light.

> *I would see coaching as the beginning of that process, to try and facilitate somebody finding the answers to a situation themselves. Because sometimes, [...] it may be the first time they've actually thought about it that way.* NM – Lesley
> *Reflection is really important to me and to have an opportunity sometimes to have a structured reflection process and somebody to prompt you when you might not have thought about it yourself, I think is very constructive.* NM – Dale.

This is also confirmed from the coaching perspective by coach Jadyn.

> *I think they have to have a genuine talent for listening. I think the ability to reflect on what you're hearing is also extremely useful. I think having the courage to ask stupid questions, and I do see that as quite courageous, because you don't always get what you expect back from that.* Coach – Jadyn.

However, NM Dale goes on to make the point that, in their experience, not everyone is able to reflect effectively or is willing to. There needs to be an element of the NM wanting to engage in the coaching process in order for them to get something from it.

> *But you can only take a horse to water; you can't make them drink necessarily. So you have to be a willing participant.* NM – Dale.

Some of the interviewees had experienced coaching in groups and through peer group coaching. These were described in terms of either coaching via an action learning set or in formalised peer groups. NM Jo recalls the value of reflecting back issues with peers.

> *So we did the action learning and then it became a self-regulating, actually we still meet now every four months.* NM – Jo.

As well as reflecting back, the interviewees valued having a variety of approaches used by their coaches. Some coaches were more challenging in their coaching methods than others. This difference is illustrated by NM Jo.

> *It's his life's work and he's really good at Transactional Analysis and he's done a lot of reading around theory. I just felt really comfortable with xxx and he also understood our organisation culture, because we've spoken about it throughout all my coaching. … So because I've known him for so long, they're really challenging and really tiring*
>
> *The different style that xxx used, she had done Transactional Analysis and she was doing all the right things at the time, […] it's much more challenging now than before with xxx. It was probably more supportive then. There was a wee bit of challenge in there but I think it felt more supportive. Not that xx is not supportive but to have him challenge, I come out exhausted, I usually put my head on the desk at the end and say, "That was brutal". Whereas with xxx, I kind of skipped away feeling I'm great and that's been fab and I feel fab.* NM – Jo

Jo's example illustrates two of the different ways that a coach can elicit development for an NM and that they can both be valuable but for different reasons. For some the very challenging approach will work very effectively but for others it may not. There may also be a time factor associated as the more exposure an NM has had to coaching the more willing they may be to have a really challenging experience.

From a coaching perspective, coach Paula shared her experiences of using variety of methods and how she uses reflection herself to think about how her session has gone. This also demonstrates a coach trying to meet the needs of the NM they are coaching rather than having a set methodical approach.

> *I would describe it as very intuitive. I improvise a lot, so you probably wouldn't recognise techniques in my coaching because I've blended quite a lot of things together. There's a very strong focus on the individual and creating the best working relationship that I can have with them. […] because it's more intuitive and improvised and much more creative, I get less tired. And I know, that after a coaching session, if I still feel energised at the end of that coaching session, I know that it's been a success in, you know, the sort of indicators that I use. But if I come away feeling really tired and drained, it's a sign that maybe I've either not been paying attention, or I've not been paying attention to the right things, or something's not quite right. And I use my reflective time to try and understand what that might be.* Coach – Paula.

This section has drawn out some of the value that NMs attach to the use of reflection by themselves and by their coach and of coaches own perceptions of the value of reflection. The balance of the NM role in relation to mentoring and coaching will be explored in the next section.

6.3 Relationship between coaching, mentoring and clinical supervision

During the interviews, it became apparent that there was overlap in the way that all interview groups viewed coaching, mentoring and clinical supervision. For example, some viewed clinical supervision as a type of coaching while others saw it as a quite separate development process.

Coach Emma, from the coaching perspective, talks of the balancing act between wanting to give advice and remaining in a coaching mode, when

she can see clearly what she thinks the NM needs to do to remedy a situation.

> *From my perspective, the most difficult thing is the self-management, of when it's so familiar and you know what they're talking about. And you want to stay within coaching and not revert into a more kind of mentoring type role, which sometimes can be appropriate I suppose. I think there hasn't been, I mean there has been situations where clients have had difficult situations. So it's around helping them, how they deal with that and how they might look at it from different perspectives. And getting them to, you know, bring in some sort of transformation into it for them.* Coach – Emma.

This blurring between the activities was more common before the NMs had received coaching than afterwards. NM Dale, Julie and Val express their views in these extracts.

> *I know there are strict definitions of coaching and mentoring but they kind of blur to me to some extent. It is about support, helping people reflect and giving them, you know, direction. I think for many people the boundaries do kind of blur.* NM – Dale.

> *I thought it was going to be similar to clinical supervision I suppose, because you hear the word coaching, but it was very decidedly different. ...it wasn't quite what I expected.* NM – Julie.

> *Yes, I tend to associate clinical supervision with more the clinical practice stuff. And sometimes with more of the sort of, you might call, hard management stuff. No I wouldn't use it in the same term as, alongside coaching.* NM – Val.

DN Denise recalls how clinical supervision may have been used in the past as a type of coaching before coaching became more widely known and acceptable.

> *I've had supervision, because at the time when I was put into the Chief Nurse post, coaching wasn't really in vogue, well I certainly hadn't heard of it, and it was about clinical supervision. So I had a supervisor at that point, because I felt I was going, I was quickly promoted at the time and I was way out of my depth. So I approached somebody, who works in organisational development, and my clinical supervisor was very much, now that I know a lot about coaching, was very much in a coaching capacity.* DN – Denise.

This appears to illustrate that the need for a coaching style of support has been a long-standing one. It is only more recently when coaching has

gained more widespread use and credibility that it is more easily accessed by health care and in particular NM staff.

In summary, the section illustrates the coaching experience, expressed as a whole in Figure 6-1. This figure shows the full range of experiences expressed by the interviewees in relation to their experience of coaching and their relationship to their coach. The three sections have shown the importance to the NM of the relationship they have with their coach, with the relationship built on honesty, confidentiality and challenge. The degree of challenge and whether it is useful for some NMs to be taken out of their comfort zone has been described, along with personal factors, such as the boundary between coaching and counselling, and environmental factors such as the coaching venue.

The importance of self-affirmation emerged as well as the need for the coach and the NM to hold the same ethical values. Self-reflection by the NM and the coach's ability to summarise the NMs discussions and reflect that back to the NM surfaced as an important part of the coaching process. The usefulness of having a set of tools for life was recognised. Additional types of relationship were also identified between coaching, mentoring and clinical supervision.

Figure 6-1 Coaching experience.

6.4 The researcher's voice

Key areas will now be analysed with further interpretation of the data undertaken with reference to the literature.

One of the main areas that emerged from the data was the complexity and value of relationships between the NM and their line manager, their team and their work organisation. What appears to emerge is how the relationships that the NM has with their coach, mentor and clinical supervisor are intertwined with their effectiveness in their relationships with their line manager, team and organisation.

The Johari window will not be used in this chapter as the analysis in this section is focused on the NM relationship with coaching, mentoring and clinical supervision and how this relationship then influences in turn the relationships the NM has with their colleagues.
This relationship construct is illustrated in Figure 6-2.

Figure 6-2 NM relationships.

There have been a number of empirical studies looking at coaching and mentoring and mentoring and clinical supervision (Joo, Sushko and McLean, 2012). However, not all three have been looked at together from the perspective of the NM and in particular, how they affect the NM relationship with other staff.

In this study all of the interviewees had a different understanding about coaching, mentoring and clinical supervision before they commenced coaching, an understanding that was altered following coaching. Prior to them receiving coaching most interviewees thought that coaching was a different name either for mentoring or for clinical supervision. This section will therefore analyse this relationship construct and how these relationships influence the NM role.

NMs are in a unique position: they can receive coaching, mentoring and clinical supervision but are also responsible for conducting coaching, mentoring and clinical supervision, as illustrated in Figure 6-3. The NM role is also unique in that it is the one managerial role that undertakes direct clinical care on a daily basis. By contrast management positions above this grade will only perform clinical care on an intermittent basis. This therefore requires NMs to have regular clinical supervision.

Figure 6-3 Role of NM to coaching, mentoring and clinical supervision.

NMs and DN talked of the value of receiving all three development types and there appears to be wide overlap between the three. A combination of these appeared most valuable, rather than just one development approach. However, if there was only one type of development on offer, the interviewees indicated that they would favour coaching above mentoring and clinical supervision. This could stem from the fact that they were already a skilled clinical practitioner by the time they became NMs, but it was their management and leadership, which needed refining.

Figure 6-4 illustrates the different relationships that the NM will have with coaching, mentoring and clinical supervision. This figure has been developed following the interviews and is further developed from Table 2-1 in the literature review section 2.3.4 adapted from Jarvis (2004, p.20) and Joo, Sushko and McLean (2012, p.30).

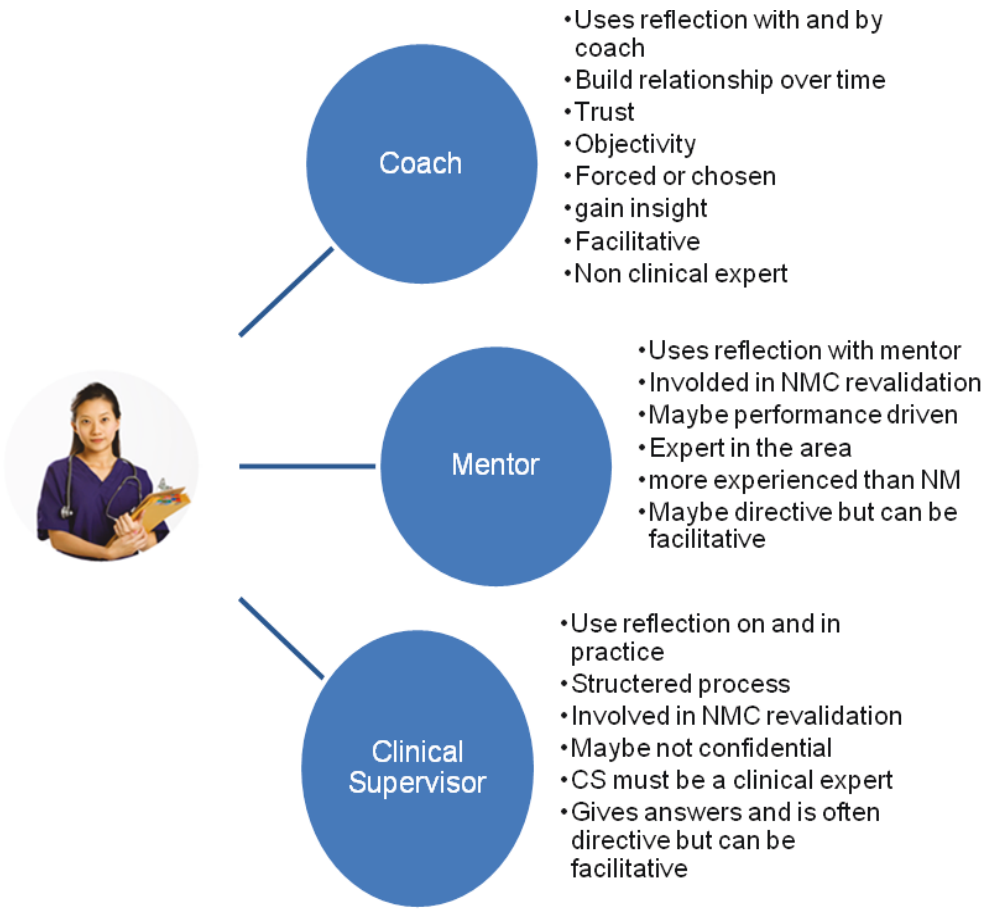


Figure 6-4 Relationship of NM to their coach, mentor and clinical supervision

Thomas (2013) talks of the value of having a mentor but mentions this is described in terms that could be also be interpreted as coaching. He also advises that NMs also have clinical supervision so that they can be expert in their own clinical practice. This provision is supported by Jasper and Jumaa (2005) who describe the value of clinical supervision for effective clinical leadership.

While clinical leadership has considerable overlap with the leadership of staff it also has key differences. Clinical leadership is centred on the patient and the requirement of leadership to ensure excellence in nursing care from the team. However, the leadership of a team in addition to the leadership of their clinical work is a much broader task and requires a wide skill set. The overarching framework, (Figure 6-4) resulted from the overview created from discussion with all research interviewees emphasizes the role of reflection.

Reflection seemed to take the form of the NM reflecting back on their own experiences as well as the value of the coach reflecting back to the NM

what they had understood of their issues. Given The NM role is enmeshed in a complex set of interpersonal relationships the value of reflection was very apparent, helping to guide the NM through these complexities.

The NMs in general set their own agenda when they received coaching. This may have been influenced by the assessments undertaken on a leadership programme, such as a 360-degree evaluation etc., but the NMs reported usually being able to work on the areas they really wished to. The importance of this focus was reported by coaches working with the NMs. They described being led by the needs of the NM, although coach Paula did report that in the back of her mind, from the coaching perspective, was also the needs of the organization.

This organisational remit may be a consequence of a coach also being an employee of the organisation, as opposed to a coach who is from the outside. Organisational knowledge could be seen as a help or a hindrance as far as the NMs were concerned.

Some of them felt that institutional knowledge was useful so the coach knew in which context they were working. However, others felt that this may blinker the coach and they would prefer to be coached by someone who was a skilled coach and who was not 'tainted', as they saw it, by organisational knowledge (Wasylyshyn, 2003). See also Table 5-1 for descriptive words such as politics, toxic, fear and suspicion, which were used by some NMs to describe their relationship to their managers.

6.4.1 Relationship to mentoring

Coaching engagements are reported in the literature as often being shorter than those with a mentor (Passmore, 2007; Joo, Sushko and McLean, 2012). This was not the case with many of the NMs and DN. They had, in some cases, worked with the same coach for a number of years and through a variety of jobs. Elsewhere there is also a difference between an NM having a short relationship with an individual coach while having a long relationship with coaching itself and seeking coaching when they move into other jobs, as had been the case with many of the DN.

The relationship had been short in some cases when the first coach had been one assigned during a leadership programme. However once the NM had decided they wished to have a coach to support them beyond the programme they contracted for a relationship which was much longer term.

The experience of the NMs in this study was that they used a mentor for a project, or when they were new to a role or organisation to gain knowledge and skills, but that they did not have a long-term relationship with their mentor. It could be speculated that managers who had a long-term relationship with a mentor did this because they did not have a coach and the goal of the mentor relationship may also be very organisationally orientated.

6.4.2 Relationship to clinical supervision

The goal of the clinical supervision relationship will be directly related to the needs of the patients in the NMs' care, either for management skill development or direct clinical expertise development. Clinical supervision has been seen as being vital to CPD according to many policies and reports (Bond and Holland, 2010). This need for the clinical supervision part of the NM role to be high profile has been expressed by Northern Ireland's Health Minister Edwin Poots: '…he wants all hospital wards to have a sister with a distinctly supervisory role who can oversee care standards and be a role model' (Duffin, 2014, p.5).

However, in addition to it appearing not to be desirable to have one's line manager as a coach there has also been role conflict identified as a potential problem when the clinical supervisor is the line manager (Howatson-Jones, 2003). This leads one to deduce that in health care the relationship between any staff member and their coach and clinical supervisor is crucial for the relationships to be effective. In neither case, should the coach or clinical supervision be the NM's line manager.

The needs are reflected in Figure 6-1 where the interviewees reported needing honesty, confidentiality, someone who was affirming and also a coach who was able to help the NM to be self-reflective. This is not to say that a skilled clinical supervisor could not undertake some of these roles but their main brief is clinical development. They will not usually be skilled in helping the NM to gain personal insight into their management style or

problems and will not have the set of tools (described in section 6.1) valued in the coaching process.

Some authors suggest that there is less clinical supervision when there is too big a workload for the supervisor (Doran et al., 2004). This would be the case if a NM's line manager were a clinical supervisor to them; it may also be the case if the NM is providing clinical supervision to their whole team. Therefore, delivering clinical supervision outside the line managerial chain and without too big a supervisory workload could potentially be the most valuable modus operandi for an organisation to adopt.

6.4.3 Use of reflection

Using reflective practice to help the NM to gain a better understanding of their practice through mentoring and clinical supervision has been well documented (NMC, 2006; Bulman and Schutz, 2013). Reflective practice has been heavily influenced by Schon's (1983, 1987) work where he talks of reflection in action and on action. Reid's (1993, p.306) definition seems to sum up well the reflection that can be undertaken by NMs during mentoring and clinical supervision development: 'reflection is a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice'.

NMs will have used reflection in their own practice to make sense of a situation and to gain new insight from it. Using such reflective elements to gain self-awareness is seen as key by Driscoll and O'Donovan (2006). While this process of reflection was used in the coaching relationships described in this study, what was particularly valuable to NMs was the way that the coach used summaries of their discussions to reflect back to the NM. This enabled them to see their own issues in a different light or from a new perspective, with (see Table 5-1) an NM expressing it as being 'loosened from glue' and 'didn't know what didn't know'. This was one of the valuable differences about coaching for the NMs, compared to mentoring and clinical supervision. Consequently, the coach was identified as needing to be skilled in order to achieve this.

Thus, the experience of the coach and their skill in being able to help the NM see their issues in a different light was seen as very valuable to the coaching experience and the relationship with the coach. The reflection

that occurs in this relationship could be identified as the 'Joint Experimentation', 'Follow Me' and 'Hall of Mirrors' modes as determined by Schon (1988, p.26), where both the NM and the coach are participants in and on practice where their work is contingent on the partnership with each other.

The ability of the NM being able to develop awareness of their own personality and insight into their behaviour was valuable to both the NM and their coaches. According to the NMs, this was most effectively gained through reflection with a coach, rather than purely undertaking a Myers Briggs type personality evaluation.

6.4.4 Coaching continuum

Both West and Milan (2001) and Hawkins and Smith (2006) talk of a continuum of coaching moving from skills through performance to development and finally to transformation. This model can also be used to explain the relationship between clinical supervision, mentoring and coaching.

Clinical supervision might be seen as sitting at the skills end of the spectrum, with coaching for NMs lying at the transformational end of the spectrum. The same continuum can be used to explain the role of the NM to their team and organisation with the role itself on a continuum as the NM develops and becomes more skilled in their own role. This can be illustrated by Figure 6-5 derived the interviewees' responses, West and Milan (2001) and Hawkins and Smith (2010).

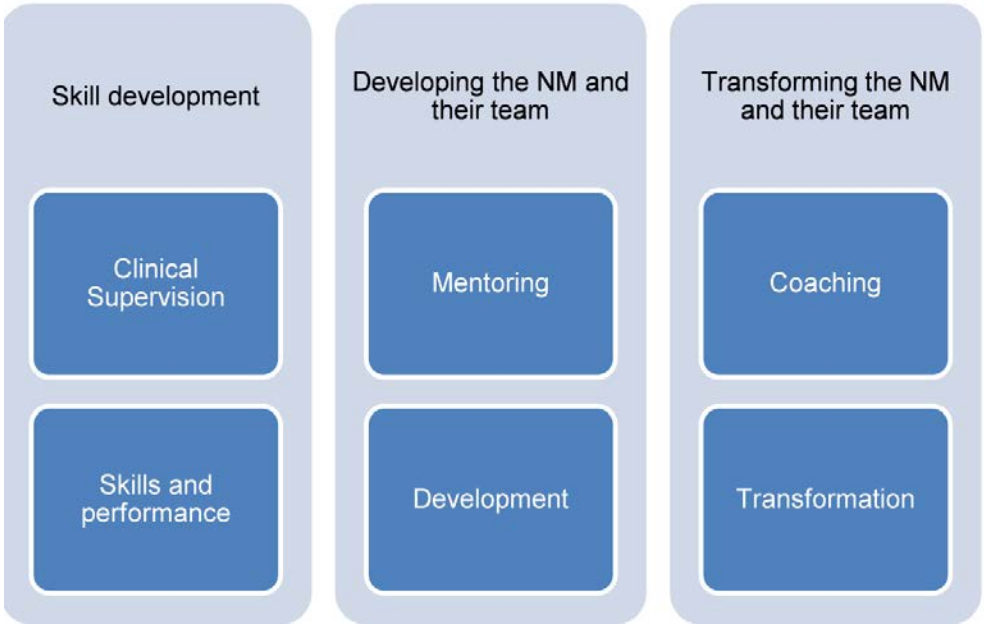


Figure 6-5 Continuum of development.

In summary this chapter has explored how NMs experience coaching and the distinctions they made between coaching, mentoring and clinical supervision. It has also explored how the relationship the NM has with their clinical supervisor, mentor and coach is on a continuum of development and how this continuum is mirrored by the NM development of their team. The following Chapter 7 will analyse what the outcomes are for NMs and their organisations following coaching.

Chapter 7 - Outcomes Following Coaching

Following on from Chapter 6 detailing the experience of coaching for NMs, this chapter will explore the outcomes of coaching for the NMs and for their organisations. In this chapter, the themes that emerged from the data will be described in three sections:

7.1 Organisational outcomes

7.2 Return on investment

7.3 How the NMs have changed following coaching

In section 7.4, the focus will shift to the researcher's voice and the holistic interpretation of the data. Existing literature is used to interpret findings and additional literature is introduced to draw insights from the data and literature in this section. The three sections with original findings are as follows:

7.1 Organisational outcomes

Following NMs receiving coaching the main positive outcomes of benefit to their organisations included the enhanced ability of NMs to remedy difficult situations including staff problems, for example poor performance or high staff turnover. NMs reported a better understanding of themselves, the type of manager they were and the type of staff they were working with. In addition, they had a greater understanding of how to use different leadership styles for different situations.

These enhanced skills led to more effective implementation of strategies, use of resources and improved project management. The interviewees reported that these improvements had resulted in less crisis management and more proactive leadership, which had also improved the quality of patients' services either through improved care or through improved use of infrastructure.

7.1.1 Seeing the bigger picture

According to NMs, DN and coaches improvements such as those outlined above appeared to be directly attributed to coaching, outcomes they felt would not have occurred with a purely development programme. The ability of NMs to be able to reflect and see a bigger picture allowed them to

remedy difficult situations more effectively and feel as though they had some control over their practice area. They reported being more able to work within the resources they had and to be more creative about using these resources. NM Fran summarises this.

> *It gave me, you know, a better insight into how I could use my band 6s instead of me doing all the work. I can now help them to work with me and get them to come up with the ideas. The meetings went so much better when we did this. […] I feel much happier in my role and less feeling that the weight is all on my shoulders.* NM – Fran.

It appears that some organisations invest in both the time for the NM to undertake coaching and for the cost of supporting as all NMs interviewed had their coaching paid for by their employer. However, some of the coaches reported that they coached NMs who were self-funded.

DN recognised that the coaching the NMs received was confidential, reporting that they had suggested coaching for NMs for a variety of reasons. These reasons included an NM being new in role, having some problems in their role, for example under-performance and recommendations to undertake a development programme and receiving coaching through this route.

When coaching had been requested for an NM by a DN, the coaches reported that they had varied engagement with DN, as recalled by coach Paula.

> *The organisation has also got some objectives for coaching... I very rarely spoke to a Manager; I very rarely had a contracting session with a Manager and a coach together. So very rarely did we come with organisation objectives set by somebody else, and personal objectives set by the coach.*
>
> *I knew that the organisation had organisational goals... so periodically that would be introduced into the mix, so that we could almost put in place some sort of three way relationship, well probably more than that, because often conversations would relate to the team, the individual, worked with individual relationships that they had with peers at the same level, that sort of thing.* Coach - Paula

Even though in Paula's case, she did not have much interaction with the DN, she was employed in the Trust to be a coach and therefore was able to

relate the coaching sessions with an NM to the organisational objectives. This would not be the case with an external coach, which in turn may be a problem for an organisation.

However, this relates back to the reason for and the value attached to, the coaching. If coaching is for development of the individual, then their development will lead to better work performance for the organisation and as such not making explicit organisational objectives part of the coaching sessions may not matter.

Following coaching DNs reported that they monitored the effect of the coaching through a variety of methods including: feedback from the NM; changes in quality scores from patient feedback or audits of quality of care in the NM practice area; and observation of changes that had occurred in the NM's management style.

7.1.2 Suitability of coaching

A few NMs and DN reported that they thought that coaching was not suitable for all staff.
An example of this is from DN – Maria:

> *One of my members of staff that has been difficult, who I have tried and tried and tried to get her to see where I find her weaknesses are, she just can't see them. And she's gone to coaching and she still can't see them. I just wonder if she's up for looking into herself. And the problem is, with six coaching sessions, if it's all on the thing to actually get, if it's you that has to change or if it's you that has things that you have to try and improve.* DN – Maria

However, the coaches countered this view. They mostly had the opinion that coaching was suitable for all staff but some may take longer to gain from the coaching process than others. This was how coach Paula expressed her views.

> *I think it's all about readiness for coaching. When a Manager refers somebody for coaching, it's often because they're under, well in the situation where it's been because they've been underperforming or they've got difficult relationships with the team, they've come to me for coaching and it's taken a little while for us to establish and reach the starting point for coaching. But they have continued to come because they've found it useful to be able to talk.*

> *…sometimes you need that time before coaching actually begins before they're ready... it's important at that stage to build a trusting relationship with that individual, so that that's part of the preparation that's required before the coaching actually starts. And I think they've appreciated that, they've continued to come. … sometimes, when somebody comes to you through different routes, you've got to prepare for that and you've got to recognise that and not jump in with coaching straight away.* Coach – Paula.

This investment in time to gain the trust of the NM and then to gradually build up the coaching sessions seemed to pay dividends in terms of eventually being able to see improvements in an NM's performance. The key issue seems to be the investment in time on the part of the NM and coach to enable progress to occur.

7.1.3 Investment in coaching

Investments of time and resource require a variety of commitments: personal and organisational. What came across from the interviewees were the problems an organisation faced when the commitment diminished and they disinvested in development and coaching. As well as the staff feeling undervalued and demoralised, the benefits gained from prior investments in staff were quickly lost as either the staff left or future development was not supported. This cyclic investment followed by disinvestment and reinvestment is illustrated by NM - Lesley.

> *…the fact that they (the development team) were made redundant, I think it reflected the way the Trust felt, it was a low priority. And so if you take out that level, I think you'll have really lost something. And it makes a difference; I think it makes a huge difference. But I think the way that they've now included coaching and action learning in this leadership development, has showed a change in the Trust, a recognition that actually the way people behave and the skills they have, is intrinsic to the success of the Trust.* NM – Lesley.

This 'double whammy' effect worked across a number of dimensions with the lack of investment resulting in more than just a lack of development, as illustrated in Figure 7-1.

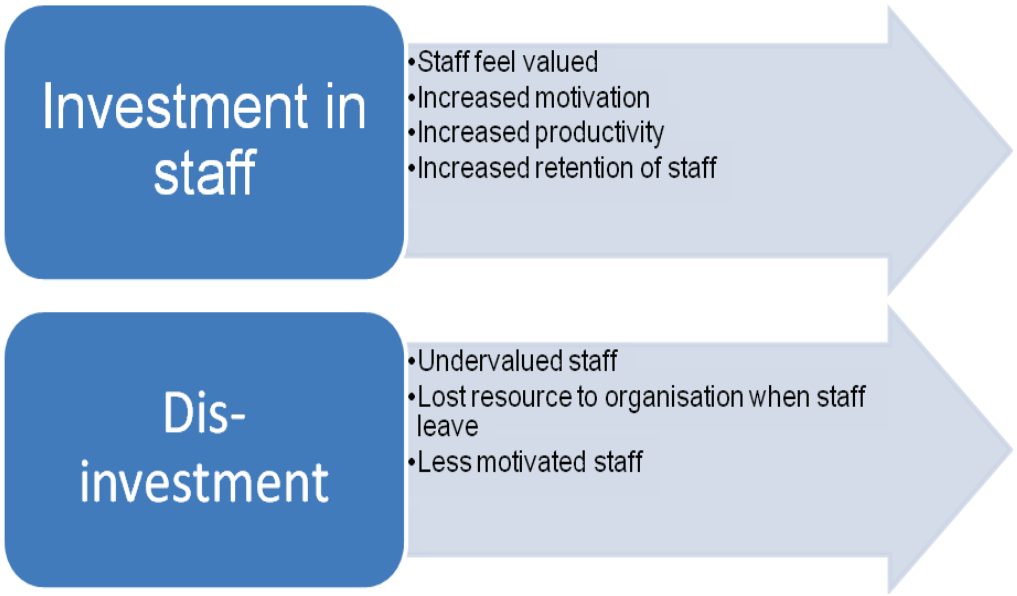


Figure 7-1 Relationship to investment.

7.1.4 Project management

Successful project management and the ability of NMs to undertake this more effectively was reported as a key benefit of coaching. This ability stemmed from their increased understanding of how to enable their staff to work more effectively and what leadership and management strategies would be most effective with the staff involved. It also flowed from the NM's ability to be able to plan more effectively and to be more assertive when explaining the project to superiors. NM Lesley illustrates this.

> *I think it makes your interactions, when you're trying to negotiate above, more productive. I think you can be listened to more. I think it can, because you can get more from the Trust, you can actually improve patient care.* NM – Lesley.

Interestingly a number of interviewees said they could identify staff who had received coaching just by the way they more effectively managed themselves in meetings and the improved interpersonal skills they had. They were, in the opinion of many interviewees, better managers because of the coaching.

> *Able to identify who has been coached, as they are better managers.* NM – Lesley.

This was also echoed by DN – Beth, who said:

> *Before the NM had coaching I was worried about an area and after, it could leave my radar and I wasn't worried.* DN – Beth.

Informatively, this recognition of staff performing in a particular way in meetings appeared to be more obvious to staff who themselves had received coaching. This may have been because they were more attuned to the skills being used by the NM.

7.1.5 Disciplinary processes

Coaching had also been used by a DN to prevent a problem becoming a formal disciplinary process. Their NM was given a number of coaching sessions and was able to change their behaviour enough that formal performance management was not necessary. However another DN cautioned the use of this approach when they talked about the fine dividing line between someone needing coaching to improve their performance and their performance being so bad that disciplinary action was required. The DN talked also of the problems with a manager being a coach in this situation as they would then be the person commencing the disciplinary process. This gives additional strength to arguments about the manager not being a coach but instead using a coaching style of management as mentioned in section 6.3. This is illustrated by NM – Lesley.

> *I think if it was heading towards a disciplinary situation, I think, it would be more using a coaching style in that situation, in a one to one, rather than this is a coaching session. This is using a coaching style, we have this situation, obviously it needs to be dealt with, how do you think we can deal with this, you know, how can I support you to deal with this? ... So it's more of a coaching style then because I'm aware that we might have to tip over into the policy, and they're quite different.* NM – Lesley.

This section has shared the insights gained from the interviewees in respect of improved project management, preventing performance problems with a staff member from becoming a disciplinary issue and the importance of organisations not disinvesting in staff development and coaching once introduced. The following section will review the areas to surface in respect of return on investment.

7.2 Return on investment

Return on investment (ROI) is usually associated with finance: the size and nature of the upfront fiscal investment and its cash flow payback through improved financial performance over time. However, it can also be used to refer to the investment in terms of time and money for a staff member and whether that investment has proven to be valuable (Spence, 2007; Hawkins, 2008).

Coaches and NMs saw ROI as a secondary consideration when reflecting on the outcomes from coaching with their priority reflecting what was most important to the NM at the time. However, not surprisingly DN had ROI as a high priority when considering how and whether they would support coaching in future. The main need of the DN was to ensure their organisational resources were being used in the most cost effective manner DN Beth talked of how difficult it was to see benefits overtly from coaching.

> *It's often in the intangibles and the cause and effect relationship is really difficult to see. DN- Beth*

There were a number of positive ROI outcomes reported by the interviewees attributed directly due to coaching. The nine key areas were as follows:

a) Improved patient experience and improved patient safety were seen to result from the NM being more assertive. They felt able to manage staff more effectively to ensure they performed their role to the standard required;
b) There was a better fit for the role and the NMs reported being able to undertake the role more effectively;
c) It was reported that better interpersonal relationships and better understanding of the different leadership styles and needs of the whole team had led to less conflict within teams. This is reflected by NM Lesley:

> *I think by making more reflective practitioners, by learning coaching skills, enabling you to embed it to become a more, to have more of a coaching method in everything that you do, reduces conflict*. NM – Lesley.

d) It was reported that projects were managed more effectively and this had led to better patient outcomes and more effective prioritisation.

e) While there seems to be an understanding in some health organisations that coaching is mainly useful for developing skills or managing a particular project this contradicts the view of NMs and coaches interviewed who saw it as a far wider developmental opportunity. They viewed it as a method to understand themselves and manage their teams more effectively. This, in turn, helped them to manage projects more effectively. The value of coaching to help with project management is expressed by NM Jane.

> *Working together in the coaching setting, enabled me to come up with the ideas of how I would change manage certain projects that we were doing at the time, or proactively manage certain situations that we dealt with.* NM – Jane.

Within project management there was an appreciation that much of the success of a project is due to management of change. NM Julie and Val recall their perspectives.

> *Actually, what I found from it, is I've had more success with change management than I did before.* NM – Julie.

> *And certainly, with a lot of the change management that we've done, I think having that bottom up approach to leadership, rather than that sort of top down, directive, I think has helped, yes. And I think that has come out of my coaching.* NM – Val.

From a coaching perspective coach Paula also recalls how she helped NMs undertake more effective project management and management of change.

> *…project management became a big theme within the coaching work that I did, and particularly, the management of change and the implementation of change, as a result of a lot of the Government initiatives that were going on at that particular time.* Coach – Paula.

f) The ability to turn around poor areas was used by a few NMs as an example of how coaching had helped them, as expressed by NM Val.

> *When I started within the clinical area where I work at the moment, it was deemed as one of the worst performing clinical areas in the Trust. I think it was identified very early, that I would need a coach to help support me through that, in order to make the right decisions and to guide me in making some of the right approaches. And it was effective, I think it took time, as that coaching relationship needed to build and for me to be able to trust that person and to understand that their advice was often the right advice.* NM – Val.

g) It was reported that resilience and mindfulness, confidence in negotiating and challenging were all increased as recalled by NM Val.

> *Having that distance, it's easier for them to ask you the questions because they'll ask questions about politics and personalities, because they don't know any better. Because they don't have their own agenda and it doesn't affect them personally, whereas if you're trying to do that with somebody who you work alongside of, it's dangerous.* NM - Val.

h) The ability to think strategically and to understand the politics of an organisation was seen as a positive by some but also as being too embedded by others. NM Dale gave a perspective.

> *I've had the pleasure of working with a coach, who was senior within the xx, and understood the politics that I didn't have any insight into.* NM – Dale.

i) Career challenges were seen as a valuable reason for seeking coaching and were described from a coaching perspective by coach Paula.

> *I think so often people are rushed into making decisions and choices about their career. Whereas if they're given the opportunity to think very, very carefully about what they do, and what plays to their strength, I think they make a lot better choices. And I've seen that happen in some of the career coaching.* Coach - Paula

In summary, Figure 7-2 illustrates the benefits of coaching to return on investment. The following section will detail how the NM has changed following coaching.

Figure 7-2 Return on investment.

7.3 How the NM has changed following coaching

A common problem that NMs had taken to coaching was working with their line managers. Following coaching NMs appeared more able to take problems upwards to their senior staff, gaining new interpersonal skills in order to do this effectively. This was a common theme reported by both NMs and coaches and is recalled from the coaching perspective by coach Emma.

> *A common theme actually, which is starting to appear, is people who are unhappy with managers, and they don't know how to deal with it or how to change the situation.* Coach – Emma.

The ability to manage more effectively upwards and downwards was also encompassed by the NM having a better understanding of different leadership and management styles of both the staff that they manage and the managers who manage them. This is expressed by NM Val.

> *So it's about accepting other people's personalities and other people's leadership styles. But dealing with it on a day to day basis, I think, my coach would often be my first port of call, to talk it through.* NM – Val.

Some coaches reported that some NMs had wanted to deal with more personal issues than work, which they felt were inhibiting the way they functioned in their role. An example of this from the coaching perspective is illustrated by Coach Emma.

> *For some people it might be about balancing home and work life. Another thing is around not taking home the stresses from work, letting it affect what's happening at home and, you know, ways that they can, again, manage that and deal with that.* Coach – Emma.

One of the key points that NMs emphasised was the importance of receiving coaching when the NM was new to the role.

> *My feeling is right at the very beginning because a Ward Sister was previously not a Ward Sister, most likely. So much of the learning is on the job and there's a rollercoaster of, you know, good and bad things that happen, lots to talk about, lots to reflect about. So I think coaching could be a journey supporting that Ward Sister, right from the very beginning of her appointment. And actually, should it ever stop? And I say coaching, but I also mean a coaching style. So I think someone who's gone through a coaching course can adopt a coaching style.*
> NM – Lesley

7.3.1 Coaching style of management

The use of a coaching style of management, mentioned by Lesley, was echoed by many NMs. They reported that having received coaching themselves had opened their eyes to the value of using a coaching style of management with their staff, rather than necessarily actually coaching them. It appeared to help to deflect conflict and made the NM more productive in their role. This is expressed by both NMs Chris and Sandy.

Yes, I definitely do. I tend to use a coaching style with colleagues. And my own boss definitely has a strong coaching style in her management approach, which I respond to very well. NM – Chris.

I mean it was not just me, but actually using that style of negotiation improved things for patients. So I think the end product is improvement for patients. If you reduce staff sickness because they feel better about themselves, if you motivate staff because they feel better about themselves, all of those things are beneficial for the Trust, but at the end, they're beneficial for patients. It's a long term thing. NM – Sandy.

NMs also reported the usefulness of having a toolkit of skills that they had amassed during the time they received coaching. It had helped them to embed the skills learnt, so that they came naturally to a given situation. NM Chris reported the following.

So he was able to sort of give me a toolkit that meant that I would get what I need out of this person or would engage this person in the best way possible. And I think there's been many situations like that. NM – Chris

They also developed confidence and assertiveness, which enabled them to get the best out of a given situation, as recalled by NM Jane.

So, therefore, through the coaching you realise, it wasn't actually your fault and actually you are able to benefit from having those, giving you the inner confidence to actually say to your staff, these are the things I've actually proactively managed and this is what I've done about it. And I'm really sorry it's like this at the moment, we all have to group together. NM – Jane.

However, some NMs did not agree that coaching was always useful and that they did not adopt a coaching style of management. They reported that they felt they did not have time to be able to make use of coaching and make use of a coaching style of management. NM Alexis expresses this view and the issue of time constraints, echoed by many interviewees.

I don't have a totally negative approach to coaching and I do use elements of it. At the end of the day, it is about problem solving. And so there's ways of doing that and saying, well how do you want to do this, what would you do? If I wasn't here today, how would you do that problem? So I cannot, I cannot afford the time, I think, that coaching needs, I don't have that time. And I defy, defy, defy, any nurse manager that has that amount of time. NM – Alexis.

Most NMs however did feel that the time invested in coaching did give them more time later. Here is an example from NM Pauline who shares her experience of managing a difficult staff member and how coaching helped with this. Although she does resent the time this staff member took up with her coaching session it did enable her to gain support to deal with the situation.

> *I was having a lot of difficulties here with one member of staff, who I was finding very challenging to manage. So she actually, that staff member actually took up most of my coaching time, which made me feel slightly resentful because that's not why I went into the coaching, but it was also helpful.* NM – Pauline.

NM Chris sums up the thoughts of many of the NMs interviewed about how their experience of coaching has helped in their role.

> *I think it's probably one of the best things that I could have done for myself. I've learnt more about myself personally and professionally over the last three years, than what I had in the ten years of my nursing career prior to that. And I don't think the last three years have been the easiest three years. And I probably wouldn't still be here now had I not had my coaching. That's the one thing that's kept me on the straight and narrow and kept me sort of focused, if you like, and kept me sane sometimes as well. I would highly recommend it to anybody. I think it's absolutely the right way forward.* NM – Chris.

In summary, this section has shared the areas to emerge following coaching. These included NMs more effective working with line managers and their using a coaching style of management with their own staff. Coaching also appeared to help with managing difficult staff situations, also enabling some NMs to be able to cope with, and stay in, their role.

7.4 The researcher's voice

The Johari Window was used in Chapter 5 to illustrate why coaching had been accessed by the NMs. It is used again in this chapter to further explore the outcomes and benefits of coaching to both the NM and the organisation.

The four rooms talked of by Handy (2000) have been used to illustrate the understanding of the outcomes from coaching for NMs and their organisations. Figure 7-3 below is a representation of three of the panes in

the Johari window, highlighted in bold, and how the benefits of coaching for NMs have been reported by the interviewees.

What the NM and others see	**What others see of the NM**
What only the NM knows	What no one sees

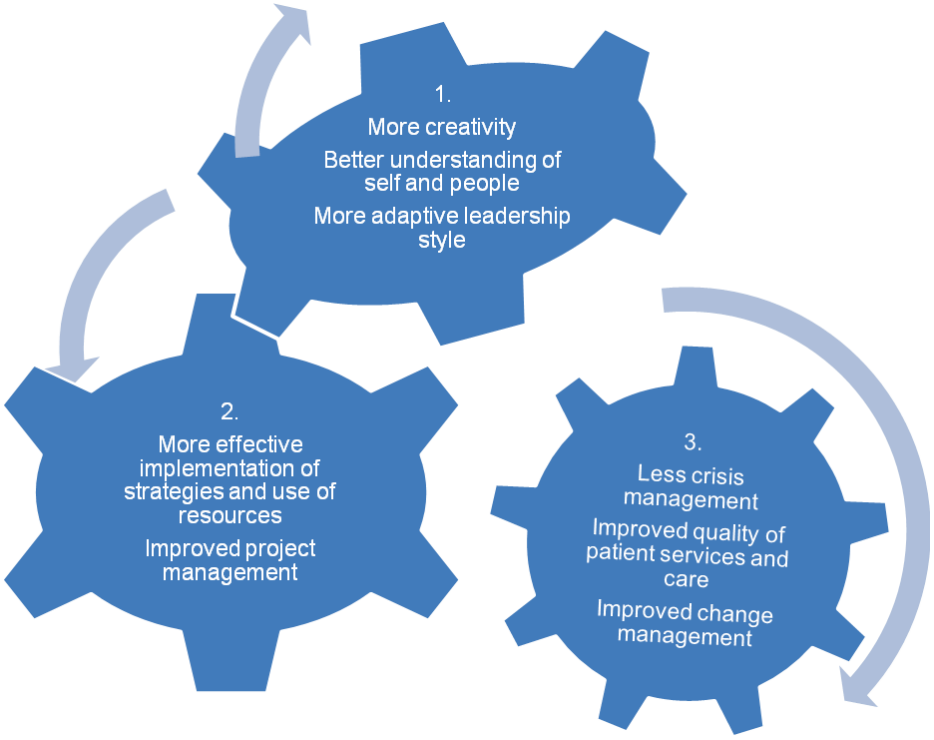


Figure 7-3 Benefits from coaching.

7.4.1 What the NM and others see

There were a number of areas apparent to both the NMs and their employers as benefits accruing from coaching. These included the management of staff, projects and change. What appeared to be of value was the coaching the NM had received to be able to undertake management and leadership more effectively, as well as the coaching style of management that many NMs then adopted.

This development of a broad approach to coaching and facilitation type management can be expressed as developing a coaching culture. A coaching culture is defined as one where "coaching is the predominant style of managing and working together, and where a commitment to grow the organisation is embedded in a parallel commitment to grow the people in the organisation" (Clutterbuck and Megginson, 2005, p.19).

What appeared to become prominent was the culture that the NM inculcated into their practice area, which filtered down to their own staff thus enabling all staff to get the best out of their roles. While this culture of coaching within the practice area appeared to bring benefits to the NM and staff what was crucial was the approach of the organisation. If the organisation did not value coaching and a coaching style of management then the NM did not feel as valued when they had coaching themselves or tried to use a coaching style in their role.

The coaching culture espoused in the practice area by the NM and through the wider organisation by the senior management team can be expressed in terms of 'artefacts, behaviours, mind-sets, emotional ground and motivational roots' (Hawkins, 2012, p.22). Artefacts can be expressed in terms of how the NM and the organisation articulates its vision and philosophy and how coaching is embedded in this as a core competency.

Behaviours can be mirrored by all staff by using a coaching style of interaction, whether it is with staff or their patients. There is a collective vision for how staff are to be treated, echoed by McNally and Cuningham (2010) and West et al. (2014), suggesting the importance of collective leadership where all staff take responsibility across the organisation. Mind-sets can be conveyed by not treating staff as just 'doers' but as knowledgeable thinkers who can add value to a practice area or an organisation.

It needs the leader to believe that all staff can make a valuable contribution and treat them as such. Establishing emotional ground allows staff to reach their full potential. Finally, motivational roots are the underpinning belief that all staff can work towards their own potential.

It could be the case that a practice area can have a coaching culture, set by the NM and that this could exist outside of the organisation culture. However, while it may not succeed as well if it is in isolation it can, nonetheless, function. Therefore, there can be layers of a coaching culture for the NM to function within. Their own motivational roots and behaviours can be supported and guided by having their own coach, so they in turn can help their staff to realise their full potential. This potential is illustrated in Figure 7-4.

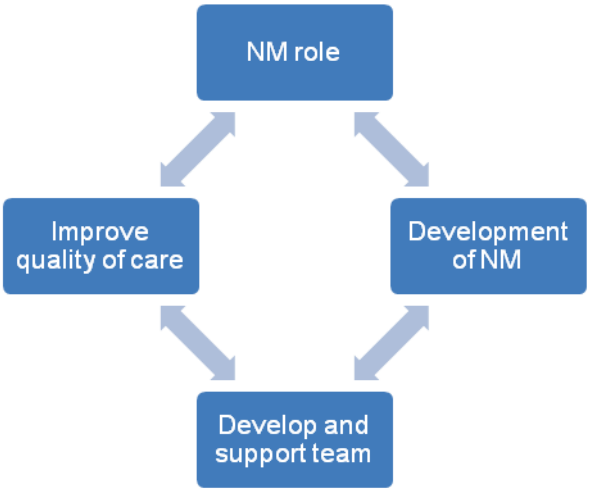


Figure 7-4 NM potential.

The ability of the NM to gain expertise in leadership and management following coaching development was reported as leading to improved relationships with their team and colleagues. This is illustrated by the descriptive words in Table 5-1 e.g. aware, competent, empowering, motivational, think strategically and transformational. 'Supportive relationships are the key to establishing supportive work settings, work places where people want to stay' (Mills et al., 2005, p.3). Thus, the value to the NM of understanding the relationships they have with their staff cannot be underestimated.

Section 7.4.1 has shown what the NM and others see, this being improved project and staff management, which appeared possible due to the coaching culture that the NM fostered in their team.

7.4.2 What others see of the NM

One of the key aspects articulated by the NMs and observed by the DN and their own organisation, was the return on investment for the organisation following coaching. In essence, the question of what value is placed on the time and money spent on coaching and what the benefits of coaching are to the NM and to the organisation.

In the context of this study, return on investment is not being measured directly in monetary terms. It is being used as an illustration of how the time spent undertaking coaching, which is time invested by the employer,

can repay the organisation in terms of societal, social and intellectual capital (Wilson 2014). The social capital was seen in terms of relationships between individuals and departments, intellectual capital in terms of knowledge, skills and experience and societal capital in terms of impact on the wider community - in this case the health care organisation.

Many organisations have not been as effective as they could be at measuring the value of coaching to reflect the return on investment made (West and Milan, 2001). This has improved (Spence, 2007; Hawkins, 2008) but it is still not commonplace in organisations. The International Coach Federation's (ICF) 2009 Global Coaching Study suggests that of the businesses that provided figures to calculate ROI, 86% had at least made their investment back and 28% saw a return of 10 to 49 times the investment. It was suggested that the median return was seven times the investment (Hotel Industry Magazine, 2014).

Figure 7-5 builds on Figure 7-2 and has been designed to show the four key areas that appear to be developed during coaching. This figure has been developed following the analysis of interviews and previous literature. The four areas are: improved strategic thinking, increased resilience and coping strategies, improved change and project management and improved staff management. These appeared to give rise to four subsets of benefits to the organisation.

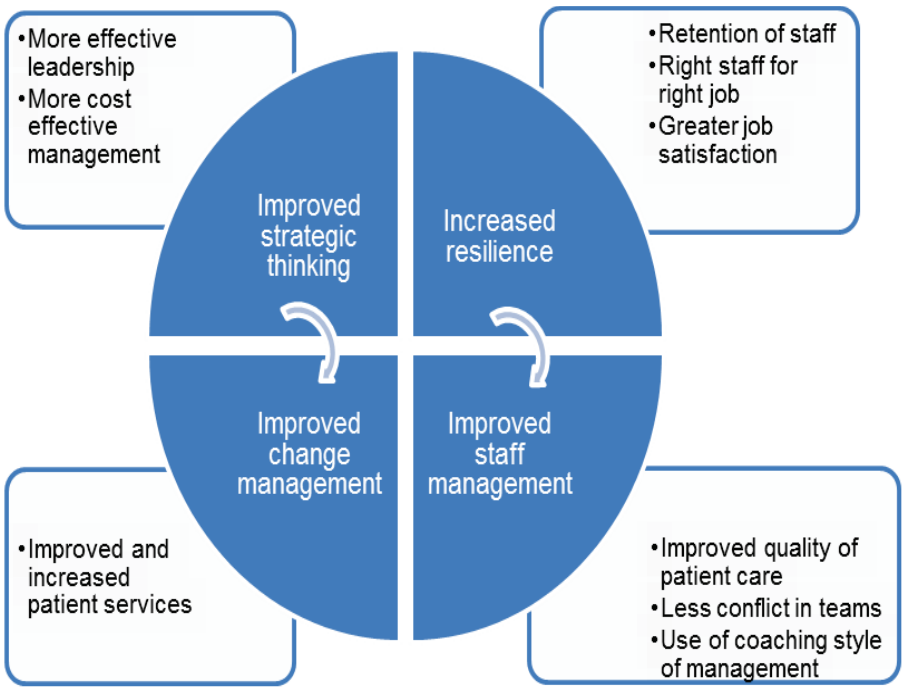


Figure 7-5 Return on investment.

A) Improved strategic thinking

Improved strategic thinking and the value for organisations of having strategies more effectively implemented cannot be underestimated. In light of the improvements in care that all health organisations are being required to demonstrate following the Francis Enquiry (2013) and the revised role of the Care Quality Commission, an organisation needs to be confident that high standards are being maintained and that policies are being implemented.

Godfrey (2013), following the Francis Enquiry (2013), identified that leaders of successful wards shared a number of characteristics. These included caring for staff and having a good team ethic , having responsibility for budgets, ensuing best practice was applied and most notably for this study, seeking coaching and mentoring to improve their performance. The interviewees in this study showed that coaching played an important part in their improved strategic thinking.

B) Increased resilience and coping strategies

The result of increased resilience and improved coping strategies appear to link directly with increased retention of the NMs and the staff that the NM manages. This appears to be due to the improved support given to the NM

and, in turn, the improved support and motivation they can give their staff (Ng, Sorensen and Eby, 2006). It was also recognised that coaching might enable the NM to determine that they are not in the right job and help them to make the decision to leave. This result of having the 'right staff in the right job' was seen as a positive result even if the NM left following coaching.

C) Improved change and project management

The interviewees reported what appeared to be improved and increased patient services through receiving coaching. As such, the findings from this research project seem to concur with the findings from the evaluation undertaken by the Institute for Employment Studies (2012). The money spent on coaching enabled the client to either manage projects more effectively and/or deliver a service change that was more effective than expected. The clients directly attributed their ability to undertake these projects and changes to the coaching they received (Institute for Employment Studies, 2012).

D) Improved staff management.

The improved management of staff appeared to lead to improvements in the quality of care given to patients, which was measured for example, by improvements in patient satisfaction audits. Table 5-1 illustrates this through the words used to describe the outcomes following coaching such as 'change behaviour, deal with politics, develop as a leader, try things differently'.

There have been issues in nursing management concerning the ability of NMs to manage their staff. Some of this has stemmed, as was mentioned in the introduction section 1.3, from the numerous reorganisations of the nurse manager role. Following coaching there appeared to be less conflict in teams because problems were identified quickly and managed in a more effective manner (McNally and Cuningham, 2010). The NM appeared to have more skill in identifying how to deal with a problem and more insight into how to manage different types of staff.

Using a coaching style of management made a difference to the way NMs felt as they were facilitating staff to work effectively rather than being overly prescriptive. This seemed also to resonate with the staff themselves in that they felt more part of a collective team rather than that they were simply being told what to do. This effect also translated into better working with their line managers and to being sensitive to a line managers' working style. This is echoed by Gabarro and Kotter (2005), where the importance of working effectively with your line manager is seen as essential for good working relationships and role satisfaction.

This section has evidenced the value of coaching NMs in respect of investment in development by the organisation, with the results of coaching being tracked right through to improvements in patient care. This was due to a combination of factors including improved strategic thinking; resilience; and improved staff, change and project management - all of which appeared to lead to improvements in the quality of care given to patients.

7.4.3 What only the NM knows

A) Own self-confidence

The NMs reported enhanced self-awareness, ability to clarify personal strengths and enhanced professional and social skills, resonating with the study of Law and Aquilina (2013). They appeared to feel more confident in their own decision-making ability and were able to use a range of tools to achieve this.

The NMs had reported that the suite of methods that they had learnt while receiving coaching was highly transferable to new problems and allowed the NM to use their own initiative more fully. The DNs who had started coaching while they were NMs also reported the value of having coaching at different stages of their career, in particular, when new tools and skills were required for new projects or new roles.

B) Resilience building

The need for developing resilience was introduced in Chapter 5 (section 5.4.4) as an area that the NMs had not appreciated before they started

coaching. Following coaching the interviewees appeared to identify it as a valuable outcome from the coaching process and one, which they would actively seek before they became too stressed in their role. The need for coaching to be undertaken before the demands of the role make the leader ill has been identified by Haycock, Kean and Baggaley (2010). The key findings of their study, for example, the emotional toll the role was taking on the managers and the feeling of being very unsupported in the role, were issues raised in this research. They appeared to be areas that became triggers for some NMs and DN who would then actively seek coaching if they felt this occurring.

The NMs also appeared to gain greater job satisfaction in their role following coaching. This stemmed from them reclaiming their role and being in the driving seat with it, rather than the role driving them. This locus of control appeared to be driven by how much the NM felt they were in control of a situation and how much they were unable to control events around them. As such, the locus of control is related to the achievement of self-efficacy mentioned in Chapter 5 and has been identified as a predictor of performance (Howell and Avolio, 1993; Ng, Sorensen and Eby, 2006). Greater motivation and improved ability to undertake projects was positively associated with an increased locus of control (Ng, Sorensen and Eby, 2006), an area where coaching appeared to help the NMs.

The importance of resilience to cope with job stress in the current health care climate in the UK appears to be key to the NM surviving in the role and has a direct relationship with their ability to be effective in their role (Chou-Kang et al., 2005). Coaching has been seen also to build resilience and reduce depression and increase workplace wellbeing in the public health sector (Grant, Curtayne and Burton, 2009).

This section has described the areas that only the NM sees. It has shown that the benefits of coaching appear to be within an envelope of developing self-confidence and building resilience.

7.4.4 What no one sees

What is less visible is the how the whole package of development and coaching fits together within the organisation. It can be considered that the culture in an organisation consists of underlying assumptions, beliefs and

values that are shared by the staff but which operate unconsciously (Schein, 2004) and so it classifiable as something which no one obviously sees.

Leadership and the culture in an organisation are important constructs that influence outcomes and performance (Schein, 2004) with the culture of an organisation bearing directly on its performance (Denison and Mishra, 1995). As such culture, often difficult to identify as an organisational characteristic, may bear the most responsibility for an organisation's success. It is of concern, therefore, that a recent survey has shown that in the NHS there is a consistent mismatch between the very positive views of executives about the organisation's culture and working environment and the much less positive views of other staff (The Kings Fund, 2014).

Investment in leadership and management is therefore crucial. With directive transformation and transactional leadership at one end, and non-transactional, laissez faire leadership at the other (Antonakis, Avolio and Sivasubramaniam, 2003; Avolio and Bass, 2004), the full-range leadership theory looks at leadership as if it were on a continuum. Using this theory, NM leaders who have a more transformational style (Bowles and Bowles, 2000; Doran et al., 2004) have been shown to be more likely to empower their staff and lead to higher quality and innovative practice and lower staff turnover (Kleinman, 2004).

In addition, it could be argued that there is a link between investment in staff and staff moral and motivation which then leads to beneficial effects on patient care and overall satisfaction levels (Gifford, 2002; Wooten and Crane, 2003). NMs having access to coaches who can support them with a transformational approach to their role, appear therefore to be an important factor in determining morale and improved quality of care of patients.

Figure 7-6 illustrates how the NM role following coaching can appear to lead to improved patient care.

Figure 7-6 Benefits of coaching from the NM to the patient.

While the culture discussed here is influenced by the potential benefits of a coaching culture within an organisation (as discussed in 7.4.1), the culture of an organisation is derived from more than whether or not it adopts a coaching style. It is also heavily influenced by its service users, the patients. Recognising this, the NMs' role in the future may be to facilitate their staff to adopt a coaching style of working with patients. This would fully realise the shift in culture within an organisation and would need skilled NMs who have been coached and understand the concept of coaching to help to facilitate their staff, to use a coaching approach with patients.

This section has shown that what no one appears to see is the unrecognized, 'by-product' link between an organisation supporting coaching for NMs, the culture the organisation supports and how this ties in with transformational leadership to improve staff morale and motivation and improve the quality of care for patients.

In summary, this chapter has examined what outcomes occur for the NM and organisation following coaching. The Johari window has been used to summarise the researcher's voice.

What the NM and others see	What others see of the NM
Improved project management Improved team leadership Coaching culture	Return on investment potentially leading to improved quality of patient care
What only the NM knows	**What no one sees**
Improved self confidence Improved resilience	Unconscious link between the support for coaching NMs – transformative leadership – improved patient care.

The key areas to emerge from the data and its analysis are: the value of a coaching culture within the practice area and the organisation; the wide range of return on investment indicators that could be measured in future; the building of resilience and locus of control; and finally, how using a coaching style appears to benefit not just the NM's team but also, potentially, patient care and outcomes.

The concepts raised in the four results chapters will be drawn together in the conclusion that follows in Chapter 8.

Chapter 8 - Conclusion

This chapter will review the objectives and identify key findings (8.1). It will summarise the contribution this study makes to the body of the knowledge and practice on development and support of nurse managers (NMs) and on coaching in this and similar contexts (8.2). It will discuss the implications for employers of coaching NMs (8.3). The limitations will be discussed together with recommendations for future research (8.4). This chapter will end with my reflections as a researcher on this study (8.5).

8.1 Review of objectives and key findings

The aim of the study was to explore the role that coaching is playing in the development of NMs. The literature review, **objective one** of the study, identified gaps in understanding a national picture of NM development and the overlaps between clinical supervision, coaching and mentoring. It had been reported that there was a positive 'return on investment' from coaching executives in health care, but there was no evidence to illustrate this in relation to NMs. Although some NMs had received coaching, there was little empirical evidence to confirm or dispute the value of this to the NM, their team, their organisation or to patient care.

The review identified the need for NM development as being crucial for NMs to be able to undertake their role effectively (Platt and Foster, 2008; Middleton, 2012; Willcocks, 2012). It also identified a lack of development programmes for NMs (Loo and Thorpe, 2003, McKenna, Kenney and Bradley, 2004, Pitkanen et al., 2004). It revealed also a paucity of empirical evidence for the role of coaching of NMs (Law and Aquilina, 2013). This study therefore investigated the national picture of the development of NMs and what role coaching plays in this.

Objective two, to explore empirically how coaching is used in nurse manager development on a national scale, was undertaken via a national survey. It had respondents from a range of organisations representing all four UK countries and included NHS foundation and non-foundation trusts, community trusts and the private sector.

The results showed variable access to development programmes. Most trusts offered access to coaching but it appeared there was no coaching

available to NMs in the private sector, matching what appeared to be their lack of provision of development programmes for NMs.

Although small scale and undertaken for contextual purposes only, the survey did pose a number of follow up questions which would be valuable for further investigation. These were:

- Whether the independent sector has access to coaching and development elsewhere, rather than in their own organisation.
- Whether all small organisations do not offer much development and coaching or whether this again is offered outside of the organisation.

In addition, there are wider questions about the scope of NM development across the UK and the need for a standard effective approach to their development to ensure all NMs have access to development.

Objective three, to explore empirically the experiences of nurse managers who have received coaching, was undertaken using qualitative interviews of NM, directors of nursing and coaches. This was accomplished via interviews of NMs who had received coaching, coaches who have coached clients who were NMs and directors of nursing who employ NMs within their organisation. Thematic analysis was used to analyse the rich data collected.

The outcomes of **Objective four,** to present a multi-faceted analysis of the use of coaching in the development of nurse managers and **Objective five,** to advance theoretical understanding of coaching in this context and to develop practical recommendations for developmental programmes, have been presented in the four results chapters of this study and the Conclusion Chapter.

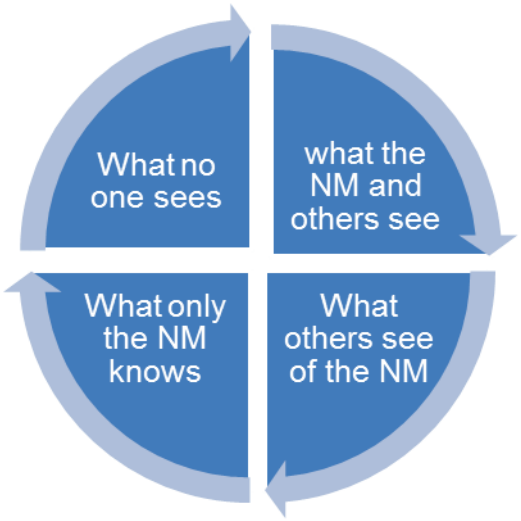


Figure 8-1 Johari Window framework

The key findings that stand out from the study are shown in Table 8-1 and are illustrated using the Johari Window framework from Chapters 5 and 7 in Figure 8-1. The following sections 8.2 and 8.3, will summarise the findings from all four results chapters and identify the contribution to knowledge and practice and the implications of this study for employers.

1. What the NM and others see
1. The importance of the first line managers adopting a coaching style of management. The NMs reported that being introduced to coaching enabled them to more fully utilise a coaching style of management in their role 2. The need for NM development but the current lack of consistency in this provision 3. Coaching helps with difficult decision making and 360-degree line management 4. Improved project management results from coaching 5. Improved team leadership results of coaching 6. The value of a coaching style in clinical supervision to develop skills and performance 7. The value of a coaching style in mentoring to aid development. 8. There is a continuum between coaching, mentoring and clinical supervision
2. What others see of the NM
1. Coaching leads to transformation of the NM and their team 2. Coaching needs to be accessible to all NMs and can be introduced as part of a development programme 3. NMs desire to be excellent managers and how coaching can facilitate this

4. 'Return on investment' can be seen as improved quality of patient care 5. The added value that a nurse as a manager brings to a management role in terms of reflection ability and the natural caring style that comes from being a nurse 6. Organisations other than health care could learn from the caring side of nursing as a useful asset and is reflected in the value of using a coaching style of management 7. Using a coaching style isn't being a soft manager but is getting the best out of staff
3. What only the NM knows
1. Coaching improves and maximises resilience and self-efficacy 2. Coaching can help in the very difficult transition to NM role 3. Improved self-confidence in NMs following coaching 4. Improved self-understanding following coaching 5. Line manager should not be the NM's coach but should have a coaching style of management 6. Coaching can help the NM understand themselves and their colleagues
4. What no one sees
1. Unrecognized, 'by-product' link, between support for coaching NMs – transformative leadership – improved patient care 2. Coaching can help in a shift to problem focused coping 3. Coaching can help with moving from vulnerability to resilience 4. The coaching style of leadership that seems to afford staff better management is closely aligned to the caring side of nursing 5. Insight gained from coaching allowed NMs to be able to enhance their caring nature to most effect 6. The following three areas seems to be intertwined: coaching style of management, organisational coaching culture and the NM receiving coaching

Table 8-1 Key findings.

8.2 Contribution to knowledge and practice

8.2.1 Relationships

NMs used coaching to understand themselves better in relation to their role and to know how they appeared to others, which in turn helped NMs to realise their potential (see Table 8.1). It also appeared important for the

NM to be able to interpret their teams and their own line manager's behaviour styles so that the NM could adapt their management style to get the best out of a situation. The importance of working effectively with a line manager is seen as essential for good working relationships and satisfaction in the role (Gabarro and Kotter, 2005; Goldsmith, Lyons and McArthur, 2012).

While some NMs reported using coaching to help them manage a project, what was important was the work undertaken prior to the project management to understand themselves. Coaching enabled the NM to define themselves in terms of their self, rather than just by the role they were undertaking.

This insight led to more effective relationships with their team (Van Commenee, 2013) and prompted the NM to behave in a more transformational style (Bowles and Bowles, 2000; Doran et al., 2004). This is associated with empowerment of their staff and leads to higher quality and innovative practice and less staff turnover (Kleinman, 2004).

The importance of the relationship between the coach and the client has been discussed in the literature (De Haan, 2008; Palmer and McDowell, 2009; Machin, 2010). There are two key findings in this study that support and add to this:

a) The strong message is to have a coach who is not the NM's line manager or with direct line management links with the NM within their own organisation. This doesn't just relate to concerns about confidentiality but is compounded by the fact that some NMs need coaching to address the problems they have with their line manager. The issues with the line manager being a coach are well documented and the idea of the line manger not being a coach but applying a coaching style in their management is supported by the literature (Beattie, 2002; Talarico, 2002; Ellinger, Hamlin and Beattie, 2008; Ellinger, Beattie and Hamlin, 2010).

b) The findings also contribute to debates in coaching about the importance of a coach being knowledgeable about the area of work of the client (Sue-Chan and Latham, 2004; Passmore, 2007). This seemed important for the NMs initially, providing confidence to the NM that the coach knew what the

NM was ‘up against’. However, with more trust in the coaching process and as its duration increased, this requirement became less relevant in comparison to other benefits.

8.2.2 Enhancing resilience

The value of nurturing and developing the leadership skills of nurse managers to develop resilience in a complex health care world has been identified by Ashworth (2010), Gooch (2012) and Fenton and Phillips (2013). In this study, coaching benefitted NMs undertaking a role that is complex and, at times, lonely, pressurised and vulnerable. One of the findings was the importance for the NMs to either develop or enhance their resilience. As suggested before, leaders need coaching for development of both capacity and capabilities for resilience to enable them to manage the future (Lawton-Smith, 2013). Resilience, it is suggested, is interlinked with the values of the employee and those of the organisation. If these values were in alignment then resilience was increased (Lawton-Smith, 2013).

First line managers have been seen as a ‘resilient but put upon survivors of organisational change’ (Hales, 2005, p.502). The development of resilience through coaching is also associated with ability to face adversity more effectively and to improve self-efficacy (Rappe and Zwick, 2006; Avey, Luthans and Jensen, 2009).

This study supports these prior findings in the context of NMs. The supportive relationship gained by the NMs through coaching enabled them to reflect on both professional and personal issues. The study provides evidence that it relieves both anxiety and stress (Myers 1999). In addition, the support to set goals and work through issues, shown to enhance self-efficacy and well-being by Sheldon and Houser-Marko (2001), was indicated by the participants in the study. The reflective components, plus the goals and working through issues, combined with a systematic engagement in coaching, was reported to lead to increased resilience in NMs and increased self-efficacy (Baumeister et al, 2006). Their increased resilience was connected with increased self-confidence in their own ability, which in turn led to less stress. They were reported to be more proactive in their role.

As well as developing resilience, the NM developed a healthier approach to coping, which is considered important for dealing with stress. They used a problem focused approach to managing rather than an emotion focused approach (McLeod, 2010; Lawton-Smith, 2013) helping to shift their coping approach from being vulnerable to becoming resilient (Giordano, 1997). This shift in coping is a significant factor in the NM being more effective in their role and supporting their team to be more effective.

8.2.3 Identifying the differences between coaching, clinical supervision and mentoring

The findings suggest some new angles to the debates about the relationship between coaching, clinical supervision and mentoring in respect of the NM role (Joo, Sushko and McLean, 2012). This study has taken further the continuum of coaching identified by West and Milan (2001) and Hawkins and Smith (2006), developing this to be a continuum between clinical supervision at the one end of skills development and coaching and transformation at the other end (see Figure 8-2). This concept of a clinical supervision – mentoring – coaching continuum helps to illustrate the role and value of these three areas of development.

The value of health care staff, and in particular NMs, to be able to understand the differences between and roles of coaching, clinical supervision and mentoring are important (Jarvis, 2004, Joo, Sushko and McLean, 2012). What came to light was that some NMs saw clinical supervision and mentoring as the same as coaching until they had experienced coaching, and in turn underestimated the value of coaching until they had received it.

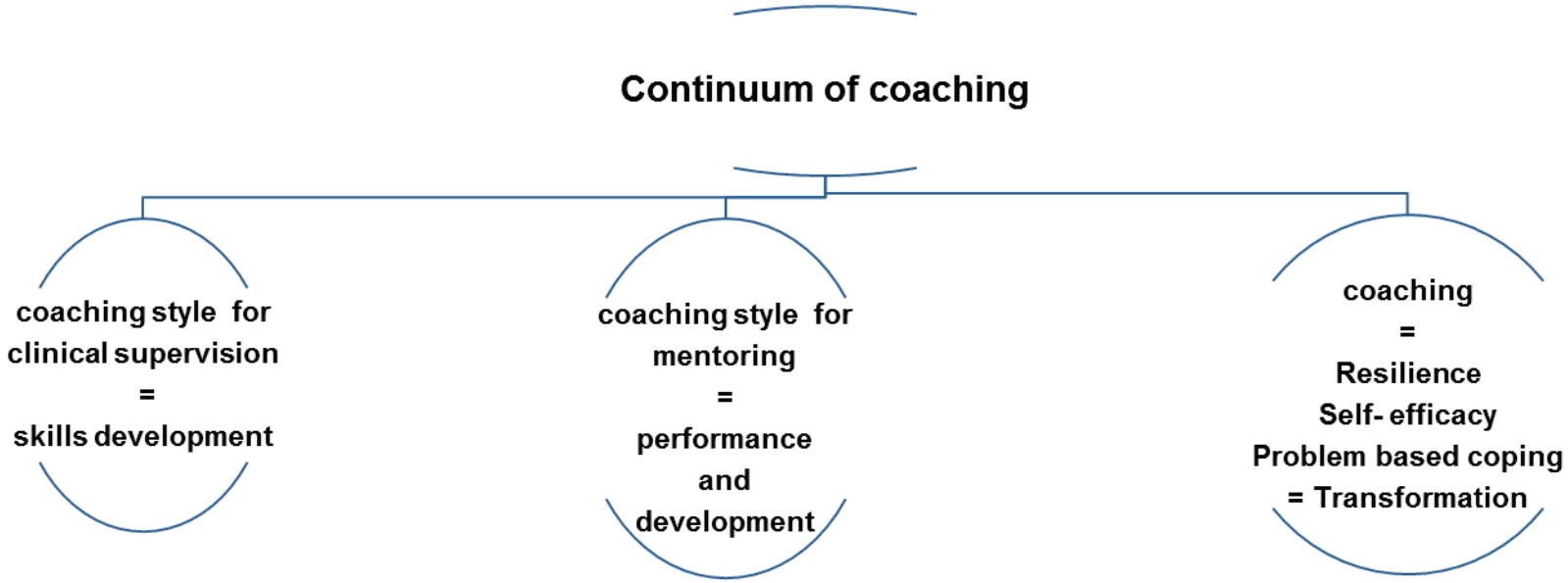


Figure 8-2 Continuum of coaching.

It appears that coaching when undertaken in a safe and effective environment, leads to the NM being able to develop more confidence, resilience and self-efficacy than by purely being exposed to mentoring and clinical supervision.

If this difference is appreciated, the organisation may invest in the most appropriate support when needed. However, if managers are acting as coaches, when they are not trained or skilled to do so, they may be just replicating the clinical supervision and mentor role. This would result in the benefits of coaching not being realised.

The need to clarify the distinctiveness and overlap of each role is also reflected in non-health disciplines. There has been a debate for at least 10 years about the role of mentoring, supervision and coaching (Garvey, 2004; Law, 2013; Garvey, Stokes and Megginson, 2014). Therefore, the importance of being clear about what is coaching and what is a coaching style of management appears to be crucial for future knowledge in determining the effectiveness of coaching.

From a different angle, it has been suggested in the literature that nurses are too caring to make good managers (Hay Group, 2006). The findings in this study question this supposition. The coaching style of management can be compared to the supportive and nurturing relationship that a nurse has with their patients. This study has shown that through coaching the NM can develop and enhance their 'caring and nurturing style' by using a coaching style of management. Using a coaching style therefore should be viewed by organisations as getting the best out of their staff (Nyberg, 2005). The nurses' ability to use a coaching style effectively is possibly why nurses are being encouraged increasingly to use coaching with their patients to improve health outcomes (Lindner et al., 2003; Bennett et al., 2005; Allen et al., 2008; Crowe et al., 2011).

As a summary Table, 8-2 identifies this study's key contribution to knowledge

Summary of contribution to knowledge	
Relationships	1. Value of increased self-understanding 2. Value of understating others behaviours 3. Coaching not to be undertaken by line manager 4. Relative importance of context related knowledge by the coach
Resilience	1. Coaching as a means for developing and enhancing resilience 2. The employers' values and a coaching culture 3. Increased self-confidence and self-efficacy 4. Using a coaching style with staff
Definition of coaching	1. Clarifying some of the confusion associated with the role of coaching in the context of NM role 2. Value of using a coaching style of management 3. Understanding the coaching, mentoring, clinical supervision continuum 4. Value of using a coaching style in mentoring and clinical supervision

Table 8-2 Summary of contribution to knowledge.

8.3 Implications for employers

This section emphasises the role of coaching in the development of NMs and in the organisational culture.

8.3.1 Development needs for NMs

There has been coverage in the media about the need for good management and leadership in health care (Sawbridge and Hewison, 2011; Francis, 2013; Keogh, 2013), in particular from NMs as the leaders of staff who deliver direct patient care. This implies the need for organisations to invest in the development of NMs. It has been argued that the lack of investment in NMs has potential implications for organisations in terms of

their ability to fulfil their requirements to deliver quality care to patients (Johnson, Sonson and Golden, 2010; Institute for Employment Studies, 2012).

The development of managers has been associated with many benefits including their own motivation and their team cohesion (West and Milan, 2001; Mills, Francis and Bonner, 2005; Hawkins and Smith, 2006). It is difficult to explain, therefore, why at the very time when enhanced management and leadership skills are required of health care leaders, NMs are reporting lack of access to development programmes, including coaching (Thorpe and Loo, 2003; McKenna, Kenney and Bradley, 2004; Pitkanen et al., 2004).

While most NMs had been introduced to coaching through a development programme, it is important to note that coaching does not need to be accessed solely via that route. However, the survey indicated that access for NMs to a development programme is variable and not all organisations include coaching in their development programmes. As NMs appear not to know the value of coaching until they have received it they may not request it even if there is an opportunity. Therefore, NM developmental programmes would benefit from the introduction of coaching even in informative terms.

8.3.2 Organisational culture

The development of an organisational coaching culture is important for NMs to feel supported and for an organisation to value investing in coaching. The coaching culture (Clutterbuck and Megginson, 2005) relates back to the coaching style of management identified by NMs as being a more effective way to manage their team and also their own line manager. What is noteworthy for an organisation is that an NM may develop a coaching culture in their own practice area but if this is not replicated by the organisation, they will not function as well in their area (Lee and Cummings, 2008; Law, 2013) relying on the own resilience and losing the gains they made from coaching.

8.3.3 Investment in development

The findings suggests that there are benefits to investing in coaching NMs and this investment in development may give long-term value to an organisation in terms of societal, social and intellectual capital leading to staff satisfaction and improved quality of patient care and experience. The link between investment in staff, in this case the NM, and the effect this has on patient care and satisfaction has been reported in other studies (Gifford, 2002; Wooten and Crane, 2003).

What this study has shown is how coaching of the NM and their coaching style of leadership could ultimately affect patient experience, as summarised in Figure 8-3. It has been argued that the benefits for an organisation of investing in coaching for NMs may result in long-term benefit to the patients.

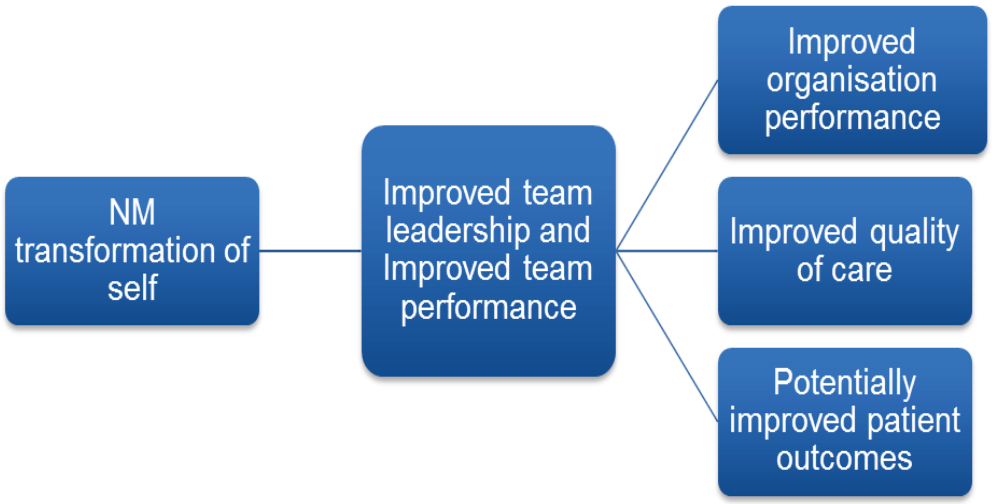


Figure 8-3 Potential organisational benefits of NM coaching.

8.4 Coaching Impact Circle framework

The following section draws the key findings and contributions to knowledge and practice together into a Coaching Impact Circle framework.

The framework builds on Figure 7-6, which illustrated how the NM role, following coaching, can appear to lead to improved patient care and develops into a Coaching Impact Circle. It also illustrates how, from the literature, the three gaps identified in the Conceptual Framework in Chapter 2, have been addressed through this study;

- What development is occurring for NMs?
- Will coaching benefit NM and their organisation?
- Are the benefits of coaching, identified at senior level, transferable to NMs?

The Coaching Impact Circle framework commences with the NM 'psychological self' and depicts how personality, behaviours, previous experience and lack of development all contribute to how the NM functions as a manager and leader. The key words and metaphors identified by the NMs in Table 5.1, such as lack of support, firefighting and frustrated have influenced the psychological self component of the framework.

The psychological self of the NM starts with a need for development and the study has shown that there are limited development programmes for many NMs. However, access to coaching is one of the crucial components within the NM development. The framework shows that following a coaching intervention, NMs report increased resilience and self-efficacy, which further enhances and matures the psychological self.

Coaching develops the leadership and management skills of the NM. This helps to either create or enhance the NMs transactional and transformative leadership style. The latter (Bowles and Bowles, 2000; Doran et al., 2004) having been shown to be more likely to empower staff, leads to higher quality and innovative practices and lowers staff turnover (Kleinman, 2004).

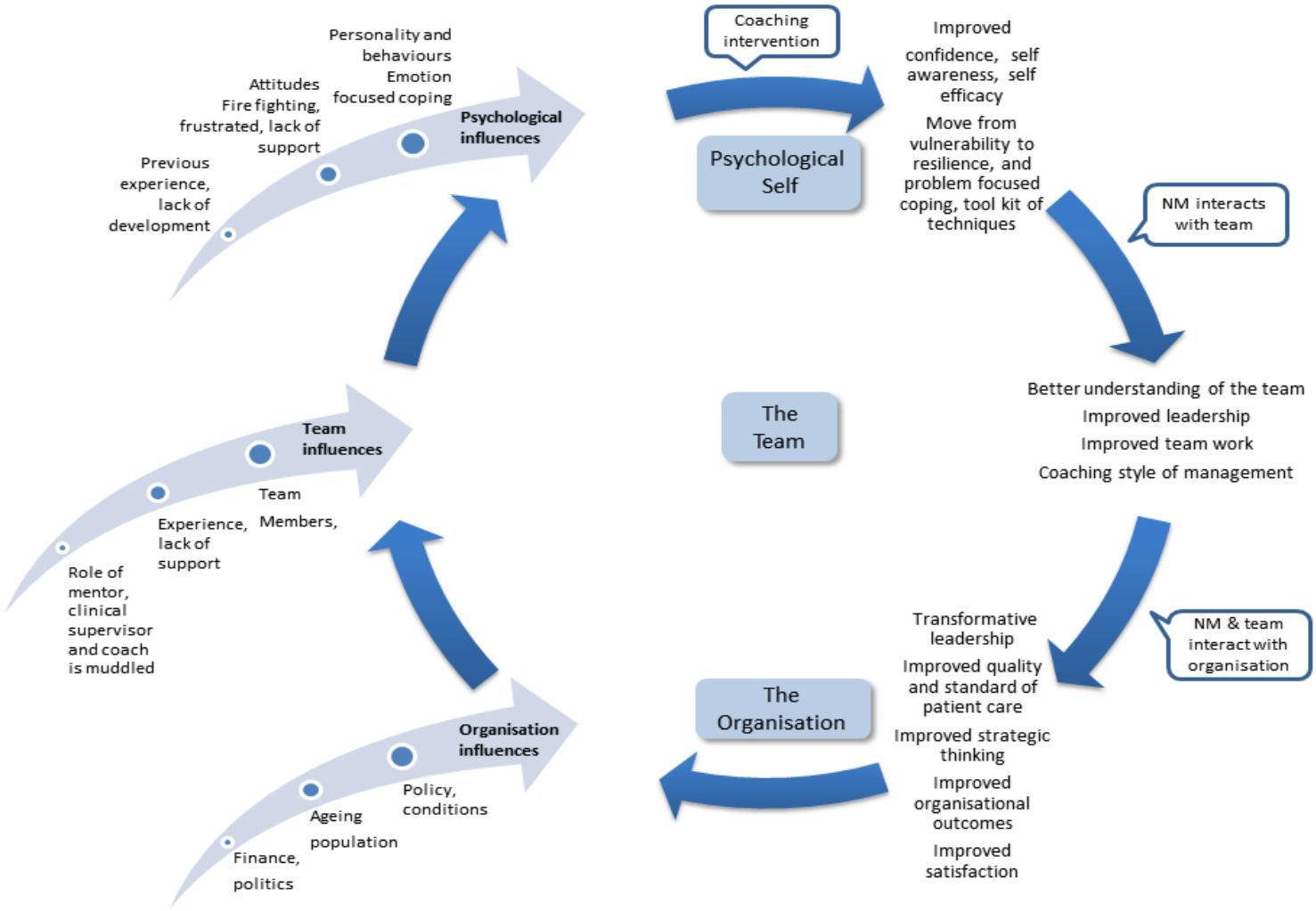


Figure 8-4 Coaching Impact Circle framework

The team that the NM manages, has its own pressures. These will include potential lack of support, impacts of a less effective manager, the pressures of caring for a wide range of patents in either acute and community settings and meeting organisational targets. Following the coaching intervention, the NM, in managing and leading their team, enacts the newly learnt or developed skills. The NMs' enhanced skills in change management and leadership will aid in managing their team more effectively. The NM, having more skill in identifying how to deal with a problem and more insight into how to manage different types of staff, can deliver, for example, less conflict in teams because problems are identified quickly, and managed in a more effective manner (McNally and Cuningham, 2010).

This study shows that NMs develop a better understanding of how to manage their team, the individuals within it and interactions with wider health care staff. They reported that coaching gave them more insight into individual staff needs and gave them greater skills to bring about change successfully, manage projects and raise standards of care. Thus, this study has shown that coaching benefits both the NM, the team and the organisation.

Following the NMs intervention with their team, the framework demonstrates how, the organisation's performance is enhanced in turn, thereby creating a virtuous circle of cultural reinforcement, as it faces multiple issues and drivers. These issues will include an increasingly older population, numerous policy changes, reduced finances and the need to constantly change care to enable new evidence based practices.

It has been reported that the presence of coaching in a development programme for senior managers in the public sector is correlated with improvement of both management and leadership skills (Ponte et al., 2006; Coates, 2013). Now, this study has shown how coaching is similarly effective for the NM level of manager in the public sector.

The strategic thinking that is facilitated when working with a coach enhances an organisation's ability to manage change. It has been argued that the benefits for an organisation of investing in coaching for NMs may result in long-term benefit to the patients. Following coaching, there was an increase in transformational leadership and improved strategic thinking

which can lead to improvements in management for the team and higher standards of patient care.

The value of using a coaching style of management was also identified. Leadership and the culture in an organisation are important constructs that influence outcomes and performance (Schein, 2004) with the culture of an organisation bearing directly on its performance (Denison and Mishra, 1995). As such culture, often difficult to identify as an organisational characteristic, may bear the most responsibility for an organisation's success. Using a coaching style has been identified as valuable in mentoring and clinical supervision. This study has contributed to a better understanding of the role of coaching, mentorship and clinical supervision in nursing practice.

The NHS Leadership Academy's nine 'leadership dimensions', seen in Chapter 1 section 1.2, can be aligned within this developmental framework (NHS Leadership Academy, 2013). They lead to a manager developing wider capabilities, which will ultimately affect their team and effect change in their organisation. Furthermore, the culture in an organisation will influence staff satisfaction and can lead to improved quality of patient care and experience.

Within the Coaching Impact Circle framework, one can see how coaching of the NM develops leadership, management and team development. This intervention affects the team that the NM manages and then the organisation itself. A close inter-relationship can be seen between the performance and skills of the NM and those of the organisation. It demonstrates how a positive outcome, following coaching of individuals, can generate a positive feedback loop in the organisation that enhances the organisation and the future development of NMs.

8.5 Study limitations and recommendations for future research

8.5.1 Issues with the mixed methods approach

The main limitation with using a mixed methods approach is the perception by some researchers that there is a dichotomy in views about the world and that a single study cannot have different epistemological and ontological

origins. However both Onwuegbuzie (2002) and Howe (1988) postulate that researchers should be pragmatic in nature and work with whatever works best. Johnson and Onwuegbuzie (2004) do intimate that one researcher, undertaking both qualitative and quantitative studies at the same time, maybe problematic and that it may require a team approach to manage big data sets. However, in this study the interview data set and survey were deemed to be manageable for one researcher.

It is also important for the researcher to have enough knowledge of both qualitative and quantitative approaches to be able to mix them appropriately (Harding, 2013). Using this knowledge, it was judged that the number of survey responses was too small for statistical analyses to be undertaken and as such, they were used for contextual and illustrative purposes only.

The methodology and size of research population naturally lead to concerns with the generalisation of these research results. Silverman (2000, p.300) defines generalizability as that feature of research which allows 'generalising from particular cases to populations'. There is a view that replacing generalization with extrapolation can partly solve the issue of how 'the researcher demonstrates that the analysis relates to things beyond the material in hand' (Alasuutari, 1995, p.156).

The data collected was rich, with common themes emerging, indicating a common understanding of an area. The number of interviewees is not large and as such, the results cannot be generalised to the whole population of nurse managers. The themes that emerged from the inductive analysis process were compared to previous theory and further generalisations of the empirical literature can be made following this research (Willig, 2010).

I am very conscious that having been an NM and experienced coaching myself, some bias could have been introduced during the research process. Being aware of this I was particularly careful during the interviews, paying attention to all sides of the NMs stories. I also hope that my bias was ameliorated as much as possible by being open to any data collected and by being very transparent about each stage of the analysis.

There could have been a concern that only NMs who had positive experiences of coaching were self-selecting to take part in the interviews. However, this proved not to be the case, as interviewees gave a balanced view and did articulate the problems they saw with coaching.

Some of the directors of nursing were known to me, as I meet many of them at national events. The interviews however illustrated that responses of interviewees did not show significant differences between the interviewees I knew and those I did not.

8.5.2 Recommendation for further research

This study has built upon the research already undertake in this area by giving voice to the view of NMs, coaches and directors of nursing as to the role of coaching for NM development. The survey illustrated some of the development being undertaken in UK.
The following areas could be identified for further research.

1. The survey could be administered again to a wider audience, which would have the value of testing a number of hypothesis identified in the results. For example, whether the existence of a coaching programme is a function of organisation size whether there really are any NHS Community Trusts with a NM development programme and whether 100% of NHS Foundation Community Trusts do have programmes.

2. Resilience and self-efficacy have emerged as key areas that are of benefit to NMs following coaching. This could be further investigated with a larger study to investigate at what point in the career of an NM, coaching is most effective.

3. This study has shown some linkage between coaching for NMs and improvements in patient care. This return on investment for health care organisations, leading to improvements in the quality of care, could be explored more comprehensively.

4. There appears to be much overlap and some confusion as to the role of coaching, clinical supervision and mentoring. There would be value in exploring making this more explicit, maybe through use

of a reflective framework to fully realise the benefits of all three support mechanisms.

5. To identify if there is a monetary return on investment that can be identified through monitoring for example complaint rates, re-admissions or staff turnover etc. following the NM receiving coaching.

6. To undertake a longitudinal study of NMs who have received coaching to identify any long-term benefits of coaching.

8.6 Recommendations for Practice and Policy Makers

1. Continue to support management and leadership programmes for nurse managers and include 360' feedback and personality tests such as Myers Briggs

2. Include coaching sessions in leadership and development programmes to introduce nurse managers to coaching if they have not used it already

3. Advise nurse managers to have coaching when take on the new role and when they move into any subsequent role.

4. Ensure that formalised coaching is not undertaken by the nurse managers' line manager but is a senior staff member removed from the nurse manager or a person from outside the organisation.

5. Advise nurse managers to seek coaching if a major project is to be undertaken by them.

6. Coaches for nurse managers need to understand the context of the NHS or at least health care and the accountability and code of conduct that nurse managers have to work within as managers of nurses.

7. Encourage nurse managers to use a coaching style of management with their direct reports and peers.

8. Ensure that any coaches used for nurse managers have undergone training and undertake supervision.

9. Identification of the differences between coaching, mentoring and clinical supervision and develop a clear framework to show this.

10. Advise all health care organisations to engender a coaching culture in their staff.

8.7 Reflections as a researcher

This thesis encapsulates the data that was gathered and analysed as well as my personal journey as a researcher. The data at times seemed overwhelming but a pragmatic approach to seek clarity where it could be established, was helpful in enabling a pathway to be found through the findings.

This journey as a researcher has been invaluable for me, confirming that the whole was much more significant than the sum of the parts. There have been eureka moments and many moments of confusion, but the lessons learnt in being persistent to reach what is hoped is a valuable outcome, have been prized.

What has been a revelation is the process of thought development from the concept of an idea, to the analysis of findings and the further generation of new ideas. These could not have been generated without such a study being undertaken. In particular, this can be said about the link between the coaching of NMs and enhancement of their resilience and coping strategies. This is also apparent in the link between NMs receiving coaching and the resultant reported improvement in patient care.

My own logical and quick approach to work has been curbed at times, to enable the data to be fully explored and to not to jump to quick conclusions. I am naturally a ‘quick fix’ person having worked in acute nursing care for many years where quick decisions and actions are required. This study has made me stand back and think about what I am seeing, allowing

themes and ideas to emerge over time, helping me to recognise the value of taking time to think and reflect in the process of research.

The use of thematic analysis threaded through from the literature review to the data analysis to identify patterns, has been a valuable learning tool that will be used in future. I have also learnt to embrace the occasions where I could think of nothing to write. These times enabled me to take a step back, focusing on a different area to clear my mind, eventually allowing me to re-focus on the writing I was unable to do previously.

This study developed out of my own experience of having been an NM and of later receiving coaching in another role. These two experiences gave me an insight and passion for this area of practice and knowledge.

Therefore, when the opportunity to undertake this study arose it was serendipitous and too good an opportunity to miss, feelings amplified by the adverse media coverage of leadership in nursing (Jacobs-Summers and Jacobs-Summers, 2011; Ford-Rojas, 2012) extensively reported during the 3 years of the study.

However, I have needed to ensure that my own experiences were not overwhelming for the study and I have aimed throughout to keep an open and unbiased mind about the value of coaching for this group of health care staff. This was undertaken for example by designing and then asking open-ended questions during the interviews and being open to negative comments about coaching.

My initial view was that coaching for NMs seemed to be a good ‘fit’. During the data collection and subsequent analysis my views have been widened to incorporate much more benefit than I could at first envisaged. For example, it was a revelation that NMs connected coaching with improved quality of care for patients. It was gratifying also to see the literature on transformational leadership reinforcing this effect of coaching (Bowles and Bowles, 2000; Doran et al., 2004).

The journey I have undertaken during this study has been personally very challenging due to many external factors. My overriding desire to develop my research skills and knowledge, the result of which is this thesis, has

been the one constant over the last few years. I hope this research may spark further research and debate to support the development of these valuable health care managers and through that the health and wellbeing of us all as patients

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Appendices

OXFORD BROOKES UNIVERSITY

Appendix 1 - Information sheet

BUSINESS SCHOOL, FACULTY OF BUSINESS

Study title 'The role of coaching in nurse manager development.'

Dear Nurse Manager

I would like to invite you to take part in a research study, to share your experiences of receiving coaching while being a nurse manager. Before you decide whether to take part, it is important for you to understand, why the research is being undertaken and what it will involve. Please take time to read the following information carefully.

The term nurse manager is being used to illustrate nurse manager, community manager, charge nurse, ward sister and ward manager roles.

What is the purpose of the study?

The nurse manager role is recognised as the cornerstone of the patient experience and of maintaining nursing standards (Prime Minister's Commission on the Future of Nursing and Midwifery 2010, Royal College of Nursing 2009). Therefore, how nurse managers are developed and supported in this role is crucial.

The aim of this study is to explore empirically how coaching is used currently in nurse manager development on a national scale, by means of a survey sent to Directors of Nursing and through qualitative interviews of those nurse managers who have experienced coaching while being in this role. The data collection period will be 10 months and forms part of my study on a Doctorate in Coaching and Mentoring programme.

Why have I been invited to participate?

You have been invited to participate as you have received coaching (at least 3 sessions) while being a nurse manager and your experiences are really important for this research.

Deciding to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. If you do decide to withdraw any unprocessed data gathered will be removed from the study and destroyed.

What will happen to me if I take part?

I would like to interview you. This will involve a one to one semi structured interview with me, Liz Westcott, at a location convenient to you. The interviews will be recorded and the data transposed into an electronic format. The interview will last no longer than 2 hours and with your

permission, I will take notes and audio record the interview. The interview questions will be about your experience of coaching and what changes occurred following your coaching. You will be provided with a summary of the interview themes within 2 weeks of the interview to give you an opportunity to check the accuracy of the themes.

What are the possible benefits of taking part?

I hope you will enjoy the interview. The main benefits to taking part are the sharing of your coaching experiences and the potential benefit that this research may offer to the development of future nurse managers. You will also be able to reflect on your own development and what role coaching has played in your role as a nurse manager.

Will what I say in this study be kept confidential?

All information collected will be kept strictly confidential (subject to legal limitations) and will be stored in a secure manner in a password protected computer. Your name and the organisation you work for will not appear in the published work or in the transposing of the data. If you agree to any quotes being used these will be under a pseudonym.

Data generated by the study must be retained in accordance with the University's policy on Academic Integrity. The data generated in the course of the research will be kept securely in paper or electronic form for a period of ten years after the completion of a research project.

What should I do if I want to take part?

If you wish to take part please, email me at westcottej@brookes.ac.uk marked 'Nurse manager research' and I will email you a consent form for completion and also arrange an interview date and location which is convenient for you.

What will happen to the results of the research study?

The results will form part of the thesis for my Doctorate in Coaching and Mentoring. Following completion of the Doctorate, I aim to publish my results in key nursing and coaching journals. I will send you a copy of the relevant publications.

Who is organising and funding the research?

I am conducting the research as a Doctorate in Coaching and Mentoring student at Oxford Brookes University, Business School in the Faculty of Business.

Who has reviewed the study?

This research has been approved by the University Research Ethics Committee, Oxford Brookes University

Contact for Further Information

For further information please contact Liz Westcott on westcottej@brookes.ac.uk or 01865 482565.

You can also contact members of my supervisory team Dr Tatiana Bachkirova, tbachkirova@brookes.ac.uk or Dr Jan Harwell, jharwell@brookes.ac.uk.

If you have any concerns about the way in which the study has been conducted, please contact the Chair of the University Research Ethics Committee on ethics@brookes.ac.uk.

Thank you for taking time to read this information sheet.

Liz Westcott
Doctoral Student

Appendix 2 - Consent Form

Full title of Project:

What is the role of Coaching in Nurse manager development.

Name, position and contact address of Researcher:
Liz Westcott
DCaM student
Department Head Clinical Health Care
Faculty of Health and Life Sciences
Jack Straw's Lane, Marston, Oxford
OX3 0FL

	Please initial box
I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
I agree to take part in the above study.	☐
I agree that my data gathered in this study may be stored (after it has been anonymised) in a specialist data centre and may be used for future research.	☐

	Please tick box	
	Yes	No
I agree to the interview being audio recorded and transcribed	☐	☐
I agree to the use of anonymised quotes in publications	☐	☐

Name of Participant Signature	Date	
Name of Researcher Signature	Date	

Appendix 3 - Interview Guide

Indicative Interview question guide		
1	**Introduction**	
	Thanks	
A	Opening questions e.g. How long have been a nurse manager, is this first NM post etc	
B	Details about practice area e.g. how manage staff managed etc	
2	**Before coaching started**	
A	What led to you receiving coaching in your role?	
B	Did you have a chance to choose your coach and how you chose him/her?	
C	What did you know about coaching before you started working with a coach?	
D	What you were expecting of coaching and what you were expecting of your coach?	
3	**The process of coaching**	
A	What type of coaching did you receive? E.g. was it in a group, or one to one, did you have tasks to complete, how many sessions you had and over what period of time	
B	Examples of issues you brought to your coaching sessions	
C	Examples of how your coaching and coaching relationship developed	
D	What was easy and what was difficult during coaching?	
E	What you have noticed about your role during coaching?	
4	**After coaching**	
A	What changes you may have noticed in your nurse manager role following your coaching	
B	Have these changes impacted the organisation	
C	If you had a chance to have coaching again, what issues would you take to work on with your coach?	
D	How would you approach coaching in this case?	
E	What your views are on the role of coaching in nurse management development in your organisation	
F	Do you know of other staff who have had coaching	
G	Have you undertaken any other development programme as a nurse manager	
5	**End of interview**	
	Thanks When will receive summary How like to receive it	

Appendix 4 - The Survey

Dear Director of Nursing / Chief Nurse

My name is Liz Westcott and I am currently undertaking a Doctorate in Coaching and Mentoring at Oxford Brookes University.

My research area is the development of nurse managers and the role that coaching plays in their development. The term nurse manager is being used to illustrate nurse manager, community manager, charge nurse, ward sister and ward manager roles.

The research has 2 parts.
Part 1 the survey of the situation from the perspective of Directors of Nursing and
Part 2 qualitative interviews with nurse managers who have received coaching.

This survey is concerned with Part 1: The aim is to:
• establish the nature of development programmes for nurse managers across the UK
• to establish the extent to which coaching is offered as part of nurse manager support and development

This survey has support from Elaine Strachan-Hall, Chief Nurse, Oxford University Hospital NHS Trust and the South Central SHA Leadership Academy and has been approved by Oxford Brookes University Ethics Committee.

I would be very grateful if you could take 20 minutes to complete this survey and your contribution would be much appreciated. The results of the survey will be anonymised and will be reported in general terms across the UK.

If you have nurse managers who have had coaching, I would be very grateful if details of my research could be passed onto them, to give them the opportunity to take part in the research.

The commitment of nurse managers would be one interview lasting up to 1 hour and I will travel to a location most suitable to the nurse manager.

I am very grateful for your time and, if you wish, I will send you a copy of the findings of the survey. For further information please contact Liz Westcott on westcottej@brookes.ac.uk or 01865 482565.

You can also contact members of my supervisory team Dr Tatiana Bachkirova, tbachkirova@brookes.ac.uk or Dr Jan Harwell, jharwell@brookes.ac.uk

If you have any concerns about the way in which the study has been conducted, please contact the Chair of the University Research Ethics Committee on ethics@brookes.ac.uk

Yours faithfully

Liz Westcott
westcottej@brookes.ac.uk

1.1. Please indicate the locality of your trust / organisation

Please indicate the locality of your trust / organisation
- ○ North East
- ○ North West
- ○ Yorkshire and Humber
- ○ East Midlands
- ○ West Midlands
- ○ East of England
- ○ South East Coast
- ○ South Central
- ○ South West
- ○ London
- ○ Scotland
- ○ Wales
- ○ Northern Ireland

2. Please state what type of organisation you represent

Please state what type of organisation you represent
- ☐ NHS Foundation Trust – Hospital
- ☐ NHS Trust Hospital
- ☐ NHS Foundation Trust – Community
- ☐ NHS Trust – Community
- ☐ NHS Foundation Trust – mixed Acute and community
- ☐ NHS Trust – mixed Acute and community
- ☐ Private Sector Hospital

3. Approximately how many nurse managers work in your organisation. Please answer in terms of staff and not whole time equivalents

Approximately how many nurse managers work in your organisation? Please answer in terms of staff and not whole time equivalents.
- ○ Less than 20
- ○ 21-39
- ○ 40-49
- ○ 50 and above

4. Do you have a development programme for nurse managers

Do you have a development programme for nurse managers?
- ○ Yes
- ○ No (If no, please go to question 11)
- ○ Don't know

5. If yes is the programme mandatory or voluntary

If yes is the programme mandatory or voluntary
- ☐ Mandatory
- ☐ Voluntary
- ☐ Mixed voluntary and mandatory parts

6. If you have both mandatory and voluntary parts please write a few sentences about what they consist of.

If you have both mandatory and voluntary parts please write a few sentences about what they consist of. Voluntary / mandatory

7. If it is voluntary please state the approximate uptake

If it is voluntary please state the approximate uptake
- ○ Less than 25% of nurse managers take the programme
- ○ 26-49%
- ○ 50-69%
- ○ 70% and above

8. What is the approximate length of the nurse managers' programme?

What is the approximate length of the nurse managers' programme
- ○ 5 days or less
- ○ 6-10 days
- ○ 11-20 days
- ○ over 21 days

9. Is the programme undertaken within a certain period of time of the person commencing a nurse manager post?

Is the programme undertaken within a certain period of time of the person commencing a nurse manager post?
- ○ Yes
- ○ No (if no, please go to question 11)

10. If yes, please tick within which period of time it is undertaken

If you please tick within which period of time it is undertaken
- ○ within 6 months of appointment
- ○ 6-9 months
- ○ 10-12 months
- ○ 13-18 months
- ○ don't know

11. In your organisation, is the nurse manager development programme offered to nurses before they consider applying for a nurse manager role?

In your organisation, is the nurse manager development programme offered to nurses before they consider applying for a nurse manager role?
- ○ Yes
- ○ No
- ○ Don't know

12. On appointment are nurse managers offered any of the following: Please tick all that apply

On appointment are nurse managers offered any of the following? Please tick all that apply:
- ☐ A mentor
- ☐ A buddy
- ☐ Coaching in a group
- ☐ Coaching individually
- ☐ Structured peer support
- ☐ Action learning sets
- ☐ A structured development programme
- ☐ Other (please specify)

13. If they are offered a mentor who chooses the mentor? Please tick all that apply

If they are offered a mentor who chooses the mentor? Please tick all that apply:
☐ The nurse manager themselves
☐ Human resource department
☐ Their manager
☐ Other (please specify)

14. Do you have a coaching programme available for coaching nurse managers in their role?

Do you have a coaching programme available for coaching nurse managers in their role?
○ Yes
○ No (If no go to question 22)
○ Don't know

15. How many sessions does your organisation support? Please tick any that apply

How many sessions does your organisation support? Please tick any that apply:
☐ Up to 3 sessions
☐ 4-6 sessions
☐ 7-9 sessions
☐ More than 9 sessions

16. Are the coaches from within your organisation?

Are the coaches from within your organisation?
○ Yes
○ No
○ A mixture from within the organisation and external
○ Don't know

17. Please tick any of the following staff in your organisation who undertake coaching:

Please tick any of the following staff in your organisation who undertake coaching:
☐ Senior nurses
☐ Human resource staff
☐ Any senior manager in the organisation
☐ Any senior clinical staff in the organisation
☐ Other (please specify)

18. Are your staff required to have training before they become coaches?

Are your staff required to have training before they become coaches?
○ Yes
○ No (if no go to question 19)
○ Don't know

19. If yes, who delivers the training? Please tick all that apply

If yes, who delivers the training? Please tick all that apply
☐ Human resources
☐ Training department staff
☐ External coaching company
☐ Previously trained staff in the organisation

20. If they are offered a coach who chooses the coach? Please tick all that apply

If they are offered a coach who chooses the coach? Please tick all that apply
☐ The nurse manager themselves
☐ Human resource department
☐ Their manager
☐ Other (please specify)

21. Do you collect data on the coaching received?

Do you collect data on the coaching received?
○ Yes
○ No (if no go to question 22)
○ Don't know

22. If yes how do you undertake this? Please tick all that apply.

If yes, how do you undertake this? Please tick all that apply
☐ Questionnaires
☐ Interviews
☐ Via PDR process
☐ Other (please specify)

23. If you do not have a coaching programme do you know if any of your nurse managers have accessed coaching independently?

If you do not have a coaching programme do you know if any of your nurse managers have accessed coaching independently?
○ Yes
○ No
○ Don't know

24. That you very much for taking part in this survey.
If there is any more information you would like to add about your nurse manager development or the role of coaching nurse managers in your organisation please do so in the box below

If you have nurse managers who have received coaching and who may wish to participate in this research please ask them to contact me on westcottej@brookes.ac.uk

Appendix 5 - Themes nurse managers

✓ = in mentioned, where the page number occurs it is to direct me to use a quote or has been particularly emphasised

		Jane	**Alexis**	**Lesley**	**Julie**	**Pauline**	**Val**	**Sandy**	**Dale**	**Jo**	**Chris**	**Fran Pilot, notes only**
1	Not first NM job	✓	✓	✓	✓		✓	✓	✓	✓	✓	
2	Clinical supervision type coaching	✓ p.1			P3					P2		
3	Identify new ways of working	✓ P2		✓ Delegate p.12	P7	✓ and new tools p.11	✓ Influence and innovate p.14	✓ P2	✓ P6	✓ P6	P4	✓
4	Do change management	✓ P2	P2	Time manageme nt p12	✓ p.1			✓ P2	✓ P12	✓ P6	✓ P5	✓
5	Different ways of leadership	✓ P2			P7	✓ stand back p.6	P6	✓ P2	✓ P4	✓ P6	✓ P5	✓
6	Wanted to learn techniques from coaching to help when line managing	✓ P3		P5	P4	Learnt p.6 P4	✓ P6	P2	P4	✓ P6	✓ P3	✓
7	Not have line manager as coach	✓ P2	Not worried p2	✓ Suspicion truth p4	✓ P3	P2	✓ p.2	✓ P3	✓ P3	✓ P9	✓ P5	✓
8	Need for impartial	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
	coaching	P2		Someone who I didn't know. Out of politics p4	P3	Safe P2	p.2	P3	P3	P9	P5	
10	Someone with understanding of area	✓ P2		P4	p.3 not needed	P7	✓ P6 in first time coaching	P3	✓ P3 in first time coaching	✓ P9	Not needed	
11	Difficult if don't understand background	✓ P3		P4		P7		P4	✓ Unless previous coaching p.3			
12	Trust did train lots of coaches but didn't maintain it	✓ P3	Trust trains some	P5	✓ Did support P11	✓ Trust prog.p1						
13	M&C sit side by side	✓ P10										
14	Now use coaching style as a LM	✓	To some extent p8	P3	✓ P3	✓ P8	✓ P6	P4	✓ P5	✓ P10	✓ P3	✓
15	Have always done this too ^	✓ P11		P6	✓ P3	New to this P8						
16	Brain storming – reflecting	✓ P3	P8	P6			✓ P8		✓ P4	✓ P10	✓ P2	✓
17	Getting them to develop tools to work out solution	✓ P4	Can make staff	P12	✓ P4	✓ P5		✓ P3		✓ P7	✓ P2	✓

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
			deskilled if always give them the answers p7									
18	Have tools in your mindset	✓ P4	✓ Life tools P6	P12	✓ p.4	✓ p.6	✓ p.8	P3		✓ P7	P2	
19	Comes from being a manager anyway ^	✓ P4		P12	P3		P6					
20	Didn't always have things to take to a coach	✓ P5										
21	Not become a moaning session but	✓ P3										
22	Try to remedy a situation difficult at start	✓ P3	It's about problem solving p2		P7	P4	P8	P5	P2	✓ P2	✓ P3	✓
24	Focus group discussion and use coaching skills	✓ P4			P8							
25	Getting team to come up with ideas using coaching style	✓ P5	Didn't agree with all of it P2	P3 integrated into my personality really		P7	P4	P5	P5	✓ P10	✓ P4	✓

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
26	Project management	✓ P5		P10 and p15	P7	✓ p.6	P5				✓ P6	✓
27	Staffing levels within tight resources	✓ P5	P6		P8	P6	✓ P6	P4				
28	Learnt it wasn't my fault there was a problem	✓ P5		P12	P5	P9			P2	P2	✓ P13	
29	Inner confidence	✓ P5		P16	P5		P13	✓	✓ p5	✓ p15	P14	✓
30	Can be more proactive now	✓ P5	P9	P16	P1	✓	P13	✓	✓ P5	✓ P15		✓
31	Confidence to say no	✓6	P5	P16	P2		P13		✓p.5	✓ p15		
32	Not so much crisis management	✓ P7	Be proactive to prevent problems p5		P2		P13					✓
33	Must be confidential	✓ P6		P4	P8 So I'm very careful about who I select to coach	✓	✓ P3	✓ P3	P4	P2	✓ P13	✓
34	Staff say thanks for coaching through a situation	✓ P6				✓ Better feedback	p.13 staff notice	p6				
35	Go away from area to coach	✓ P4		P4	P9		✓ p3		P4		✓ p14	

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
36	Think more creatively	✓ P7		P4	P5		P11			✓ p8	P10	✓
37	Helps implementation of strategies	✓ P7			P11				✓ P5	✓ P8	✓ P10	
38	Develop new ways of working	✓ P7		P7	P11	✓	P11	P2	✓ P5	✓ P8	✓ P10	
39	Good for NM new in post	✓ P8		P13	P14	✓ p.11	P11	P6	✓ P11	✓ p12	✓ p16	✓
40	And when have a problem	✓ P8		✓ p.14		✓	✓ P11	P6	✓ P11		P3	✓
41	Or when go for next role	✓ P8		Get embedded p.14	✓			P6			✓ P3	✓
42	Learn on job with a supportive line manager		✓ P2		P3	✓						
43	Confusion between clin sup, M and C	P1		Some better p.5 clear	p.3 CS p.4		p.3 p.15	P2	P3	✓ P2	P14	✓
44	NM have world on their shoulders											✓
45	Getting staff on board	✓ P7	P3	P12	P3		P4			P10		
46	Keen on own devt		P4	P3	P8		✓ p5	✓ P3	✓ P2		P3	

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
47	Coaching might enhance management style	✓ P7	P6	P3	P2		P6	✓ P4	P5	P10	✓ P4	✓
48	Not time to use coaching style		✓ Do elements P7	Time constraints for C p. 9								
49	Patient safety and need to be direct		P6					✓			✓	
50	Fight with senior managers		P6	Deflect conflict p3		Battle with staff p.8					✓ P8	
51	Have made mistakes		P9			✓ p.7					✓	
52	Have been on development programme	P2	P1	✓ Historical offered p3	✓	P10	p.11 still need development programmes too	✓ P3	P2	✓ P2	✓ P3	
53	Using coaching style of management after having coaching		P7	P3	P2	P8	P6	✓ P4	P5	✓ P10	✓ P4	
54	ROI	P6		↓ conflict More productive negotiate pt care ↑ p.17	p.3 change manage ↑ P.4 priority system	Project work ↑ Feedback staff	Way to talk and take things to senior managers Different	Changed career p3	Interview prep Strategic thinking Difficult	Deescalate issues p.8 Confidence to challenge things p.9	Mental health Manage proble	More proactive, Better at delegating

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
				Advocate p.15 Listening Confidence to negotiate p.16 If removed lost something & core skills ↑		Able to listen and take criticism p.8 Good for pts p8	leadership p.7 Understand others Turn around poor area p10		conversations Interrelated career prog Interview prep p.5 Performance improvement	and less clumsily Resilience p11	m	Better quality reports
55	Have done a coaching course		P1	✓	✓ p.2		X	✓ P3			✓ P3	
56	Trust disinterested in programmes			P3	✓ p.1							
57	Coaching upwards			p.15 ✓ ++		✓ 10 Better line man	✓ p.7 p.9	P5	P9	Manage up ✓ p4	P18	
58	Able to identify who has been coached			P14	✓ p.4			p6		And who not P6		
59	By being better manager	P7	P10	P13	✓ P12	P10	P11	P5	P9			✓

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
60	Own life experience has shaped me		P3							P9		
61	Peer coaching			P10								
62	Affirming			Talk about me p.12 valued as a person		P6			P5	P9		
63	C M CS	✓ ✓ ✓		✓ p.5	P3	P9		P2	P2	P11	P13	
64	Relationship building			Short term ✓		P4		P4	P5	✓p3		
65	Type of coaching	X	X	X	✓	P10				Trans analysis		
66	Coach not counsellor			✓ Balance boundaries p6			Broad overlap	✓			P13	
67	Coach acknowledges what's going on in person's life			P8			P2	P3	P3	P3	P8	
68	Age and sex of coach			✓ p.8								
69	Learn about myself			P12	✓ p.4	P9	P2 and p6	P2	P5	P3	P8	✓
70	Told may cry					✓ p.4						
71	Worked on staff problem			P12	P3	P8	✓ p.4	P4	P4	✓ P3		✓

		Jane	Alexis	Lesley	Julie	Pauline	Val	Sandy	Dale	Jo	Chris	Fran Pilot, notes only
72	Transition to NM role difficult	P8		P13	P7	✓ p.11,12	P11	P1		✓ P12	✓ P19	
73	Unhappy in job which is why choose coach					P4				✓		
74	Good NMs role model need for develop and coach		P7	P7		P12						
75	Emotional intelligence				P4		✓ p.6					
76	Nursing culture to be dubious about own help and support										✓ p.14	
77	Coaching not for everyone		P3						P9		✓ p.5	

Appendix 6 - Cross cutting themes

1. NM Self development	**Coaching plus clinical supervision and mentoring**
Not first NM job NM have world on their shoulders Now use coaching style as a LM Have tools in your mindset Didn't always have things to take to a coach Try to remedy a situation difficult at start Focus group discussion and use coaching skills Learnt it wasn't my fault there was a problem Inner confidence Mindfulness Can be more proactive now Confidence to say no Must be confidential Good for NM new in post Good when have a problem good when go for next role Keen on own devt Have made mistakes Have been on development programme Coaching upwards Own life experience has shaped me Affirming Coach not counsellor Coach acknowledges what's going on in person's life Learn about myself	Not have line manager as coach Need for impartial coaching Someone with understanding of area Difficult if don't understand background M&C sit side by side Have always done this too Brain storming – reflecting Go away from area for coaching Confusion between clin sup, M and C Peer coaching Age and sex of coach Coaching not for everyone How to have difficult conversations Coach not be a line manager Go to a different Trust to find a coach Link clinical supervision with a coaching style Coaching is there for coachee benefit Quality of coaching varies Balance coaching and counselling Peer coaching is useful Coaching needs to be restorative, motivational transformational Coaching is about building a relationship Need coach who is challenging Not all staff suited to coaching

Told may cry Transition to NM role difficult Emotional intelligence Nursing culture to be dubious about own help and support Myers Briggs plus 360' evaluation Learn how you function before you can coach Work life balance more effective Career advice Getting unstuck More suited to role Couldn't do job without coaching	
2. Organisational issues	**Benefits of coaching and Return on investment**
NM role pivotal NM role accountable and responsible. Trust did train lots of coaches but didn't maintain it Getting team to come up with ideas using coaching style Staffing levels within tight resources Learn on job when have a supportive line manager Not time to use coaching style Patient safety and need to be direct Fight with senior managers Trust invest in programmes Trust disinterested in programmes Time commitment for coaching Variation on whether coaching offered Staff have to be willing to be coached Coaching come as part of after leadership programme Promote managers to use coaching style Trusts didn't support it long term Invest in NM	Clinical supervision type coaching Identify new ways of working Do change management Different ways of leadership Wanted to learn techniques from coaching to help when line managing Getting them to develop tools to work out solution Comes from being a manager anyway Project management Not so much crisis management Staff say thanks for coaching through a situation Think more creatively Helps with implementation of strategies Develop new ways of working Getting staff on board Coaching might enhance management style Using coaching style of management after having coaching Able to identify who has been coached by being better manager Relationship building

Need NMs to know how to lead Understand politics	Worked on staff problem Good NMs role model need for develop and coach Great to see staff reflect and come back differently More creative Self-belief of coachee and self-efficacy. Builds self-awareness Transformational Dealt with problems better More effective at work Performance improvement Engenders loyalty Develop coping strategies Develop strategic plans Understood new systems Help to reflect Have difficult conversations

Appendix 7 - Cross cutting themes

1. NM Self development	**Coaching plus clinical supervision and mentoring**
Why Coaching Occurred	
NM have world on their shoulders Nursing culture to be dubious about own help and support Myers Briggs plus 360' evaluation Learn how you function before you can coach Work life balance more effective Career advice Transition to NM role difficult Good for NM new in post Good when have a problem good when go for next role Keen on own devt Have made mistakes Have been on development programme Coaching upwards Own life experience has shaped me	
The Experience of Coaching	
Have tools in your mindset Didn't always have things to take to a coach Try to remedy a situation difficult at start Coach not counsellor Coach acknowledges what's going on in person's life Learn about myself Told may cry Learnt it wasn't my fault there was a problem Inner confidence Mindfulness Affirming Emotional intelligence Getting unstuck Must be confidential	Not have line manager as coach Need for impartial coaching Someone with understanding of area Difficult if don't understand background M&C sit side by side Have always done this too Brain storming – reflecting Go away from area for coaching Balance coaching and counselling Peer coaching is useful Coaching needs to be restorative, motivational transformational Coaching is about building a relationship Need coach who is challenging Confusion between clin sup, M and C Peer coaching Age and sex of coach How to have difficult conversations Coach not be a line manager Go to a different Trust to find a coach Link clinical supervision with a coaching style Coaching is there for coachee benefit Quality of coaching varies
Outcomes Following Coaching	
Now use coaching style as a LM Couldn't do job without coaching Focus group discussion and use coaching skills Can be more proactive now Confidence to say no More suited to role	Coaching not for everyone Not all staff suited to coaching

2. Organisational issues	**Benefits of coaching and Return on investment**
Why Coaching Occurred	
NM role pivotal NM role accountable and responsible. Trust did train lots of coaches but didn't maintain it Staffing levels within tight resources Trust invest in programmes Trust disinterested in programmes Trusts didn't support it long term Invest in NM Need NMs to know how to lead Understand politics Patient safety and need to be direct Fight with senior managers	Worked on staff problem Good NMs role model need for develop and coach Wanted to learn techniques from coaching to help when line managing
The Experience of Coaching	
Time commitment for coaching Variation on whether coaching offered Staff have to be willing to be coached Coaching come as part of after leadership programme	Great to see staff reflect and come back differently More creative Self-belief of coachee and self-efficacy. Builds self-awareness Transformational Help to reflect Have difficult conversations Staff say thanks for coaching through a situation Think more creatively Clinical supervision type coaching Getting them to develop tools to work out solution Comes from being a manager anyway
Outcomes Following Coaching	
Getting team to come up with ideas using coaching style Learn on job when have a supportive line manager Not time to use coaching style Promote managers to use coaching style	Identify new ways of working Do change management Different ways of leadership Dealt with problems better More effective at work Performance improvement Engenders loyalty Develop coping strategies Develop strategic plans Understood new systems Able to identify who has been coached by being better manager Relationship building Coaching might enhance management style Using coaching style of management after having coaching Project management Not so much crisis management Helps with implementation of

	strategies Develop new ways of working Getting staff on board