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What are the experiences and perceptions of leadership education and development for clinical leaders in the Emergency Department (ED) of an English NHS Acute Trust?

By

Johann Heinrich Scheffer

Institute of Education

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Johann Heinrich Scheffer November 2022

ABSTRACT

Whilst there is considerable research on leadership development in the business sector, this topic is less well researched in the National Health Service (NHS), especially in relation to how clinicians in emergency departments learn to lead, what their experiences of leadership are, and their development needs for the future. This is surprising as the NHS is going through something of a crisis, with good leadership on the ground arguably being the key to its future success. This study makes an original contribution in exploring this issue from the perspectives of emerging leaders, middle management, and senior management, and specifically addresses the knowledge gap in identifying the training needs of clinical leaders in urgent and emergency care (UEC).

The main research question was defined as 'what are the experiences and perceptions, of clinical leadership development in the emergency department (ED) of an English Acute Trust?' A sample of clinical leaders (emerging leaders, middle management, and senior management) (n=36) were surveyed, alongside 12 semi structured interviews. Quantitative data were analysed using descriptive statistics while qualitative data were analysed using a thematic approach drawing on a conceptual framework based on the inter-related concepts of culture, professional identity, and leadership development.

This study offers insights into the perception of culture and the influence of values and behaviours across all three levels of management, on the organisational purpose and its norms. The impact of leadership progression on personal and professional identity, and the ethical dilemmas all clinical leaders must balance, in offering high-quality patient care, is also explored. The findings reveal that a bespoke approach to leadership development is needed. It advocates a more individual centric focus on leadership development in relation to *inter alia* multi-disciplinary team development, system collaboration and new ways of working. The study proposes an original leadership development framework for UEC staff. It proposes foundational development programmes to support clinical leaders, who are often good clinicians, to enable them to be the best leaders they could be.

The results have implications for senior management and organisational development practitioners to ensure appropriate investment in talent management, succession planning and career pathway development are in place, in the future, to ensure the sustainable success of the organisation.

Acknowledgements and Dedication

This work would not have been possible was it not for the support and encouragement of my wife Renate, my father Chris, and my wider family and friends. Your reassurance and support sustained the dedication required to complete a journey of this nature. I wish to express a sincere and heartfelt word of thanks for your encouragement, inspiration, and support.

Also, my sincere appreciation to my supervisors Prof Alan Floyd and Dr Nasreen Majid, whose guidance, wisdom, challenge, and encouragement has been invaluable during this journey. At times I felt that this was an unachievable task, but your guidance and support has been invaluable. Thank you to my current and former NHS Chief Executives, Tom Abell, Dr Jane Halpin, David Evans and Kathryn Magson, for their support in making this work a reality.

A special thank you to all the participants in this study. Be it the participants in the focus groups who tested the survey, and debated the construction of the survey questions, the survey respondents, or participants in the semi-structured interviews. Your time, contribution and frankness has been instrumental in this work, without your involvement, none of this would have been possible.

Finally, I am delighted to dedicate this study and this thesis to my lovely wife. You have been my champion, my supporter, and my constant encouragement. Thank you.

Renate

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EXPLANATORY NOTES

1. Chapter Headings are in mini caps at font setting of 28, with note headings at font setting of 22, with sub-headings at a font setting of 18, type setting in Calibri Light.

2. The Thesis text is done in a font setting of 12, and a type setting in Times New Roman, with a line setting of 2.

3. Full verbatim quotes from authors or participants are indented, in regular text at a font setting of 10.5, with a line setting of 1.5 and indented, with a type setting in Times New Roman.

4. Quotes from articles, books and authors are shown by 'speech marks'.

5. Bold is used to emphasise a heading, title, or theme.

6. Quotes from participants in the survey is shown by '*italic*' in speech marks.

7. Comments from participants who participated in the semi-structured interviews are shown by '*italic*' in speech marks.

8. Quotes from text in the survey is shown by '<u>underlined</u>' in speech marks.

9. Direct quotes from other authors are shown in "inverted commas".

10. EndNote X9 was used to populate the reference list in line with the rules of the American Psychiatric Association (APA) v. 6 reference methodology.

CHAPTER 1 ~ INTRODUCTION

1.1 Introduction

The aim of this mixed method, interpretivist study, is to explore 'the experiences and perceptions of clinical leadership development in the emergency department (ED) of an English Acute Trust'. A sample of clinical leaders (emerging leaders, middle management, and senior management) (n=36) were surveyed, and a different group of participants (n=12) were interviewed, using semi structured interviews. This study draws on a conceptual framework, based on the inter-related concepts of culture, professional identity and leadership development, this study provided clarity on some of the challenges, frustrations, and misconceptions that urgent and emergency care (UEC) staff experience.

Data were viewed, using a thematic analytical approach (Braun & Clarke, 2006) regarding the leadership development needs of individuals in UEC. This enabled this study to make an original contribution to a better understanding of leadership development in and NHS Acute Trust. The journey people take in becoming leaders of others. Why they took that path and what they needed in place to enable them to develop their own leadership style and ability. It considered the various challenges and obstacles during this journey and identify gaps or needs that these leaders have or had, to ensure that they became successful, effective, content with and successful in the execution of their role as leader.

This chapter sets out the personal journey of the researcher. It explores the aims of the thesis, defining the research problem, and articulate the main research question. It also takes note of the impact of the Covid-19 pandemic, which delayed the start and conclusion of this work. For

context, this chapter also explores a brief history of the NHS during the past 75 years [1942 – 2022]. It offers a summary of the research methodology utilised in this study, the significance of this Thesis, and the conceptual framework that was developed because of the literature review conducted in Chapter 2. Finally, it sets out a brief overview of the rest of the Thesis and the six chapters that follows.

1.2 A Personal Journey

Some thirty-eight years ago, I started with a career in Human Resources, in South Africa. This was not my original choice of career. There were various things I wanted to do, like studying theology but lacked the required linguistic skills and the thought of studying Greek, Latin and Hebrew, put an end to that aspiration. My second choice was to study law but is was discouraged by a teacher who suggested that I lacked the intellectual capacity, so eventually, and on his advice, I opted to become a teacher.

It is worth noting that as a child, my father worked in the Prison Service in South Africa, which was part of the military structures back then and resulted in us moving to a new house in a different city very regularly. This constant moving from city to city, across the length and breadth of South Africa, frequenting new schools, repeatedly having to make new friends, before moving again made me a bit of loner, withdrawn in unfamiliar circumstances, which made me feel like I never quite belonged, a bit of an onlooker, rather than a participant (Scheffer, 2018, p. 303).

It is safe to say that I struggled at school. As an Afrikaans boy, I only learned how to read, speak, and write in English during my final years at school, thanks to a very dedicated and compassionate Headmaster, Mr. Simpson. It was during this time that another teacher, Henry Hill, suggested that I should study Personnel Management. He explained the discipline as 'like teaching, but it just involves adults'. This launched my career in Human Resources.

Whilst not being a natural student, I had to work much harder than my contemporaries just to pass. The youngest of four, I have always felt that I must prove myself. I had to show that I am different, able, and capable.

I dabbled in education as I became a part-time lecturer at the then Technikon of Pretoria, (today's Tshwane University of Technology, 2000 - 2002), where I taught first- and second-year students on the same programme that I studied some fifteen years earlier. On reflection, I did enjoy being a lecturer immensely.

Considering the leaders in my career, I have worked with both inspirational and less inspirational leaders and have taken from them what to do, and what not to do. From the good leaders I worked with, I often asked myself during challenging times, what would he have done, or how would she have handled this situation. As a natural reflector, I constantly review what I do, what I could have done differently, or how I could have improved myself. This has become a part of my life that has served me well. It was this personal introspection and reflectivity that allowed me to re-invent myself over the years. Initially, in multinational corporations in the private sector, which enabled me to become an entrepreneur, owning two businesses, emigrating to the United Kingdom (UK) in 2009 at the age of 43 and starting in the National Health Services (NHS) as a volunteer, before I embarked on a UK based career in

Human Resources and Organisational Development, and more recently in Strategy and Education.

During the past thirteen years in the NHS, I have converted my South African qualifications and became a Fellow of the Chartered Instituted of Personnel and Development (FCIPD), completed both a master's degree (2012) and my LLB (Hons) (2015) and have been particularly privileged to have worked with very talented and highly experienced people in the NHS.

I started my career in the NHS, in the acute sector, initially as a volunteer and later as Deputy Director of Workforce in Lancashire (2009 – 2012); worked as Director of Human Resources and Organisational Development in Devon (2012 – 2015); Director of Workforce and Organisational Development for a number of Clinical Commissioning Groups across some of the home-counties (2015 – 2021); Director of People Transformation in an Integrated Care System (ICS) (2021 – 2022) and am currently Director of Strategy, Culture and Education for one of the Ambulance Service in England (2022 +).

During these periods I worked in two large NHS Acute Trust; within the Clinical Commissioning landscape and have witnessed the evolutionary development of the change from the Lansley reforms of 2012 to the creation of Sustainable Transformation Plans (STP's). I was part of the emerging Integrated Care Systems (ICSs), and Integrated Care Alliances (ICAs) or Integrated Care Partnerships (ICPs), and the Integrated Care Boards (ICBs) as envisaged by the Department of Health and Social Care Act, 2022.

It is against this backdrop and a personal desire to improve my own leadership ability, that I commenced with this Professional Doctorate in Education in 2018. A personal development journey, developing my own ability in considering the values of African leadership, as described by Mbigi (2004), which are defined as:

- Respect for the dignity of others;
- Group solidarity (an injury to one is an injury to all);
- Teamwork is greater than the efforts of the individual;
- Service to others in the spirit of peace and harmony;
- Interdependence and connectedness;
- Persuasion.

I originally thought that the completion of my law degree brought an end to my academic career however, this Doctorate set me on a path of self-reflection, self-development, understanding the theoretical frameworks, definitions, and principles of leadership development. In this, I hope to make a value adding and constructive contribution to the NHS, an employer that has been exceedingly good to me and my wife; to my field of human resources and organisational development; but ultimately, this thesis is about how I could improve myself as a better person, a better leader, and a better human being, for the benefit of those I lead.

It is this collective experience, growing up in South Africa, starting my career in corporate South Africa, my days as a business owner, and my career in the NHS that have paved the way for me to embark on this study.

1.3 Aims of the Thesis

The purpose of this thesis is to better understand leadership development in the context of an NHS Acute Trust in England and in particular the perceptions and experiences of those staff in an emergency department (ED), as a microcosm of a larger Acute Trust.

Many NHS staff joined the NHS as clinicians, who originally did not join to become managers, thus, the aim of this thesis is to better understand the experiences, perceptions and realities of this group of staff in assuming a clinically lead role (Démeh & Rosengren, 2015; Fulop & Day, 2010; Ham, Clark, Spurgeon, Dickinson, & Armit, 2011; Klaber, 2011). To explore their journey as they become managers and leaders, when ultimately, their original aim was to help people, to cure people, to treat people, or generally to improve the quality of life for their fellow human beings. Not everyone joining the NHS anticipate what they could do in the next role (Black, 2003), whilst most nursing leadership roles are not perceived as financially or professionally attractive (Cabral, Oram, & Allum, 2019). At the outset, they are likely to join because of their need to help others. But many of them become leaders, and this impacts on them personally, those that they lead and the organisation they work in (Vogel, 2017).

Defining the Problem

The problem definition for this thesis is to better understand the context in which leadership development takes place in the NHS. According to (Ham et al., 2011), there is a lack of qualified and competent leaders in the NHS and in Health Care generally, which was confirmed and re-iterated by several authors (Démeh & Rosengren, 2015; Dixon-Woods et al., 2013;

Fulop & Day, 2010; West, 2021; West et al., 2015; West & Bailey, 2019) who confirmed that highly skilled and competent clinicians become NHS leaders, but without the basic or essential skills development needed to enable them to be lead effectively, appropriately and sustainability. These clinical leaders come into the profession with very different clinical skills, but without some of the social science skills required to be an engaging, compassionate, and effective leader (Powell et al., 2012).

This thesis also considers the impact of such education, learning and development and how this relates to the backdrop of the complex structural context in which the NHS developed over the past 75 years (1947 – 2022). This complexity, balanced with an ever-increasing need from the British public for high quality care, free at the point of delivery (Rivett, 1997), combined with the political challenges of limited resources whilst holding local hospital management to account for effective and efficient delivery (Welch, 2018) makes for a complex and challenging system.

It explores the cultural context of the NHS, historically but pre-dominantly within one NHS Trust, whilst exploring the meaning and consequences of new public leadership (NPL). This context impacts and shapes the culture of the NHS, it's individual trusts and departments within each trust, as behaviours, values and professional identify all play a key part in terms of how leader and follower present themselves at work, and how these impacts the performance at organisational level (Brookes & Grint, 2010).

This thesis explores the perceptions and impact of three levels of clinical leaders, based on the NHS job-banding structure, called 'Agenda for Change' (AfC), which is a structure defined as bands 2 – 9. Executive directors and clinicians are employed outside of Agenda for Change

and are classified as ‘Very Senior Management (VSM), whilst medical staff are employed in accordance with the ‘Medical and Dental’ (M&D) clinical contract terms and conditions for medical staff. The levels of management are:

- Emerging leaders (band 4 – 6, including junior doctors);
- Middle management (band 7, 8A – 8D, including medical and dental staff grades);
- Senior management (band 9, VSM & medical and dental Consultants).

These levels include medical, nursing, and allied health professional (AHP’s), who all form part of the multi-disciplinary teams (MDT) offering high quality of care to the patients across England. It is these MDT’s that often are in conflict with one another as the tensions between health-care professional and managerial responsibility is not always in harmony. This, according to Spehar *et al* is due to the fact that clinicians did not always anticipate a career in management (Spehar, Frich, & Kjekshus, 2012).

It is worth reflecting on the description of ‘emerging leaders’, for purposes of this study, bands 4 – 6 as defined in AfC, including junior doctors. This group of up-and-coming leaders typically are individuals with specific skills, supporting more qualified and experience clinical staff. They are traditionally at the beginning or early stages of their career. They could either be experienced support staff, or newly qualified clinical staff with none or limited line management responsibilities. Emerging clinical leaders traditionally support with *inter alia*, observations, assessments, and triaging, under the direction and supervision of more qualified and experienced clinical staff. Emerging leaders are the middle management and clinical leaders of the future. Although they may not see it that way, at these early stages of their career,

they are respected by their seniors for their skills and expertise, as articulated by Tara, a Lead Nurse in the ED (see pg. 164).

Main Research Question

The main research question is framed as follows:

What are the experiences and perceptions of leadership education and development for clinical leaders in the Emergency Department (ED) of an English NHS Acute Trust?

The following supplementary questions to the research question emerged as the following.

SQ1. How does the concept of organisational culture influence the experiences and perceptions of leadership, leadership development and education?

SQ2. How are their personal and professional identities influenced by their experiences of leadership, leadership development and education?

SQ3. What are their perceptions and experiences of leadership development programmes and/or educational activities to date?

SQ4. What are their future development needs that will enable them to be effective in their role?

Finally, this thesis explores what future research could be done because of this study, in terms of what practical interventions would be helpful to support clinical leadership development in the NHS in time to come, as a result hereof.

Novel Corona Virus Pandemic (Covid-19)

Before one could consider the history of the NHS as described in the fifty year review (Rivett, 1997), and the living history of the first seventy years of the NHS (Welch, 2018), it is important to pause on the current world wide challenges of the Novel Corona Virus Pandemic that has gripped the world since November 2019. This pandemic had a dramatic impact on the NHS and is likely to change the NHS permanently in time to come.

It is essential to acknowledge that the Novel Corona Virus Pandemic (Covid-19 or C-19) of 2020 has stopped the world in its tracks. It is the most significant event impacting everyone's lives, since the second world war. It has been described as unprecedented, a challenging moment and a fundamental shift away from the status quo, which has added an additional layer of complexity to the context of the NHS for today and the future.

In addition, it should be noted that the NHS was created in 1948, some 75 years ago. During that time, it evolved into a vast bureaucratic, siloed, inward facing and incredibly competitive structures of independent and competing organisations. The NHS is not a single organisational structure, like for example the Royal Navy or the Military. Although often referred to as 'the NHS', as of 1 July 2022, it can best be described as a federation of more than 255 independent statutory bodies, that collectively forms what we call 'the NHS'. As the fifth largest employer in the world, with almost 1.4 million employees, (NHSD, 2022b) it is immensely complex in its very nature, and has a reputation for very slow cultural change.

The pandemic caused what seemed to be an impossible process of change in the past, resulted in a very rapid adjustment in a matter of three months and in some cases shorter, to the way

that organisations are working today. Memorandums of Understanding (MoU's) were developed to offer mutual aid between organisations, in terms of staff, equipment and resources, without any costs between different statutory bodies. Business as usual was stood down and priorities were redefined. All non-urgent surgery was cancelled. The public were told not to go to their accident and emergency (A&E) department and helplines were set up to support potential C-19 cases initially via the NHS 111 helpline. All energy, staff and resources were re-focused on combatting C-19.

This also necessitated that the launch of the survey for this study, had to be postponed several times, whilst it was difficult to confirm participants for the semi-structured interviews, due to operational pressures. A more detail consideration of the impact of the pandemic is set out in **Appendix A** to this thesis.

1.4 The NHS ~ A Brief History [1942 – 2022]

Welch (2018) describes the NHS as a health service aimed at meeting a long-recognised need to alleviate the 'five giants' of post-war Britain identified in the 1942 Beveridge Report as "*want, disease, squalor, ignorance, and idleness*" (Welch 2018, p 38). Most today, would agree that the creation of the NHS was noble in conception, but since its creation it has undergone continuous political, policy, structural and medical transformations (Rivett, 1998; Welch, 2018). According to Rivett (1997), it laid the foundations that saw extensive social reform in post-war Britain, and the creation of what became the 'welfare state' (p. 49). It expanded on the concept of 'social security' and established what is known today as 'National

Insurance', which acted as a funding mechanism for, and the establishment of, the National Health Service (NHS) (Rivett, 1997, pp. 1-49).

In 2012, Powell *et al*, reported that since the creation of the NHS on Monday 5th of July 1948, it took a further eight years to 1956, before it was acknowledged that there needed to be a structured process in place to ensure the future development of leaders in the NHS. This saw the launch of the NHS Graduate Management Scheme in 1956 (Powell et al., 2012). He reported that "the term 'talent management' was not used in the NHS until 2004, when the Department of Health (DoH) published its 'update paper on talent management" (Powell et al., 2012).

The NHS Reorganisation Act, 1973, saw the establishment of 90 Area Health Authorities which formed the administrative leadership of the NHS, reporting into District Health Authorities (Welch, 2018). Between 1973 to 2010 the NHS underwent no less than fifteen large scale organisational transformation events (Nuffield-Trust, 2018) (see **Appendix B**), which peaked with the establishment of the Francis Commission and the first Mid Staffordshire Inquiry. This epic scandal about leadership, culture, values, behaviours, staffing, performativity and professional identity and the lack of a duty of candour set the scene for a very different NHS in the ten years that followed (Martin & Dixon-Woods, 2014).

However, it was not until 2004, according to Powel *et al* (2012), that the concept of Talent Management (TM) was introduced into the NHS. He confirmed that the concept was 'hardly novel' and concluded that TM aimed to "mould the individual elements into a more coherent and cohesive system. [But, acknowledged that] … financial austerity, [the] focus on

‘workforce planning’ that appears to exclude [TM] and clinical education appears to marginalise TM” which rendered the future “far from clear”, (Powell et al., 2012, p. 49).

At this time, Carvel *et al* (2004) reported that in the more than 600 NHS organisations across the United Kingdom, there were less than 1% Black or Minority Ethnic (BME), as it was called then, Chief Executive Officers (CEO’s) in the NHS. The then Chief Executive of the NHS, Nigel Crisp (2000 – 2006) confirmed then that he ‘would expect the leadership of the NHS to reflect the make-up of the country as a whole’ (Carvel & Shifrin, 2004).

The Darzi Report (2008), introduced ‘clinical leadership’ to take on senior leadership and management posts” (p. 60). The report also recommended the creation of a ‘leadership council’ whose aim it was to identify and develop the ‘top 250 leaders’ across the NHS (Darzi, 2008, pp. 60 - 67).

By 2012 the Health and Social Care Act, 2012, (also known as the Lansley Reforms) with its well-entrenched performance targets, embarked on yet another organisational change which abolished Primary Care Trusts (PCT’s) and replaced these with Clinical Commissioning Groups (CCGs), whilst the former National Commissioning Board, became NHS England (NHSE). Regulation of providers and commissioners were split and public health, that was traditionally situated in the NHS, moved to local government (Nuffield-Trust, 2018) and **Appendix B**. Powel *et al*, (2012), published their paper on talent management, conducting a literature review and several research projects to explore the concept of talent management in the NHS. They described the ‘facilitators’ and ‘barriers’ that enabled and hampered talented individuals to progress (Powell et al., 2012). In reviewing the concept of TM, they suggested that whilst the western world and in particular the private sector have embraced and adopted

the concept of TM, what the NHS 'introduced/adopted' was not a 'novel concept' (p.49). They argued, that although many NHS managers were highly qualified, elements that mostly contributed or enabled management development were:

- self-motivation;
- line- and senior management support, and
- development needs identified from Personal Development Programmes (PDP) resulting from appraisals (p. 115).

Counter hereto were aspects that prevented development opportunities which were identified as:

- time;
- funding;
- workload; and
- a lack of organisational support.

They concluded that for leadership development to be effective, it needed to be inclusive, objective, and transparent (p. 116).

Following the publication of Powell *et al* (2012), a flurry of research papers came to light. These reflected the importance of TM and leadership development (Ham & Alderwich, 2015; Turnbull, 2010). In more recent years, the need for a strong focus on leadership development was confirmed in various publications, government-initiated reports and research papers in academia (Carter, 2016; Démeh & Rosengren, 2015; Floyd, 2016; Rose, 2015).

In 2014 Ian Cummings, a former Chief Executive of Health Education England (HEE) (2012 – 2020), called the NHS to arms to address the current 'talent gap', especially at Executive Director level. From information published by the NHS Leadership Academy (NHSLA, 2014) it was noted that 98% of Trusts recruited for Executive position in the previous three years. This remains a problem that continues to this day, whilst other Director roles are also hard to recruit to. In response hereto, a group of Chief Executive Officers (CEO's) established an Accelerated Directors Development Scheme (ADDS), aimed at defining a competency framework whilst 'growing your own' (Oliver, 2006). This has given talent development, succession planning and the creation of leadership developmental opportunities a much-needed impetus.

Since the creation of the NHS Leadership Academy's in 2012, according to Chris Lake, the then Head of Professional Development, its aim has been to empower NHS leaders to have the 'right knowledge, attitude and skills' (Calnan, 2017), in collaboration with system regulators NHS England (NHSE) and NHS Improvement (NHSI), who came together in 2019 as NHSE/I. They developed Regional Talent Boards (RTB's) across England, to counter the significant leadership challenges experienced in the NHS. With the 2022 incorporation of NHSI into NHSE, the latter replaced the RTB's with the creation of Regional Strategic Talent Forums (RSTF). Their focus is on identifying talent for the future, whilst offering development support, for those who are not ready yet, as the *status quo* is neither sustainable nor affordable (Scheffer, 2016).

It is hoped that the traditional lack of coherent vision, that Kotter (1995) referred to, may be countered to ensure that a clear vision is created for the effective delivery of leadership

learning. Cheung-Judge *et al* (2015), referenced Kotter and Cohen who defined the key question in change as

> "The core … is always about changing the behaviour of people. In highly successful change efforts, the central challenge is not strategy, not systems…but the need for significant shifts in what people do." (Kotter et al, 2002, in Cheung-Judge et al, 2016 p 191).

Significantly, the Kings' Fund published their report on 'the practice of system leadership' describing the change needed as working across organisational boundaries, affecting change, without having line management authority to enforce such change (Timmins, 2015).

The Rose Report explored 'Better leadership for tomorrow' taking a practical approach building on the Francis Report following the Mid-Staffordshire scandals and offering a range of recommendations that varied from the establishment of a single vision for the NHS to reducing bureaucracy and improving the manner in which managers, leaders and board members are being equipped to do what he describes as often being 'undoable jobs'(Rose, 2015). The Carter Report, (2016), considered, duplication, variations, performance management and operational productivity within the NHS, and the inefficiencies that this brings (Carter, 2016).

Following the establishment of Sustainable Transformation Plans (STPs) in 2016, the system embarked on a process of mergers between Clinical Commissioning Groups (CCGs) but without the legal mechanisms that traditionally offered the centre leverage to force implementation, which saw the period 2017 – 2022 entering a phase of organisational restructuring, conducted by the 'collaborative willing' (Flowers, 2019). This was met with mixed views, and those CCGs that have merged or collaborated more closely evolved into Integrated Care Systems (ICS's). The focus on leadership development and empowerment

remained a key focus with the publication of the Kerr Report (2018); creation of Regional Talent Boards (RTB's), whilst the decade was ended with the publication of the new ten year plan (NHSE, 2019b). This long-term plan set out an ambition for new patient pathways that focus on the prevention of illness, with a commitment to leadership and talent management confirming the link between 'quality of leadership and the improvement cultures leaders create' (p. 89). Nationally there is a strong desire to make the NHS the 'best place to work' and to achieve this, the conclusion of Powel *et al* (2004) remains relevant to this day, in that 'for leadership development to be effective, it needs to be inclusive, objective and transparent' (p. 116).

All of this came to a grinding halt in March 2020, with the advent of the Novel Coronavirus or Covid-19 (C-19), that started in China during September 2019. C-19 had forced the entire world to implement drastic measures to prevent the spread of the virus. By 31 May 2022, the NHS recorded 126,147 deaths because of Covid (NHSD, 2022a), whilst social media suggested nationally the deaths were 179,000 and world-wide, more than 6.3mil.

During 2020, the NHS endeared itself to the British public and it became the personification of Churchill's WWII 4th of June speech of inspiration, as it united, across sectors, organisational boundaries, structures and systems, and took the pandemic head-one '… with growing confidence and growing strength…,[the NHS cared for and protected the people of this island], whatever the cost may be…' (Churchill, 1940).

The NHS was the cornerstone that saw the British public through the pandemic and on 31 July 2020 the NHS People Plan 20/21 was published (NHSE, 2020b), that set out four key ambitions.

- Looking after our people (health and wellbeing of the workforce) (p.14);
- Belonging in the NHS (minority ethnic representation, development and ensuring that everyone has a voice) (p. 23);
- New ways of working and delivering care (p. 32);
- Growing for the future (recruitment, retention, and development of staff) (p.40).

The utilisation of leadership development frameworks is helpful however, it is one step on the journey to practical, sustainable, and measurable leadership development that support cultural change effectively and constructively. The reality of where the NHS finds itself today necessitates embracing new ways of working in a collaborative way to ensures sustainability of the NHS, supporting its workforce in the most appropriate way, whilst addressing the needs of the British public. The concerns of the impact of 'financial austerity' during the past ten years are now real concerns for the future as well, as the impact of C-19 has and will cost the UK economy greatly, whilst the true cost to the public purse remains unclear.

1.5 Methodology ~ A Brief Summary

When reflecting on reality, Kurt April wrote in his editor's note:

> How individuals, organizations, communities, and societies navigate the shifting currents of human, organizational, political, social, economic, and technical evolutions, and sometimes revolutions, represents significant opportunities and difficulties at the very same time. Transformative movements, not least the advent of, and apparent spreading of, intertwined economic-democracy, make three promises: to provide us with ever-increasing standards of living that are equally desirable and achievable, to periodize and encapsulate the unfreedoms of the past by adopting transparently different and democratic policies, and by implementing

> institutions and processes that remedy and reconcile the injustices inherited from the past (April 2007, p11).

This 'reality' and the need for 'ever-increasing standards of living' impacts the NHS in terms of its limited resources, is made ever more complicated by the lack of leadership learning from the past; combined by the likelihood of a new decade of austerity that require a new approach to leadership learning to ensure a sustainable NHS.

The research methodology of this thesis could be described as a purposeful, constructivist study drawing on the participation of twelve selected participants, four from each of the three managerial levels as set out above. A mixed method study has been used, considering both qualitative and quantitative data. Qualitative data was obtained using a survey, considering the main research question and the subsequent questions, followed up by selected semi-structured interviews. The data was coded using thematic analysis (Braun & Clarke, 2006), whilst selective semi-structured interviews also provided a richness of qualitative data.

1.6 Significance of the Thesis

This thesis contributes to the wider body of literature on leadership learning. It offers an overview of the rationale and journey that clinical leaders take in becoming leaders within their organisation. It reflects on the training they received (or not as the case may be), and the needs they have, to ensure that they could fulfil their roles to their fullest potential.

This study makes an original contribution in exploring these issues from the perspective of emerging leaders, middle management, and senior management, and specifically addresses the

knowledge gap in identifying the training needs of clinical leaders in urgent and emergency care (UEC).

It offers a framework supporting sustainable and effective leadership learning, whilst identifying areas that could be explored further as a result hereof. In addition, it takes a unique viewpoint from the leaders' perspective, to better understand that individual centric needs of clinical leaders in UEC.

This study also provides a conceptual framework that supports effective leadership learning that will not be unique to the NHS but could be considered by other public sector organisations, like Higher Education Institutions, and the wider civil service.

1.7 Conceptual Framework

Following the literature review a conceptual framework was developed to support mechanisms for effective, sustainable, and collaborative leadership learning. This framework consists of the following key elements: -

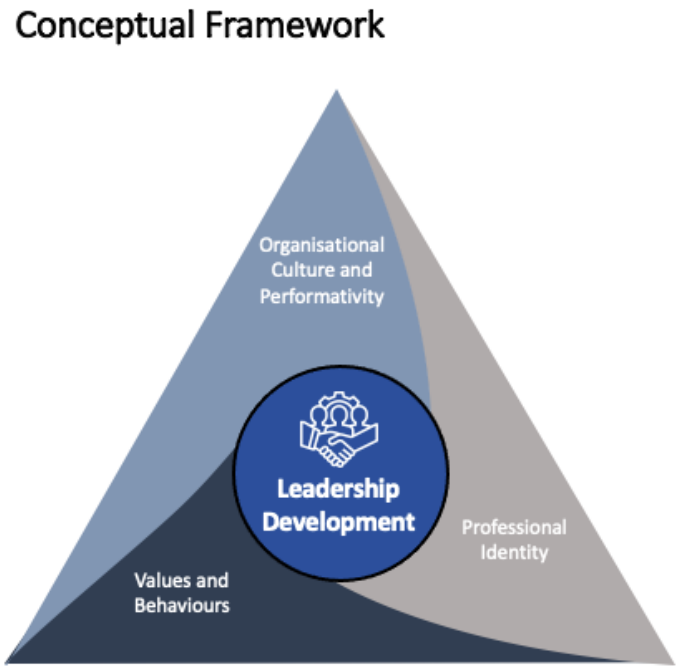


Fig 1.1 Conceptual Framework

- Organisational Culture and Performativity
- Values and Behaviours
- Professional Identity
- Leadership Development

These elements will be explored in much more detail during the literature review, exploring the organisational context, history, and realities of the NHS as a large complex organisational structure. It will also explore the political implications of this public service institution and how the requirements of its contextual realities, political nature and the public expectation of performativity impacts the organisational culture locally, regionally, and nationally. The values of clinical and non-clinical leaders will be explored and how these impact organisational behaviours and organisational climate. In addition, hereto the professional identities of the participations, which will include a mixture of clinical and non-clinical leaders all have an impact on how leadership learning is taking place within an organisation.

1.9 Overview of the Thesis

This thesis will consist of seven chapters.

- **Chapter One** ~ introduces the researcher and provides some context to the rational and need for this study. It sets out the framework for this study at a high level and offers the reader a glimpse of what is intended in the rest of the thesis.
- **Chapter Two** ~ is a detailed literature review in support of the research question and conceptual framework. It explores the literature from a research topic perspective and investigates who else has similar challenges or concerns in terms of the main topic of this thesis, which identified emerging questions to consider.
- **Chapter Three** ~ sets out the epistemological and ontological positions and rational for the research methodology utilised in the data collection, interpretation, and discussion.
- **Chapter Four, Five and Six** ~ consider, discuss, and present the data thematically. This allows for an interpretation of the evidence deducted from the data. All three of these chapters also offers new frameworks pertaining to culture, professional identity and leadership development respectively.
- **Chapter Seven** ~ draws the themes to its conclusion linking back to the conceptual framework, the thesis title, and supplementary questions. It offers new definitions of organisational culture, professional identity, and clinical leadership development, reflecting on the journey and challenges. It offers recommendations on leadership development, implications, implementation in practice, including the limitations of this study. The final chapter concludes with possible areas to explore in time to come.

CHAPTER 2 ~ LITERATURE REVIEW

2.1 Introduction

The purpose of this Chapter is to explore the literature that supports the research questions. To gain clarity on the perspective and contextual views of its meaning, its impact and what questions or challenges emerges from these, for further exploration.

Although Boote & Beile (2005) expressed their concerns about how little attention researchers pay to high quality literature reviews, they accurately argue that a comprehensive literature review, as "a necessary chore", is essential for high quality research and forms the foundation of any dissertation (Boote & Beile, 2005, p. 5) or research project. This enabled the researcher to build on the initial conceptual framework described in Chapter 1 (see ***Fig. 1.1***) however, as the content is explored, it provides more clarity and focus, which enabled an evolution of the conceptual framework.

In approaching this research, 334 articles, books, journals, and reports were reviewed, which were initially captured on an excel spreadsheet and loaded onto EndNote X9. These were grouped as follows:

- Date of data accessed;
- Article or book title;
- Name of the author(s) and the year published;
- The main aim or purpose of the article, publication, or book;

- Context ~ i.e., a study from America, Australia, New Zealand, the United Kingdom, or South Africa, etc.;
- Method used ~ qualitative, quantitative or both;
- Key findings;
- Links to the research question(s); and
- Key themes that were emerging.

This process helped with the identification of emerging themes and made the grouping of articles much easier, which directly contributed to the development and alteration of the conceptual framework referred to in Chapters 1, 2 and 7 of this study.

The conceptual framework briefly reviews some of the historic achievements of leadership development in the NHS and considers its political implications as public management and public leadership emerges. It offers a variety of views on organisational culture, commitment, and climate whilst reflecting on the concept of performativity and how this influence leadership development. Both individual and organisational values and behaviours are explored in more detail, how leadership behaviours are influence by power and politics and its collective impact on productivity. The experiences and perceptions of 'capital' in the workplace and at philosophical level are considered. Professionalism, personal identity, and ethics gives some great insight into how people see themselves, or how their 'professionalism' is seen by others, and how these impacts on their leadership of others. Lastly these are all brought together to understand what leadership development is and explore the topic as a concept. It attempts to define the typology of leadership for the future, particularly in the NHS, and explores a variety of development techniques and methodologies to facilitate lifelong learning. The chapter ends

with a refreshed, sharpened look at the conceptual framework, and setting out next steps for the Chapter 3.

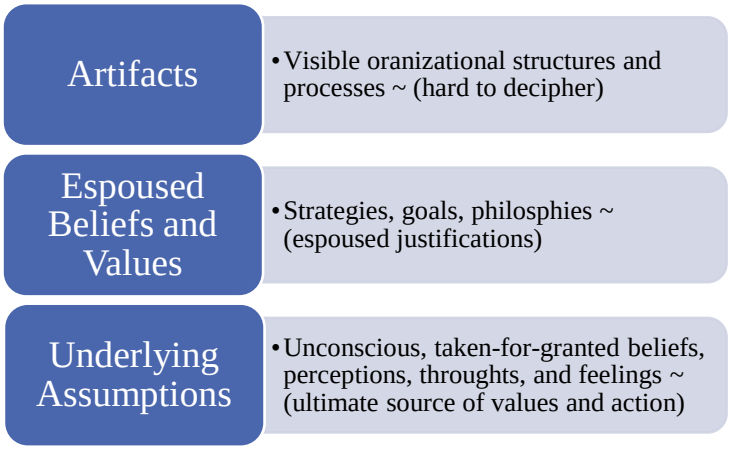
2.2 Culture

Dixon-Woods, *et al* (2013) confirmed in their large mixed-method research titled 'Culture and behaviours in the English National Health Service' that lessons could be learned from others. Whilst that study was conducted just short of a decade ago, it confirms a continued truth today, that in health care across the world, there is a 'universal desire to provide the best quality of care in global health organisations' (Dixon-Woods et al., 2013). However, several shortcomings were identified that adversely impacts organisational culture. These, Dixon-Woods *et al*, (2013) described as 'considerable variability in how organisations succeed in making their aspirations clear' to behaviours by leadership who either are 'problem sensing' or 'comfort seeking'. The former is defined as 'involving activity seeking out weakness in organisational systems and utilising 'holistic efforts' to improve organisational performance. The latter being defined as 'being focused on external impression management and seeking reassurance that all was well'; consequently, what was available was data but not the contextual intelligence to make it meaningful resulting in 'serious blind spots' (p. 111). From a culture perspective, Dixon-Woods *et al* (2013) identified several contra-indicators for positive organisational culture, some of which were a lack of 'support' for staff; employee 'appreciation'; 'respect'; and a lack of engagement, whilst leaders in comfort seeking organisations often saw front-line staff as the cause for quality problems (p. 112). Some of these challenges reported then, are still prevalent today, and is something that this study will

aim to address. To do that, it is worth exploring the definition of 'culture' according to Schein (2004), who confirmed the following.

> "A pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptations and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct ways to perceive, think, and feel in relation to those problems." (Schein, 2004, p. 17).

Schein describes the various levels of culture as :



Schein (2004, p. 26)

He argues that the principle of organisational culture is the formations of what is shared, those essential 'taken for granted' assumptions that enables the culture to manifest in visible artifacts or organisational structures and those shared espoused or adopted values and beliefs (p. 36). He points out that the culture of a group is created by the leadership of that group and warns that 'every leader should be highly conscious of his or her own assumptions in each of these content areas' (p. 86). In terms of transformation within groups, especially in complex organisational structure where different organisations or groups are required to work more collaboratively in one system, leaders figuratively act as 'parent figures' and the team members of the group becomes the children of that 'family' (p. 377).

Schein argues that these cultural differences in strategic partnership (like in an ICS or ICP) are even more complex and requires very careful scrutiny (p. 412 – 413). In terms of cultural development, he suggests that leadership is directly linked to the creation, destruction, evolution, formation, and transformation of workplace cultures, as it is formed by the actions or inactions, of the leadership (p. 414). For Schein tomorrow's leadership need to be life-long learners, who will grant them:

- renewed perspectives of the world in which they lead;
- high levels of motivation in an ever-challenging world of ambiguity and continues change;
- mastery to effectively manage their own anxiety and that of the people they lead;
- innovative skills and abilities to evaluate traditional cultural challenges; and
- the ability to engage collaboratively with others.

Organisational culture is influenced by several internal and external factors. It is shaped by the behaviour and assumptions of leaders, the climate of the organisation at both micro and macro level is influenced directly by the aspirational intentions of the organisation that should also be considered.

Culture and Commitment

The NHS People Plan 20/21 (2020) contains a pledge, a commitment to its staff, that is said will impact the culture of the NHS in time to come. These commitments are:

(NHS, 2020, p. 14)

Roberts (2005) asserts that in Australia's coalmine industry, understanding organisational and personal consciousness enables leaders to effectively change organisational culture; their own and employee behaviours; and an effective utilisation of human energy that results in sustained high-quality productivity and safety. Roberts defines workplace culture and behaviour, respectively as:

- **workplace culture** ~ the combination of behaviours and attitudes, as the feelings people have towards what they do, and how this makes them feel;
- **behaviour** ~ is the observable manifestation of human physical, emotional and mental energy (p. 113).

He argues that unless systems are effectively changed, the best training interventions and communications strategies alone will not change or improve human behaviour. He suggests that leadership is 'about choices' and advocates the 'consciousness of leadership' in that leaders inspire the people they lead to 'choose to use their time and energy' constructively in pursuant of and achieving 'a shared goal'. This proactive and deliberate 'choice', he argues also constructively contribute to improved levels of 'accountability' (p. 113). He argues that changes in employee behaviour and organisational productivity fails, because of:

- conventional approaches to ill considered '**capital investment**';
- '**new technology**' that is not fully understood; and
- the blunt approach to organisational change through '**head count reduction**', without fully understanding the processes that should be employed to improve productivity.

He offers an example from the 1990's, when Australia's largest underground mine reduced headcount by 30% resulting in cost savings of 100 mil dollars. However, a year later the executive reported that for each dollar saved in cost cutting, it cost the mine two dollars in lost productivity due to an inability to invest in any developments, or to maintain its equipment and estate. In defining a system, Roberts simplistically suggests it is, 'anything that drives ways of doing things', and offers seven actions that contributes to counterproductive behaviour as:

- conventional measurements, and analysis and reporting of performance;
- conventional performance appraisal systems;
- poorly designed 360-degree feedback systems;
- lack of process and behavioural standards;

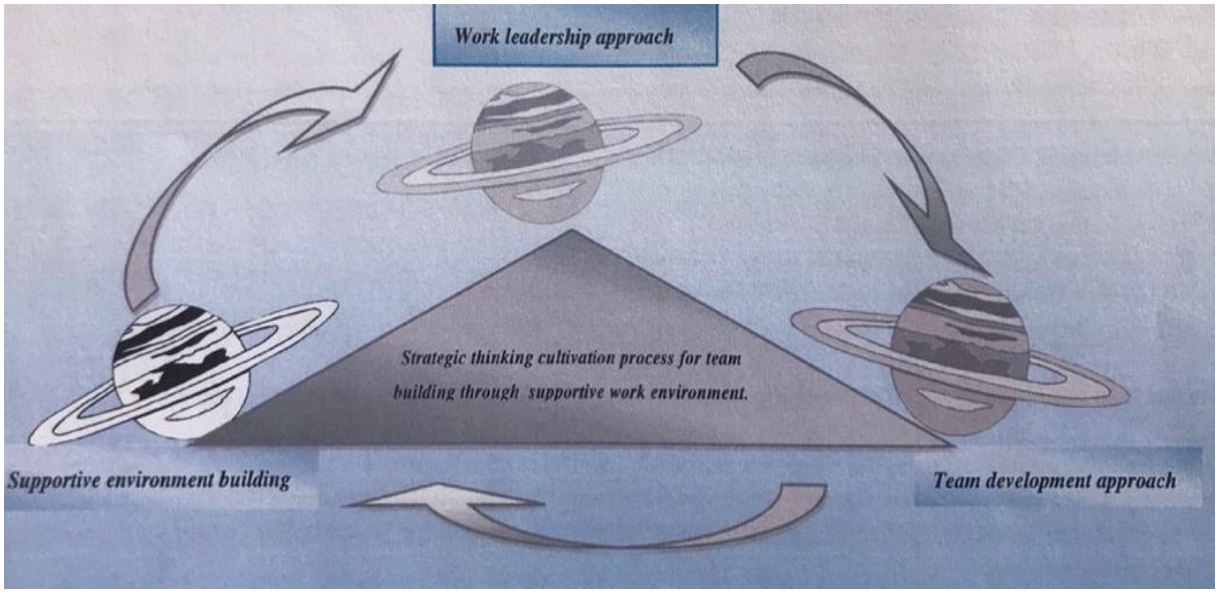
- ineffective communication and planning systems;
- organisations' structure cutting across processes preventing adequate control and undermining accountability;
- overly prescriptive with vague roles and responsibilities.

Roberts (2005) suggests that to transform organisational culture, it is necessary to change the systems driving behaviour. He concludes that to achieve successful organisational and cultural change, leaders must be aware of their own consciousness or 'Vipassana'. Seeing things as they truly are. That is, people have deep-rooted personal characteristics and that they would only change if they understand their personal place and purpose in the organisation (Frankl, 2004; Roberts, 2005). West *et al* (2015) argued that the most important element in determining organisational culture is 'leadership behaviour', whilst investment in leadership infrastructure is important, actual leadership learning is essential (West et al., 2015).

Culture and Climate

Kazmi and Naaronoja (2015) conducted a study for the Ministry of Health in Finland, in which they argue that a supportive working environment could stimulate and cultivate strategic thinking in organisational leaders, through a supportive and inclusive workforce. The research sample of the research conducted by Kazmi and Naaronoja (2015) was undergoing organisational transformation, very similar to that of the NHS at present, and the aim of their study was to explore how best to stimulate and capture strategic thinking for an organisation during a period of transformation that will lead to 'innovation and sustainability' (p. 47).

Their research offered an ‘imaginary planetary circulatory strategic thinking cultivation process’, that is presented schematically as follows:



Kazmi and Naaranoja’s imaginary resemblance of the proposed strategic thinking cultivation process with the planetary circulatory motion of nature (Kazmi & Naaranoja, 2015, p. 51).

They used this model to evaluate and judge strategic thinking among team members and suggested the following:

- Firstly, to stimulate strategic thinking in teams, leaders should implement a framework which includes all three elements of their process, being:
    - leadership development;
    - team development; and
    - the creation of a supportive work environment.
- Secondly, they argued that each category of study, have their own orbits wherein they function on their internal and independent cycle of activities or sub-categories. This, they suggest, creates a natural resemblance of their model. As, like in nature the planets

orbit around the sun, the three categories of their study create an inter-related force of balance, as they orbit around their own axis and the 'moon's that impact their orbits, supporting the organisational system of motion, as well as the respective independent systems, impacting on leadership behaviours, team development and organisational culture.

- Thirdly and lastly, they suggest that their tool creates a 'capable and valid tool' to judge strategic thinking at a deeper level as it considers the impact on the organisation from three different viewpoints and enables them to divide these viewpoints into seven different sub-categories, being the leaders' ability:-
    - to conceive a holistic view;
    - for a logical and rational approach;
    - to switch attention across multiple perspectives;
    - previous work knowledge;
    - external environmental forces;
    - workforce diversity effect; and
    - internal environmental pressures (Kazmi & Naaranoja, 2015, pp. 51 - 52).

Castro and Martins (2010) explored the link between organisational climate and job satisfaction. There sample of 696 employees from a population of 1453 across three regions in South Africa, investigated the relationship between organisational climate and job satisfaction. They concluded that different biographical groups have different needs which impacts their job satisfaction, whilst different perceptions of organisational climate impact the behaviour of staff. They confirmed that there is a positive relationship between organisation climate scores and job satisfaction scores (Castro & Martins, 2010). This was confirmed in a similar study by Eustace and Martins (2014), who conducted a study in the South African fast-

moving consumable goods (FMCG) industry to examine the relationship between leadership in shaping organisational climate. In their study, with 896 participants, they made a distinction between culture and climate. They argue that:

- **culture**: ~ forms the foundations on which an organisation's management systems are developed, how people '*behave*', which shapes its 'values, beliefs, and principles';
- **climate**: ~ they argue, is the manifestation of how it '*feels*' to be part of an organisation, which are influenced by the 'perceptions of organisational structures' and its impact the organisational atmosphere.

They suggest that previous research on 'charismatic leadership' focused predominantly on particular behaviours, high levels of personal confidence, dominance, and strong convictions. But in referencing Northouse (2011), they acknowledged that in the study of transformational leadership the focus moves to 'values, ethics, standards and long-term goals' and sited Nelson Mandela as an example of a transformational leader 'who fought for an ideal in which he believed' (Eustace & Martins, 2014, pp. 1-13).

Considering the move towards transformational leadership, Hersketh (2011) warns that contradictory to modern philosophies, i.e., that transformational leadership is the future, leaders' behaviours are likely to lean towards transactional rather than transformational as financial pressures mounts. That said, he referenced Dobby, Anscombe and Tuffin (2004), who suggested that this would be an unsuccessful stratagem for both the medium and long-term (Hesketh, 2011).

Performativity

Norgren (2008), asserts that in health-care, 'the performativity of the service management discourse' could be linked to the 'changing linguistic usage' in both health-care and the public sector, often referred to as 'new public management' (NPM) (Brookes & Grint, 2010) when considering the patient as a customer. It is this phenomena that Sommerfeldt *et al* (2014) described as a complex methodology that set the scene for interprofessional performance (Sommerfeldt, Caine, & Molzahn, 2014).

The ontological impact, i.e., the nature of or reality of the regulatory impact of the health-sector specifically, and the greater public sector generally, have seen a change in behaviours at organisational level since the early 1990's. The creation of the 4-hour target at an Emergency Department (ED); the ambulance (C1 – C5) response rate; the 18 week 'refer to treatment' (RTT); or either Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C-Diff) rates, are only a few of the plethora of performance targets that consecutive governments have introduced in response to their respective political response to the NHS.

Ball (2003) submits that this 'new mode of state regulation' enables the authorities to govern in a 'advanced liberal' way. Requiring various levels of multi-disciplinary teams having to re-organise themselves in response to targets, indicators, and evaluations. Intended to empower management rather than 'micro-manage' (p. 216) them, but at the risk that the clinical professional is 'de-professionalised and re-professionalised' (p. 217).

The key risks of performativity, according to Ball is that the 'ethical-retooling'; the 'corrosion of character'; the 'cynical compliance'; and the ultimate 'regress of mistrust', be it in health-

care, higher educational institutions (HEI), or the wider public sector, all results in the professional judgement being placed in a secondary position to the actual need of meeting the required performance targets (Ball, 2003).

The NHS, the benefits and challenges of performance targets, and its impact on leadership learning, values and behaviours, culture, and professional identity, is not unique to the NHS or the UK. These are challenges that have been explored from New Zealand (C. Lane, 2009) to Southern Africa (Mbigi, 2007), the Middle East (Al-Zaghlawan, Alsaraireh, Al-Hunaiti, & Khanji, 2017), to Jamaica (Floyd & Fuller, 2016), the United States of America (Berrio, 2003), and locally across the United Kingdom (Berrio, 2003).

Values & Behaviours

Values and behaviours of people in organisations are often impacted by the level of authority or power that leaders have over others. Their ability to influence those who are dependent on their leadership, to adjust their own values and behaviours to meet the needs of those who they lead, but also to inspire those over whom they hold power over, to adjust their own values and behaviours to alight themselves to the purpose and focus of the organisational values and behaviours.

Power, politics, and productivity

Somoye (2016), argues that power is an important phenomenon in any organisation and defines power as 'the ability to control people or things' (Somoye, 2016, p. 566). Reflecting on the concept of influence, Somoye (2016) suggests that this is the result of exercising power. He referenced Pfeffer (1992, p.30) who drew a distinction between power and politics and define the latter as 'the processes' or 'actions' that uses power to direct people's behaviour into a requisite outcome or result (Pfeffer, 1992). He concludes that the utilisation of power in a professional way, is vital to ensure that organisational goals are met. However according to a study by two American social phycologists, French and Raven (1959), there are five types of power that leaders employ in delivering organisational goals. These are defined as:

- **Coercive power**: ~ often seen in domestic abuse, a negative style of power where someone in authority or power, moves another to do something by way of threat, intimidation or at risk of punishment.
- **Expert power**: ~ could also be described as specialist power, derived from experience, qualifications, or superior skills in a specific field. Followers gain a sense of security from expert leaders, as there is a perception that they have all the answers based on their years of experience, academic knowledge, or superior skills.
- **Legitimate power**: ~ most easily defined in the military, but also in specialist positions, where someone is assigned a rank or position of authority, which gives them a level of credibility and the associated power enables them to give instructions to others, based on their position in the organisation. A CEO in the NHS, as an example, has legitimate power based on their office, but does not hold the expert power that Consultant Specialists may have.

- **Referent power**: ~ is derived by gaining the respect of others, normally because of a long and distinguished career, with many successful achievements. Leaders with referent power gains such influence because of their knowledge, their ability to guide, empower and develop others.
- **Reward power**: ~ a more transactional type of power, that is derived by the ability to reward, promote or the granting of bonusses to deserving or qualifying staff. The main aim is to encourage followers to deliver a pre-defined level of productivity (French and Raven, (1959) in Somoye, 2016, pp. 567 - 568).

Keller and Price (2011) suggested that no public sector organisation will be able to retain its mandate unless it delivers to the expectations of the people for whom they offer a service. To do this, they propose that there is a clear understanding of what performativity means and defines 'performance' as the product an organisation delivers to its stakeholders; and this can't be done unless an organisation invests in its own health, with a clear vision as to what it sets out to achieve. 'Health' in this context is defined as the ability of an organisation to 'align, execute, and renew itself faster than its competition', to ensure sustainable delivery over a period of time (p. 5). They argued that performance focused leaders invest greatly in the effort of delivering organisational targets, year on year, but neglect to focus on the position of their organisational health, which lead to the formation of sub-cultures in organisations. Keller and Price confirmed that even with the best intentions, organisations are not immune to organisational sub-cultures (Keller & Price, 2011, pp. 6-16) which result in poor performance and poor organisational health.

Burch & Vogel (2011) talked about moving organisational behaviours from 'resigned inertia to productive energy' which is the ideal position for any organisation to be in. To achieve this mobility, one needs to embrace shared engagement or reinforce organisational values. Corrosive energy, on the other hand, is described as the most challenging and focus on both individual and collective acceptance of responsibility, whilst a culture of productive energy will eliminate any form of organisational anger or blame culture (Bruch & Vogel, 2011).

Experience and perceptions of 'capital'

It is this sensitivity to power and politics that impacts the experience and perceptions of culture that requires further explorations. To understand this in more depth, consideration was given to the French sociologist and philosopher, Bourdieu (1930 – 2002), who was recognised for his insights into the human dynamics of one's experience, perceptions and behaviours, and its consequential results of personal 'capital' or worth of one's contributions, values, and behaviours within a social world. Bourdieu (1986) explained his 'forms of capital' and how this is etched into society in both its objective and subjective forms. 'Capital' or the assets inferred upon individuals in a society (or it could be argued the lack thereof) is, according to Bourdieu, developed through the investment in time. In other words, it takes time and dedication to develop personal 'capital' in life. Bourdieu claimed that it's not possible to understand the social world, 'unless one reintroduces capital in all its forms' (Bourdieu, 1986, p. 46). These forms are influenced by various fields or spaces, and Bourdieu defined these fields as part of the concept of Field Theory (FT), that forms the structures of the social setting in which 'habitus' operates (Swartz, 1997).

Bourdieu's 'Habitus' could be defined as follows:

> Our 'habitus' is a structure of life-long interchangeable personal characteristics or dispositions, influenced by past experiences, personal standing, perceptions, achievements, or failures, which becomes the reality that gives meaning to our actions and desires to achieve an array of tasks, thanks to the ability to learn from other compatible experiences within a similar social context (Adapted from Bourdieu, 1997c, p. 83, in Swartz, 1997, p. 100).

Simplistically put, Bourdieu's 'habitus' could be defined as 'the experiences in our lives, determines our perceptions, and these perceptions becomes our realities' (Scheffer, 2018), irrespective of whether they were intended as such or not.

Bourdieu (1986) argues, according to Swartz (1997), that the fields or spaces, within the various forms of capital, represents the 'arenas of production' or social context in which different 'actors' acquire, exchange, or assume 'goods, services, knowledge, or status' and the competitive advance that they derive from this, in acquiring and dominating the various spheres of capital (p. 117). Bourdieu (1986), claims that 'capital' present itself in three different forms, being:

- **Economic capital**: ~ described as the monetary relationship that helps the holder of the 'capital' to increase material or symbolic benefits;
- **Cultural capital**: ~ is made up of the relationships within the holders' networks, be it family, academic status, or wealth;
    - In its objectified state ~ it manifests itself in 'material objects and media, such as writing, paintings, monuments, instruments, etc.' (p. 50);
    - In its institutionalised state ~ it manifests itself in terms of the holders' academic qualification, and holders gain cultural capital from comparing academic qualifications (p. 50);

    - Its conversion ability ~ is the capacity to quantify a monetary value from the academic (or institutionalised) capital, been cultural capital and economic capital (p. 51).
- **Social capital**: ~ is the possession of long-lasting relationship through mutual acquittances or resources, who offers actual or potential benefit. It 'is the product of never-ending investment, at 'individual or collective' level, both 'consciously or unconsciously' intended to re-enforce social networks that are of benefit, be it in the short or longer terms (p. 52).

Some of the other applications that Swartz (1997) referred to in terms of Bourdieu's 'fields', includes studies of social-class; lifestyles; attendance of higher education institutions; religion; literature and housing policy (Swartz, 1997, p. 188).

Karl Marx (1818 – 1883), on the other hand, formulates the creation of 'capital' as a method that converts effort [or labour] into capital [or money] through labour, the 'circulation of commodities' (Marx, 2010, p. 65). According to Marx, money and commodities are achieved or created from the labour that results in capital. This phenomenal form is 'a mode of expression ... of something contained in it, yet distinguishable from it' (p. 1). Marx's views are of importance as it caused a dichotomy for Bourdieu, according to Swartz (1997), as the Marxist/non-Marxist argument presented itself in the various opinions for and against economical goods, material or ideological interests and the respective measurements of class (p. 53). Thus, cultural capital, according to Bourdieu consists of three elements as submitted by Swartz (p. 76) and explained by Bourdieu (1986, pp. 244 – 248):

- **Embodied capital** ~ begins in one's childhood, through the pedagogical action or educational interventions instituted by one's parents, family members, and teachers, through extramural activities and the help of employed third-parties to develop those expressed cultural distinctions that would shape who our parents wish us to become. Bourdieu described this as the 'external wealth converted into an integral part of the person' (pp. 244 – 245).
- **Objectified capital** ~ is the appreciation of things and objects or the special skills to invent and utilise scientific instruments. These come in the form of scientific inventions, appreciation of books, philosophy, art, and paintings. It is activities that are described in its relationship with cultural capital in its 'embodied form' (Bourdieu, 1986, p. 246), thus the ability to understand, appreciates, apply and consume them.
- **Institutionalised capital** ~ is the elements of cultural capital that refers to the educational credentials that higher education offers an individual, in elevating his/her status and which enables one to advance in society. The better the qualification, the higher the status in society, and the more likely an individual can convert culture into capital and in so doing achieve success (p. 248).

These perceptions on cultural capital are explored in this study, taking cognisance of Yosso (2005) who reflected in her paper on Critical Race Theory (CRT), on Bourdieu's insights into 'a hierarchical society' and how society replicates those results into the values, behaviours, and achievements of white people specifically. She challenged Bourdieu's views on 'white culture' and the concept of cultural capital, as defined. Yosso (2005) critically challenged the concept of culture in asking, '*who's culture has capital?*'. In her challenge of 'Bourdieuean cultural capital vs. community cultural wealth' (p. 70), she also reflected on the racial insights of the American sociologist DuBois (1989), and suggests that CRT offers a framework to explore,

challenge and hypothesise on the way that race and racism impacts the social structures of modern society. These frameworks are being considered during the semi-structured interviews of this study, as the NHS has a multitude of different ethnic groups, different cultures and all of this impact organisational culture in its own way.

Leadership Behaviour

Loke (2001), conducted a study in Singapore to better understand leadership behaviours in terms of employee's job satisfaction. She drew from 100 registered nurses and 20 managers in the health care sector and argues that very little research has been done in Singapore in this regard. She asserts that her study offers better insights into leadership behaviours and employee outputs (p. 191). In referencing Kouzes and Posner (1988) who extrapolated employee outputs from five leadership behaviours, Loke concludes that whilst the leadership behaviours did not impact employee job satisfaction, productivity, or commitment, independently, but collectively they do influence employee outcomes (p. 197). She submits that whilst leadership behaviour are likely to be key during economic difficult times; nursing managers and other middle management should focus on the leadership behaviours that is within their control; and that nursing and other top administrators should use the five interconnected leadership behaviours confidently to establish the standard for organisational leadership (p. 200). She explains these five behaviours and their impact as follows:

- **challenge the process** ~ nurse managers should be willing to challenge beyond cost management and productivity enhancement, they should be adaptable and allowed to be flexible, and must demonstrate their willingness to change and embrace the

opportunities of progressive nursing practice, or new ways of working (A. C. Edmondson, 2003);

- **inspiring a shared vision** ~ it is important to take people on the journey, to share the vision, and engage with people's 'values, interests, hopes and dreams.' This was described as the 'highest priority' of the five behaviours, but also 'the weakest behaviour among nurse managers';
- **enabling others to act** ~ Loke describes six essential elements that enable others to perform, as developing employees so that they are enabled to (1) collaborate; (2) build mutual trust; (3) empower followers; (4) offer choice; (5) developing competence and (6) demonstrate accountability;
- **modelling the way** ~ organisational culture and climate (also see Eustace and Martins, 2014; Oliver, 2006), is described as shared values, organisational experience, perceptions, and beliefs;
- **encouraging the heart** ~ giving credit where credit is due, sincerely, in proportionate measure, consistently, fairly, and transparently. Giving recognition, be it verbally, monetary, publicly, or privately goes a long way, to promote job satisfaction. Both Oliver *et al* (2006) and Loke (2001) warns that that this behaviour should not be overused as it will lose its significance, but if done regularly, and sincerely, is a very valuable leadership behaviour that should not be underestimated.

Loke concluded that her study demonstrated that leadership behaviour has a great impact on employee outcomes, that it enhanced employee performance, supported employee commitment, which all resulted in increased productivity and enhanced organisational performance. (Loke, 2001).

Dweck (2017) talks about the power of believing in one's own abilities to change, to improve and to achieve success and offers four practical steps in moving towards a growth mindset to change one's behaviours as: -

- Embrace your fixed mindset;
- Be aware of your fixed mindset triggers;
- Define your fixed mindset (give it a name); and
- As you are aware of your fixed mindset triggers, take it on an educational journey, (Dweck, 2017, pp. 254-261).

She concludes by an acknowledgement that a growth mindset will not solve all ones problems, be it at individual or organisational level, but it will enable leaders, managers and individuals to live more fulfilled, happier lives, with greater success, 'more alive, courageous, and open' (p. 264), because of it (Dweck, 2017).

Schank & Weis (2000), claims that there has been little research done to better understand the values of nurses across cultures or globally. With the growth of the global community and the interconnectivity between health sectors, countries and global practice is ever increasing, there is a more collaborative approach towards health care education, delivery, and research. Schank & Weis reflects on the meaning of values, the reality that they are 'personal in nature [and] contributing to a person's self-identity' (p. 41). They reference various authors who defined values as something that evolves over time and offer structure to our actions (Kluckhohn, 1951); or the way one ought to behave (Rokeach, 1976). They considered the work of Sawyer (1989) who conducted a comparative study of nurses' codes across 38 countries (from Europe, Asia, North America, Latin America, Africa, and Australia) and noted

that all of these codes concentrated on matters pertaining to 'patient, profession and society' (p.42). Comparing British and American codes, very limited differences were noted, which were predominantly culturally based. Concluding that there is a resemblance between professional values, considering human dignity, protecting patient privacy, safeguarding, both for the patient and the public, accountability, maintaining competence, informed judgement and individual competence (Schank, 2000).

The NHS Constitutional Values, which forms the basis for value formulation and leadership behaviours in all NHS organisations, were developed by patients, the public and NHS staff, and are recognised as follows:

- Working together for patients: ~ **patients come first**;
- Respect and dignity: ~ **value every person**;
- Commitment to quality of care: ~ **quality of care**, right for everyone, all the time;
- Compassion: ~ **humanity and kindness**;
- Improving lives: ~ through **excellence and professionalism**;
- Everyone counts: ~ full utilisation of resources to ensure that **no one is excluded**, discriminated against or left behind (DoH, 2015).

The words of a South African cleric, on Sunday 5th of July 2020 was very apt, considering that it was the 72nd anniversary of the NHS. Although his service was not for the NHS, his reading from Galatian 5: 22 & 23 reflected on values and behaviours (Oosthuizen, 2020) that could readily be adopted as key characteristics for modern day leaders. Whilst it is certain the cleric did not intend to speak to leaders only, however, in speaking about accountability and

responsibility he did articulate the following values and behaviours, as 'the fruits of the spirit' (Bible, 1978, p. 229).

- **Compassionate**: ~ demonstrably shows the ability as a leader to care for and help others;
- **Positive**: ~ confidence derived from their ability to be optimistic, identifying an opportunity in every problem, being constructive;
- **Kindness**: ~ the ability to be truly friendly, considerate, and generous;
- **Restraint**: ~ the ability to control their emotions, maintaining a certain 'Decorum' (from Latin behaving 'proper') even in difficult times;
- **Patience**: ~ the capacity to handle problems, challenges, and disappointment without demonstrating their annoyance or transferring their anxiety onto others;
- **Humbled**: ~ the ability to lead from behind allowing their team to achieve their full potential without the need for personal credit or recognition.

These could easily be defined as essential values and behaviours (characteristic) of leaders in the NHS as was confirmed in the work of Winston (2002) when he used the Beatitudes of Matthew 5, to define what is called the NHS 'compassionate leadership', when he submitted that:

> Throughout each leader-follower-audience interaction demonstrated his/her commitment to the values of (a) humility, (b) concern for others, (c) controlled discipline, (d) seeking what is right and good for the organization, (e) showing mercy in beliefs and actions with all people, (f) focusing on the purpose of the organization and on the well-being of the followers, and (g) creating and sustaining peace in the organization – not a lack of conflict but a place where peace grows. (Winston, 2006, p. 30).

The above was confirmed by several other authors (Dekker, 2017; Hougaard, Carter, Afton, & Mohan, 2022; Lee, 2022) in that values and behaviours linked and lived well, all forms the basis of effective leadership behaviours across industries and sectors.

Summary and Implications

The focus on system working, organisational change and leadership development is not something that is new to the NHS, neither is the discourse on compassion, civility, kindness, and humility. In fact authors, clinicians and academics wrote about this for the past decade (Brookes & Grint, 2010; Carter, 2016; Grint, 2008; Ham & Alderwich, 2015; Kerr, 2018; Oliver, 2006; Timmins, 2015; West, 2021), regardless, it appears that little progress has been made from identifying the need for leadership education and learning. To truly understand what cultural changes needs to happen to transition from theorising about leadership learning, to deliver a sustainable practical model of leadership learning.

It is also possible, that a perception exists that culture is considered as something that is created by others, senior management for example. Ultimately, culture is informed, shaped and created by all 'the actors' in 'the field', by the Chief Executive, but also by all the internal and external role players, all the people, in each organisation.

This study therefore aims to explore ways of conducting leadership development that brings the leadership framework alive, supporting a positive organisational culture that enables sustainable and tangible improvements in leadership development. Whilst it offers proposed key performance indicators to measure culture in an organisation.

Emerging Question (pertaining to Culture)

Limited progress was evident in more recent years, from the literature review, regarding the impact of organisational culture on staff experiences and leadership development. The following emerging question on culture was formulated for exploration in the data collection phase of this study.

- How does organisational culture impact on staff experiences of leadership development and what are the implications of this for leadership development theory and practice?

2.3 Professionalism, Professional Identity & Ethics

According to Dartey-Baah & Harlley (2010) there is an inter-relatedness between transactional and transformational leaders and organisational performance. In their literature review they considered the meaning of both job satisfaction and motivation. Whilst they reflected on a variety of definitions for job satisfaction, they referenced Mullins (2005) who suggested that job satisfaction is a complicated and multidimensional concept and defined job satisfaction as being 'more of an attitude, an internal state. It could, for example, be associated with a personal feeling of achievement, either quantitative or qualitative' (Mullins, 2005). Dartsey-Baah & Harlley confirmed that although various writers took different views in terms of the function of human resources management (HRM) as a branch of management, it does contribute to the effectiveness of the organisation, through the utilisation of policies that influence employee behaviour, promote job satisfaction and motivation which impacts the organisation. They reflected on the contemporary views of both job satisfaction and motivation, as articulated by

McGregor in terms of his Theory X (pessimistic leaders) and Theory Y (optimistic leaders); Maslow's Needs Hierarch Theory and Herzberg's Hygiene Theory. They also explored Adam's Equity Theory and Vroom's Expectancy Theory and concluded that 'employees who are satisfied with their work' are not automatically 'highly motivated employees and vice versa'. However, they recommended that management should endeavour to link both workers needs and aspirations to organisational goals and work diligently to find a good balance between the two. (Dartey-Baah & Harlley, 2007).

Professionalism

In understanding the concept of 'Professionalism' Archer *et al*, (2008) considered the definition of Arnold and Stern (2006) of what professionalism is in a medical setting and argued that the concept is based on:

- clinical competence;
- communication;
- skills; and
- an understanding of both legal and ethical issues, (Arnold & Stern, 2006, in the work of Archer *et al* 2008) (Archer, Elder, Hustedde, Milam, & Joyce, 2008, p. 773).

According to the American Board of Internal Medicine (American Board of Internal Medicine, 2011) 'Professionalism in medicine requires the physician to serve the interests of the patients above his or her self-interest' (p 5). They went further in defining the 'core of professionalism' as constituting those attitudes and behaviours that serves to maintain an altruism approach to

patient care with the following specific core elements that forms the basis of professionalism to include:

- altruism;
- accountability;
- excellence;
- duty;
- honour & integrity; and
- respect for others (p 5-6).

Lastly, the Royal College of Physicians (RCP) established a working group, in 2005 to explore 'the nature and role of medical professionalism in modern society' (RCP, 2005). The RCP defined professionalism as:-

> "a compilation of attitudes, values, behaviours, and relationships that supports the public's trust in doctors" (RCP, p 45).

As was the case within the definitions of the ABIM (2001); Arnold & Stern (2006); the RCP (2005) elaborated on the meaning of their definition of professionalism as to what is expected from a professional perspective in medicine, when they confirm that:

> "Medicine is a vocation in which a doctor's knowledge, clinical skills and judgment are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability" (RCP, 2005, p 45).

Interestingly, neither the NHS guidelines for 'Maintaining High Professional Standards' (MHPS, 2005), which governs the professional standards and practices expected of clinicians

in the NHS, nor NHS Employers' toolkit on 'Professionalism and Cultural Transformation' (PACT, NHSE, 2019) contains a definition of what is meant by 'professionalism', which underpins the RCP's concerns about the 'lack of research on 'professionalism' in the professions [they] regulate' (RCP, 2005, p 1). As the LTP's ambition remains for the entire NHS to change its approach in delivering pro-active and preventative healthcare, through improved collaboration, reduced duplication, increased efficiency, a better utilisation of workforce and all of its resources, contributing to the NHS being an employer of choice (NHSE, 2019b).

Swick, *et al* (1999) argued at the end of the last decade that undergraduate medical education should focus on teaching professionalism to medical students. In their review of 125 medical schools in the United States of America (USA), 89.7% (104) of medical schools reported that they 'offer some form of instruction' (p. 830), in the field of professionalism; whilst only 55.2% had defined methodology to evaluate professional behaviours. They concluded that the teaching of professionalism in medical schools in the USA varies considerably and whilst some have improved on this approach, the strategies may not be adequate (Swick, Szenas, Danoff, & Whitcomb, 1999).

Professional Identity

Professional identity is not something that could be easily defined. It has been described as how people see themselves within their chosen profession but also how other see them within a defined profession. Beijaard *et al* (2004) conducted a review of a variety of studies pertaining to the professional identify of teachers and concluded that this is not a static state. They felt that, although more research is required, most studies with teachers focused on:

- the formation of professional identity;
- characteristics of teacher's professional identity; and
- identity influenced by the discourse around teachers own perceptions of their identity (Beijaard, Meijer, & Verloop, 2004, pp. 107-126).

During their review several authors defined professional identify. The definitions varied from:

- professional identity being 'similar to professional reality' (Goodson & Cole, 1994);
- it is 'open for continuous redefinition' and is not a set of pre-defined fundamental features which are common to all professionals (Sugrue, 1997);
- to a 'complex and dynamic' balance vis-à-vis 'personal self-image' and the 'roles one feels obliged to play' (Volkmann & Anderson, 1998).

Ultimately, professional identify is 'not a fixed or a stable entity' but a means used by professionals to make sense of the context in which they operate (Coldron & Smith, 1999).

Samuel & Stephens (2000), offered a South African perspective in their definition as 'competing and sometimes contradictory values, behaviours and attitudes grounded in the life experiences of the self in formation.' (Goodson *et al*, 1994; Sugrue, 1997; Volkmann *et al*, 1998; Coldron *et al*, 1999, Samual *et al*, 2000; in Beijaard *et al*, 2004, pp 107 - 112).

Li *et al* (2009) explored Wenger's concept (1991 and 2002) of 'community of practice' (CoP), which suggests that within a CoP an environment is created for informal learning (Li et al., 2009). Wenger (2006) describe the concept as 'a useful perspective on knowing and learning' and define the concept as '…groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wegner, 2006). This is confirmed by both Day (1999) who stated that CoP developed due to collaboration between schools and university in Australia (Day, 1999, p. 184) and Handy (1989) who was referenced by Fisher (2003) who confirmed that 'a company ought to be a community, a community you belong to, like a village' (Fisher, 2003). According to Fisher, Handy argued that in his 'village' analogy, 'Nobody owns a village. You are a member you have rights…', but with those rights comes responsibility (Charles Handy, as referenced in Fisher, 2003).

Nearey (2014) suggests that what one calls oneself defines one's identity (Neary, 2014, p. 14 & 15). She referenced various subject matter experts, who collectively considers personal identity as a process of evolution through socialisation and observation of one's peers. Something that is based on shared experiences; a shared sense of commonality; and any profession that is underpinned by a professional association (Ibarra, 1999; Larson, 1977; Hughes, 2013; in Neary, 2014).

Several researchers indicates that more research is needed in this field (Floyd & Dimmock, 2011; Floyd & Fuller, 2016). However, Floyd (2012) argued that the professional identity of middle managers in academia is under threat. In his study of why middle managers in academia becomes Heads of Department, he defines 'turning points', and challenged Bourdieu's traditional view that everyone has a destined path to follow, in relation to their 'societal path' (Bourdieu, 1984, as reference by Floyd, 2012). Floyd referenced Jenkins (2012); Hodkinsons & Sparkes, (1997), who suggested that Bourdieu's argument is not applicable to all, as some of Floyd's respondents were able to navigate their careers beyond traditional limitations. Whilst Floyd's study was conducted in an academic environment, there are similarities between education and healthcare, that will be explored further in this study. Floyd suggests that one's professional identity 'matches to varying degrees the organisation they join' and identified various reasons why academics took up HoD roles, as being:

- for **research purposes**;
- because a **superior recommended**, they do, and this 'vote of confidence' gave them more assurance that they would be successful;
- more **flexibility** and control over their own working environment;
- **improved influence** and control within their own organisations;
- and **improved opportunity** to making a constructive difference (Floyd, 2012).

Floyd (2012) concludes that teachers join academia through two avenues (1) directly into academia because of their own values and personal identity; and (2) those who joined mid-career seems to have experienced some form of internal conflict, necessitating them to consider their career aspirations and the conflict they have in their former career. They then align their professional and personal identity to their personal values. It is this 'turning-point' that he

argues enable academics, and by extension health and social care professionals, to 'change their job or leave the profession altogether' (Floyd, 2012). These will be considered in relations to clinical leaders in the ED and will be explored in the survey and semi-structured interviews of this study.

In the health and social care environment, and since the earliest reform of healthcare, the emergence of 'the new public leadership challenge' (Brookes & Grint, 2010), resulted in a desire for 'inter-professional education and collaborative professional practice' (Floyd & Morrison, 2014). In this regard staff in the NHS often describes themselves as working in multi-disciplinary-teams (MDT), and therefore see themselves as 'collaborative-practice ready'. Floyd & Morrison (2014) review this concept in considering Bourdieu's 'field-theory' and describe this as 'inter-professional education' (IPE) and 'collaborative professional practice' (CPP) as a practice where the professionals understand their purpose and function within their 'field' which is aimed at resulting in better health-outcomes for end-users. However, they concluded that both IPE and CPP are both good and significant; that it is of equal importance to explore and understand the complexities of these concepts in reality; and that the 'historical, social, and cultural narratives' wherein professional and inter-professional identities are formed must be understood (p. 50).

Ethics

The BBC (2014) published an article explaining what 'ethic's is and defined it as a 'system of moral principles'. Ethics could be described as a structure of honourable values according to which people live their lives. The origin of the word is found in Greek and is derived from *ethikos* that had its origin in the word *ethos*, which means nature, habit, character or disposition

(OCD, 2008, p. 341). According to Mintz (2010), ethical behaviour in philosophical terms is describe as 'that which is good'. Whilst the field of ethics or moral philosophy aims at defining and recommending ideas or notions of conduct that is considered good or bad behaviour (Mintz, 2010). The concepts of ethics has its origin in religious, philosophical and cultural doctrines (BBC, 2014).

The German Philosopher, Immanuel Kant, (1724 – 1804), is well known for his philosophy of ethics and metaphysics. His specific view on ethics is often referred to as *Kantian Ethics*. He formulated his philosophy against a deontological framework, which had its origin, in the concept of duty, from the Greek word *deon* (duty) and *logos* meaning plan, science or study of (Larry & Moore, 2016). Kant believed in what he called the 'categorical imperative' – there is a duty to tell the truth no matter what the consequences. The alternative to the 'categorical imperative' is the hypothetical imperative' which he described as those things we do because we have a need or a desire for it. However, a 'categorical imperative' is those things that we must do irrespective of our desires, it's a moral obligation derived from pure reason, an absolute duty. His philosophy could be placed in the category of moral theories, that guides humanity's choices as to what we are, and what we should be. His ethical framework is based on three elements:

- **Universalability** ~ which is the principle that one should act in a way that you want everyone else in the world to act all of the time;
- **Duty** ~ which is a requirement that you perform your duty, which meets the maxim of universality, i.e. it is a duty that everyone else in the world is performing, all the time, it is right thing to do;

- **Humility** ~ act in such a way that you treat humanity always as an end, and never as a mere means to an end or to your benefit.

The benefit of Kant's views on ethics, is that his philosophy has a practical methodology that one could apply to everyday work and life (Larry & Moore, 2016).

The French Jewish philosopher, Emmanuel Levinas (1906 – 1995), according to Zhao (2016), offered ethics as the first philosophy and although Levinas did write extensively on education, 'his educational ideas were intimately incorporated into his ethical philosophy' (p. 324). She argues that Levinas' philosophy of education is positioned in neoliberalism and the desire for 'certainty, uniformity and accountability' (p. 325). She contends that Levinas's philosophies of individualism and diversity; and his thoughts on language as the discourse to creating an ethical community; offers a variety of opportunities to develop an ethical and democratic society where 'the other' is more prominent than 'the self' (Zhao, 2016). Bettina (2019) clarified this as the reprioritisation of a person's focus (on the other) in terms of his/her actions, speech, and how they listen, enables humanity to receive one another as exceptional individuals. She explains that the basis of Levinas philosophy allows people to be responsible, not because they choose to be responsible, but because the focus on the other, enables the self to act in the best possible way to the benefit of the other (Bettina, 2019).

Wheeler (2006) makes a distinction between 'moral' and 'ethics', in referencing Bauman (1989), who suggests that 'the individual finds him- or herself in a position of choice' and the choice in this context is between what is right or wrong; 'good and evil'. The quandary for an individual of what is right or wrong, it is a moral dilemma, rather than an ethical choice. Wheeler claims that Habermas' perspective on ethics depends on 'networks of reciprocity

which development within ethical communities' (p.18). Whilst both Levinas and Bauman's focus on 'individuality and recognition' places them in conflict with Kant, the latter don't believe there is a choice. If something falls outside the categorical imperative and the principle of universalisability, then it should not be done.

Bauman, according to Wheeler (2006), explains the limitations of ethics as the parameter that was created by society for the individual to follow, the rules, laws, or regulations, whilst morality is the remnant that impacts the individual's choice to what is right, or wrong; to ensure that 'the other rather than the self is at the centre'. According to Wheeler, Bauman's interpretation of Levinas views of ethics, is that ethics is a modernism, while the notion of 'morality' is a concept of post-modernism (p.23). According to Bauman, an individual has a choice to be moral or not (Wheeler, 2006).

In an attempt to define what is meant by 'ethics', Archer *et al* (2008) reference the American Accreditation Council for Graduate Medical Education, who suggested that 'professionalism' is one of several core competencies required to be displayed in medical education, and by extension to be lived demonstrably within the health and social care sector (West, 2021) to:

- Demonstrate a commitment to professional responsibilities;
    - Respect;
    - Compassion;
    - Integrity;
- Adhere to ethical principles;
- Sensitivity and responsiveness towards patient diversity in the population that is served (p 772).

Although there is often a intertwine-ability of the concepts of ethics and professionalism, whilst they are different concepts, both often share the same characteristics. However, Salloch (2016), described a distinction between professionalism and ethics. The former, is the ability for specialised workers with particular skills to organise their work; whilst the latter considers the ethos or character that is expected from specific individuals. She warns against the narrowing of the gap between ethics and professionalism, especially when it comes to medical education, against a backdrop of understanding, for example, suicide assistance in Germany. Whilst the professional nature of medics enables them to systemise their medical duties, the protection of life as medical professional, has an ethos that requires professional systems and moral actions to be two very distinguishable concepts (Salloch, 2016).

It is with this warning in mind, that Summers' (2009) views about the principles of ethics, values and ethical behaviour is noteworthy, as he submits that these came from medical research, which formed the ethical basis of medical ethics in the health-services. He articulates these as:

- do no harm;
- ensure anonymity;
- confirm consent; and ensuring that the
- end-users have the right to withdraw (Summers & Morrison, 2009).

Balu & Singh (2017) on the other hand defines ethical values, as 'care, justice, integrity and respect' as 'the raw material of ethical leadership'. They defined three approaches in ethical leadership as, utilitarianism theory, or 'ethical cost-benefit analysis' where the leaders focus primarily on the welfare of his/her staff; libertarianism theory, where the freedom of the

individual is paramount; and ethical theory which confirms the compliance to acceptable rules and customs (Balu, 2017, p. 1395).

Summary and Implications

The work on culture and behaviours (Dixon-Woods et al., 2013) and the impact of values on professionalism as defined by the Royal College of Physicians (RCP, 2005) offers great scope for exploration in this study.

This study will offer a revised new definition of professionalism however, the behaviours defined above, and in particularly those from the RCP, forms the basis of the 'moral contract' between NHS professionals and the population they serve. Each is responsible to collaborate with the other to achieve the best possible outcomes for society in general.

The definition of 'professionalism' offered by Archer *et al* (2008) captures the principles of ethical doctrines, values, and behaviours when they submit that 'Professionalism itself rests on the principles of excellence, humanism, accountability and altruism' (Archer, et al, 2008, p 772).

The impact of 'professionalism' and the above will be explore in more detail in the survey and semi-structured interviews of this study.

Emerging Question (pertaining to Professional Identity)

The reality of values and behaviours, and the process of transition for clinicians to clinical leaders, will be tested in this study, through both the survey and semi-structured interviews. The following supplementary question on professional identity was formulated to explore the journey of clinician becoming clinical leaders, and the impact this might have on their professional identity.

- How does becoming a leader/manager impact on their professional identity and what are the implications of this for leadership development theory and practice?

2.4 Leadership Development

Day (2000) makes a distinction between leadership development and leader development, the former is defined as programmes that are utilise in the development of collective leadership competencies, whilst the latter develops individuals in organisation (Day, 2000).

Concept of Leadership

Although multiple research projects concur that more needs to be done to truly understand the complexity of the human brain, neuroscience suggests that whilst everyone is different, the brain is a remarkable structure that is never fixed. It is the process called 'plasticity' that enables the brain's ability to support life-long learning, to adapt and to unlock the power of the unfocused mind, reduce stress and anxiety (Blackman, 2014; Blakemore & Firth, 2005; Gould

& Stevenson, 2008; Pillay, 2017). Blakemore & Frith (2005) confirmed that 'teaching and learning applies to all ages' (p.462).

> A leader is one or more people who selects, equips, trains, and influences one or more follower(s) who have diverse gifts, abilities, and skills and focuses the follower(s) to the organizations' mission and objectives causing the follower(s) to willingly and enthusiastically expend spiritual, emotional and physical energy in a concerted coordinated effort to achieve the organizational mission and objectives. (Winston and Patterson, 2006, p. 6)

During their review of 26,000 articles on leadership Winston & Patterson (2006) uses an analogy of a lot of blind men describing a moving elephant, in that leadership has been defined in part, by many, but never in its entirety. Whilst they do not profess to have defined a conclusive definition but suggests that the definition of leadership will continue to develop as scholars develop more insight into the concept (Winston, 2006, pp. 6 - 32).

Ham *et al*, (2010) confirmed that clinicians who assume managerial leadership roles, find a shift in their professional identity. They conducted an exploratory research project, interviewing 20 clinicians who became Chief Executives in the NHS. From being a clinician to being a manager, some continue to identify in the first instance as a clinician, whilst others did an complete transition in identifying as being a manager first and a clinician second. They are described as so-called 'keen amateurs' (p 113) and the NHS as a system offered little structure in terms of professional development and preparing them for the demanding role of Chief Executive. They concluded that the day of 'keen amateurs' are numbered and recommended that the NHS should offer more structured leadership development to clinical leaders to ensure that they are enabled to transition from skilled clinicians to skilled professional managerial leaders. The career path and development opportunities by participants were reported to be varied, whilst most indicated that they received little structured learning to prepare them for the challenges of their leadership roles. Some reported that 'the

NHS' had shown little interest in their career, and they were left to their own creative resources in building their skills (p. 116) in terms of on-the-job development using the methodology of 'see one, do one, teach one' (p.116). The reality is, as articulated by Ham et al, that the ever increasing need for scrutiny in the public sector, also requires a higher degree of professionalism, which is achieved through structured high quality leadership learning, that at the time was just not available (Ham et al., 2011).

Grint (2010) defines three categories of problems, being tame-; wicked-; and critical problems and confirms that the challenge in the third category arises when high performing leaders do well in dealing with critical situations and view themselves as demi-gods who becomes untouchable leaders. Traditionally good managers are often ignored, as there is no 'crises' under their watch, but charismatic leaders, who thrive in a crisis situation could artificially present any challenge as a crisis, with disastrous effects to their followers (Grint, 2010, pp. 169 - 185). Although the NHS has been slow to develop the principles of talent management (Powell et al., 2012), progress had been made in developing senior leaders and comparisons between 2014 vacancy rates and 2018 suggested that the average tenure of Chief Executives has increased from 2.5 years, to 3 years (Al Ariss, Cascio, & Paauwe, 2014). The 2014 expectations of Al Ariss *et al* (2014) seems more appropriate today than ever, as they suggested that:

- Technology will be an enabler for effective talent management;
- Prospective employees would likely be customers as well;
- Fewer boundaries, as talent management is impacted on by globalised labour markets;
- Diversity will become much more important to create unity within diversity (Al Ariss et al., 2014, p. 178).

What then, are the knowledge and capabilities for leadership in today's public services system? According to Benington & Hartley (2010), the public sector is in need of leadership that is able to operate across systems, (across public, private, voluntary and informal community), developing, designing and implementing practical improvement, (drawing on different professions) whilst being innovative in creating measurable outcomes (Benington & Hartley, 2010, pp. 187-190). Leaders who are not just able to ask the 'so what question', but also being able to provide vision and clarity to 'why' the transformation is required (Sinek, 2009; Sinek, Mead, & Docker, 2017). Turnball (2010), confirmed that there is a need for strong collective leadership and asserted that leadership cannot be about individualism, but the ability to allow everyone within an organisation, or a system of organisations to have a voice. He submits that leadership is to involve, inspire and motivate others (Turnbull, 2010, pp. 121-123).

Internationally, various leadership styles and the impact of these on employee experience, organisational commitment and productivity are being considered. From transactional to transformational leadership in Malaysia that concluded that transformational leaders are more likely to secure employee commitment to the organisation (Marmaya, Hitman, N., & B., 2010). This was confirmed by another study in Nigeria where effective transformational leadership resulted in improved employee effectiveness (Sakiru et al., 2013). Interestingly, Bolden *et al* (2003) conducted a leadership theory review and produced an evolution of the traditional view of leadership from 'the great man' believed to be born with exceptional qualities, predominantly male, and endowed with great charisma; to 'transformational leadership' that at its core is leadership who are visionary and who can build on people's need for meaning (p.6). They quoted Bass (1985) who wrote:

> Transformational leadership is closer to the prototype of leadership that people have in mind when they describe their ideal leaders, and it is more likely to provide a role model with which subordinates want to identify. ~ Bernard M. Bass – in Bolden *et al* (2003).

Bolden (2003) explored a variety of leadership styles, whilst (West & Bailey, 2019) explored the challenges of compassionate leadership. Collectively, these different styles of leadership styles, could be presented figuratively as follows:

Fig. 2.1 Different Leadership Styles

Bolden offered a helpful comparison crated by Covey (1992) that demonstrates a comparison between transactional and transformational leadership.

Transactional Leadership	Transformational Leadership
Builds on man's need to get a job done and make a living;	Builds on a man's need for meaning;
Is preoccupied with power and position, politics and perks;	Is preoccupied with purpose and values, morals and ethics;
Is mired in daily affairs;	Transcends daily affairs;
Is short-term and hard data orientated;	Is orientated toward long-term goals without compromising human values and principles;
Focuses on tactical issues;	Focuses more on missions and strategies;
Relies on human relations to lubricate human interactions;	Releases human potential – identifying and developing new talent;
Follows and fulfils role expectations by striving to work effectively within current systems;	Designs and redesigns jobs to make them meaningful and challenging;
Supports structures and systems that reinforce the bottom line, maximise efficiency, and guarantee short-term profits.	Aligns internal structures and systems to reinforce overarching values and goals.

(Covey, 1992, in Bolden *et al*, 2013, p. 15)

He argues that both models could be suitable and appropriate, as was confirmed by Bolden *et al* (2013), who confirmed that a combination of leadership styles are essential, depending on the organisational reality, however considering what Grint had said about change in the NHS (Grint, 2008), then it does appear that the NHS generally requires transformational leaders.

If transformational leadership is what is needed, and the behaviours of leaders, as defined in the 20/21 People Plan (NHS, 2020), requires of the leadership to be compassionate, representative, inclusive and ensuring that everyone belong, with a voice of their own, then the research of Gabriel (2016) is a stark warning, of what is not needed. During his study involving 197 respondents, from a population of 402, consisting of doctors, nurses, allied health professionals and administrative staff, they explored the relationship between employee behaviour and supervisor's toxicity in Nigeria's public hospitals. Blakemore & Frith (2005), argued that people observe their leaders and imitate their behaviour (p. 463), which was the same deduction that Gabriel made when he concluded that 'subordinates are quick to reciprocate Superiors' Toxicity through counter productive work behaviour of transferring aggression to either peers or other identifiable assets of the organisation.' He recommends

emotional resilience training for leaders how to get the best out of their staff, 'creating an atmosphere of mutual respect'; enabling staff to be able to report 'toxic behaviours'; whilst leaders should be held to account for their conduct (Gabriel, 2016, pp. 1363-1372).

Future Leadership Typology

Gleeson & Knights (2008) acknowledged in Fulop & Day (2010), that clinical leaders are often best described as a 'cadre of highly qualified reluctant leaders. They are mostly individuals who are clinicians first, and managers second who are commonly not well integrated into their managerial role (Fulop & Day, 2010). This viewpoint was confirmed by Ham *et al* (2011) who described doctors who become Chief Executives as 'keen amateurs' but added that there is a need for 'structured support' to develop these individuals to ensure that they become skilled professionals (Ham et al., 2011). Ham et al (2011), also described 'leadership for a purpose' that leadership development should be all inclusive, much more than just clinicians. They argue that there needs to be a 'system of care' rather than institutionalised leadership, and recommends that organisational should focus on distributed leadership, who create a climate for individuals to speak up, to act and to improve services that impact patient care positively (Ham, 2011, pp. 21 - 22).

Politis (2005; 2015), examined the correlation between 'dispersed – self-management – leadership' and various environmental factors in the United Arab Emirates, that promotes workplace 'productivity and creativity' (p.182). They argue that leaders should be the providers of work environments that is conducive to these factors, handling people in a way that stimulates their creativity promoting productivity, and by extension improve moral, staff retention, loyalty, and commitment. They should not be hierarchical, as this decreases

creativity and productivity. To maximise these abilities, leaders should be supportive, offering their staff clear objectives, a vision, freedom to innovate, recognition and a sense of ownership. Leaders should create a culture of 'warm relationships; facilitate dialogue; a creative climate and innovativeness'(Politis, 2005, pp. 182 -198; 2015).

Dalakoura (2000), draws a distinction between leadership development and leader development. She argues that the former holds a wider denotation then just the development leadership talents; whilst the latter remains an essential element for organisational effectiveness. She offer some commonly used methodology for leader development as:-

- 360-degree feedback;
- Coaching;
- Mentoring;
- Experiential learning;
- External consultant facilitated interventions.

She acknowledges though, that these interventions are often driven by the Human Resources Directorate and referenced Day (2001) and Maxwell & Watson (2006), who suggests that Chief Executive or Executive Director involvement in these interventions are mostly limited. She concluded that leadership development is the result of structured and coordinated learning events that enable leaders to learn from their seniors, their environment, their staff and from each other (Dalakoura, 2009, pp. 432 - 438).

Lifelong Learning

Okoroji *et al* (2014) confirmed that no organisation can be successful without effective leadership (p. 180). They concluded that leadership styles directly impact organisational goals, including the learning process, especially in HEI's and that the best leadership method should be applied as may be required from the relevant situation (Okoroji, Anyanwu, & Ukpere, 2014).

Liubchenko (2016) conducted a review of six popular learning methods to support lifelong learning (LLL), which could be applied across all levels of leadership and identified these as follows:

- **Case method learning** ~ which is a discussion-based approach to unresolved workplace situations which are being addressed through participatory learning, developing leaders group dynamics, communication skill and philosophical or intellectual skills (Hammond, 2002).
- **Enquiry based learning** ~ is a research-based method during which leaders develop and gain new insights, knowledge, and learning, by inquiring about the world around them. It builds on what Dweck (2012; 2014; 2017) referred to as a learning mindset.
- **Spiral learning** ~ is a method grounded in the belief that learners gain more skills and abilities every time a specific topic is appraised, thus gaining new insights, knowledge and skills (Timperley, Kaser, & Halbert, 2014).
- **Problem-based learning** (PBL) ~ is a method that uses building blocks to stimulate the inquiring mind, enabling leaders to continue on the journey of LLL by identifying critical problems with associated learning objectives whilst exploring a variety of methods to better understand these through autonomous learning (Gold, 2010).

- **Project-organised learning** ~ is a multi-disciplinary problem-based learning set during which learners focus on the learning opportunities through problem solving, considering different disciplines and their impact on the resolution of a problem. It is achieved through multi-disciplinary peer participation (Jensen, Helbo, Knudsen, & Rokkjaer, 2003).
- **Blended learning** ~ utilised a flexible methodology about when or where learning could take place, drawing on a variety of learning methodologies from live events, online-content, learner collaboration, evaluation, and educational learning materials. A particular useful methodology for adult learning (Carman, 2002).

She concludes that the most appropriate method for LLL will depend on the organisational context, the level of knowledge and level of maturity of learners (Liubchenko, 2016).

Leadership at all levels needs development and, in this regard, Boldan *et al* (2003) reviewed several leadership models and competency frameworks to support leadership development. Interestingly, in the Private Sector they reviewed seven frameworks, including AstraZeneca's Leadership Capabilities; BAE's Performance Centred Leadership; Federal Express' Leadership Qualities; the Lufthansa Leadership Compass; Phillips Leadership Competencies; the Shell Leadership Framework; and Vodafone's Global Learnership Competencies (Bolden, Gosling, Marturano, & Dennison, 2003, pp. 19 - 20).

It was interesting to note that only AstraZeneca and the Shell Leadership Framework had as their first competency providing clarity and a shared vision in terms of their strategic directions.

Bolden *et al* (2003) also explored a further seven generic frameworks (p. 24 – 26) and a variety of leadership development initiatives, including the NHS Chief Executives Programme (p. 27 – 29).

It is worth considering that for Health and Social Care, during just more than the past decade (2010 – 2022), no less than twelve leadership development and/or competency frameworks are currently in use (see **Appendix C**) in the NHS.

Whilst there has been a variety of frameworks created for NHS Leadership Development, in 2015 the NHS created a Leadership Qualities Framework (NHSE, 2015) with five development conditions (primary drivers) which were supported by 15 secondary drivers (p. 15). The primary conditions for leadership development were defined as:

- Leaders equipped to develop high quality local health and care systems in partnership;
- Compassionate, inclusive, and effective leaders at all levels;
- Knowledge of improvement methods and how to use them at all levels;
- Support systems for learning at local, regional, and national levels;
- Enabling, supportive and aligned regulation and oversight.

Since 2018 the NHS established seven Regional Talent Boards (RTB's), in collaboration between the NHS Leadership Academy and the private consulting firm Korn Ferry Hays. New national leadership competencies were developed that drew a comparison between the competencies of high performing directors today and tomorrow. They are broadly defined as:

The high performing Executive Director of today are supported by the following…	**The high performing Executive Directors of tomorrow will be supported by …**
• Drives for better outcomes	• Acts from a system's mindset
• Takes people with them	• Finds new solutions
• Speaks up	• Develops people
• Brings compassion and humility	• Creates a culture of inclusion
• Brings a learning mindset	

2019 NHS Competencies developed in collaboration with Management Consulting Firm Korn Ferry, (NHSE, 2019a)

West *et al* (2015), confirmed that there is 'no best way to develop leaders' as it is always context sensitive and is mostly influenced by the 'gap analysis' concerning the leaders desired competencies *vis-à-vis* their actual ability to lead (p. 14); whilst there is little evidence that using these competencies, results into leader effectiveness. In fact, West *et al* (2015) suggests that their literature review 'does not show that using competency frameworks is demonstrably helpful in enabling leaders to improve their effectiveness' (p. 19). They conclude that 'leadership interventions in the NHS are diverse' and reflected that experience in leadership roles is likely to be the best method for leadership learning to take place but warns that this will have to take place under and with 'appropriate guidance and support' (p. 23). In closing West *et al* confirms that the key challenge for the NHS in terms of leadership learning is to 'nurture cultures' that enables the NHS to deliver continuous 'improved high quality, safe and compassionate care'. This they argue can only be achieved through the utilisation of 'robust theory' and 'strong empirical evidence' of what works (West et al., 2015).

There are a variety of theoretic models for both leadership learning and transformation leadership that could be considered (Cheung-Judge & Holbeche, 2016; Covey, 2004; Feser, Rennie, & Nielsen, 2018; Greenway, Blacknell, & Coombe, 2018; Lencioni, 2002; Maxwell, 2005; Pillay, 2017; Scharmer, 2016; Schein, 2004; Welch, 2018).

Various authors recommend a few specific training interventions for leadership learning, which are described as follows:

- **Self-reflective inquiry practice** ~ is an introspection of personal experiences, and the impact of that learning on altered behaviour (Day, 2000; Marshall, 2001). It could be done as a personal experience, with a critical friend and through group meetings, i.e. Schwartz Rounds which is common practice in most acute NHS Trusts.
- **Action research** ~ an increasingly popular method of leadership learning, especially in a group context, where learners are developed to engage in identifying a challenge; exploring options in dealing with real life problems; encouraging constructive disruption to the status quo; evaluating suggested outcomes; and to enable new ways of working, creative thinking and practical problem solving in implementing the change required (Tripp, 2005).
- **Compassionate Coaching** ~ considering the NHS's desire to develop compassionate leaders, compassionate coaching seems appropriate, however, Day (1999) confirmed that it does requires the parties to be on the same emotional wavelength (p. 14), as their level of emotional intelligence will help fostering a trusting and caring relationship (Goleman, 2000; Vermeulen, 1999). Compassionate coaching enables the leader to focus on the people they lead in a constructive, compassionate and caring capacity, decreasing his/her 'self-preoccupation' (p. 17), which reminds of the philosophical views of Levinas where 'the other' is more important than 'the self' (Zhao, 2016).

In considering the development of teachers and the appraisal of performance, Day (1999) referenced Egan (1982) in confirming that for many it is:

- not always easy to receive help;

- difficult to commit oneself to change;
- difficult to submit oneself to the influence of a helper, as this is seen as a threat to one's self esteem, integrity, and independence;
- not easy to see one's problems clearly at first;
- sometimes problems seem too large, too overwhelming, or too unique to share easily; and
- it is not easy to trust a stranger and be open with him or her (Egan, 1982, pp. 296-7, as referenced in Day, 1999, p. 98).

Day concludes that the creation of appropriate support mechanisms and opportunity for leadership learning is essential. As is an appropriate supportive culture, that cultivates openness and trust, mutual respect, understanding of human fallibility, rather than infallibility which will enable leaders at all levels to embrace and commit to high quality of care for both the people they lead and the patients for which they care (Day, 1999).

Summary and Implication

Following the review by Bolden *et al* (2003), that although it may be implied, very few of the frameworks reviewed required of leaders to 'listen' whilst none utilised the phrase 'follow' and from the rest of the above information, this study have given particular consideration, to explore the leadership styles in the survey and semi-structured interviews of this study.

The key leadership style that is being promoted in the above, is transactional to autocratic, with limited focus on transformational leadership. The leader as an individual is being endorsed as the sole source of 'leadership', whilst fewer than half of the frameworks reviewed, according

the Bolden, indicated a need for leaders to be able to be flexible, to ‘adapt their style to different circumstances’ (Bolden et al., 2003; West & Bailey, 2019), more situational leadership with flexibility.

With people not keen to open-up, ask for, or accept help, as the fallibility of leaders in the NHS seems to be career limiting due to a lack of trust; the plethora of leadership development frameworks seems to keep a lot of management consultants in work, but the evidence that these interventions are making a significant, tangible, or sustainable difference, seems lacking.

Leadership development should support those leaders in leading others, with a vision of the future, who can put problems into perspective, focus their minds to enable those they lead to be the best they could be and understand the typology of problems as compassionate human beings. The leaders of today and tomorrow will need to work across systems and organisational boundaries, utilising technology, treating their staff like customers, whilst being inclusive and working collaboratively.

Based on the continuum of transformation in the NHS, successful leaders are likely to be transformational in their approach, whilst workplace deviance, counterproductive and disrespectful behaviour or incivility should not be tolerated at any level of the organisation. The methodology for leadership development is therefore critical to ensure its success.

Emerging Question (pertaining to Leadership Development)

From the data reviewed in the literature review, a gap has been identified regarding leadership education and development that clinical leaders have received, (or not as the case may be), irrespective of the various numbers of leadership development frameworks available in the NHS. This paradox was explored in this study, which resulted in the formulation of an additional emerging question, pertaining to leadership development.

- How did staff learn to lead and what development needs do they have for the future? (to include notions of community of practice/ peer support (formal and informal)/ experiential learning/individualised and tailored support rather than blanket approach etc).

This question has been captured, al be it paraphrased in both the survey and semi-structured interviews.

2.5 Conclusion

The literature review predisposed the development of a conceptual framework that supports the research question but also explores the essential elements for effective, sustainable, and collaborative leadership development. Yet there are a lot of leadership frameworks available, and another may be unhelpful in making a real constructive contribution.

That said, the literature review did suggest that the thematic topics identified in the conceptual framework requires further exploration in this study. Although these were initially touched on in Chapter 1, the refined conceptional framework is confirmed in ***Figure 2.2*** below.

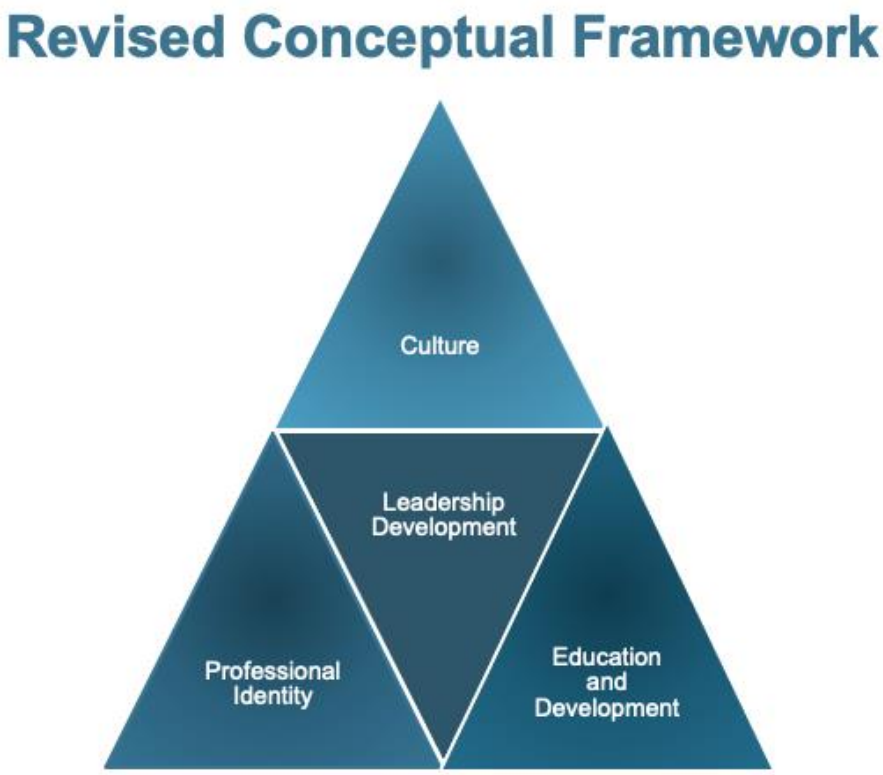


Fig. 2.2 Revised Conceptual Framework

2.6 Next Steps

The next chapter will explore a more detailed review of the methodology of this mixed method study.

CHAPTER 3 ~ METHODOLOGY

3.1 Introduction

The purpose of this chapter is to consider the research methodology that has been employed during this study. The study has been planned as 'the third paradigm' in research (Johnson & Onwuegbuzie, 2004, p. 14), as a mixed method methodology in that a survey and semi-structured interviews were used to obtain both qualitative and quantitative data, ensuring the best of both worlds in research (U. Flick, 1998), in interpreting the experiences and actual realities of participants. It is this constructivist interpretive approach of people's lived reality (Schwandt, 1998) that is intended to better understand the environment of "human experience" (Cohen, Manion, & Morrison, 2011).

This research strategy aims to explore the central research question, which investigates leadership development and education of clinical leaders, and to explore the thematic elements that influenced these. The main question has been articulated as:

What are the experiences and perceptions of leadership development and education for clinical leaders in the Emergency Department (ED) of an English NHS Acute Trust?

The supplementary research questions that follow from the main research question, are:

- SQ1 ~ How does the concept of organisational culture influence the experiences and perceptions of leadership, leadership development and education?

- SQ2 ~ How are their personal and professional identities influenced by their experiences of leadership, leadership development and education?
- SQ3 ~ What are their perceptions and experiences of leadership development programmes and/or educational activities to date?
- SQ4 ~ What are their future development needs that will enable them to be effective in their role?

This chapter sets out the rationale, approach and context of the Trust, Department, and participants, including the way in which data was collected and analysed. Finally, the chapter considers the validity and reliability of this study and ends with the ethical considerations and limitations in this study.

3.2 Paradigm Rationale

As an interpretivist, which is concerned with the scientific articulation and interpretation of people's behaviour, culture and customs, consideration was given to a variety of research methods. These included one to one interviews, focus groups, observations or case studies in terms of the qualitative paradigm (Kvale, 2007); or surveys, descriptive, experimental or correlational research in terms of quantitative paradigm (Ercikan & Roth, 2006).

Johnson & Onwueghuzie (2004) referenced others (see Smith, 1983, 1984; Guba & Lincoln, 1989; Lincoln & Guba, 2000; and Schwandt, 2000), who argues for the qualitative purists, whom they referred to as constructivists and interpretivists, who is said to reject what is called positivism and advocates the superiority of "constructivism, idealism, relativism, humanism

hermeneutics, and sometimes postmodernism" (p.14). Johnson and Onwueghuzie (2004), suggests that a duel methodology of both qualitative and quantitative research offers 'a bridge' between the schism of the two methodologies, offering an obvious potential for researchers (Onwuegbuzie, 2004).

With this in mind, and the complexity of the NHS, its federated nature, and the size and intricacy of its systems, it was concluded that a single research method may not be sufficient whilst a mixed-method has much to offer (Hegelund, 2005, p. 663). This was confirmed, as argued for by Easterby-Smith, *et al*, (2002), who submitted that qualitative research considers the world as a social construct, whilst quantitative research seeks to quantify the data and typically apply some form of statistical analysis (Easterby-Smith, Thorpe, & Lowe, 2002). The combination of the two methods, that integrates qualitative and quantitative research into a new synthesis (Dawson, Fisher, & Z., 2006, p. 230), could offer the best of both worlds, as a multitude of angles could be taken in "triangulation" to validate a study, whilst reducing the possibility of misinterpretation from such a dualistic approach (U. Flick, 1998).

Research Design

Following the literature review, all academic papers, articles, books, internet links, and journals were captured on an excel spreadsheet. These were also entered into EndNote X9, to build a directory of references. The Excel spreadsheet was then sorted to see if any themes could be identified, which resulted in the development of the revised conceptual framework (see ***Fig. 2.2***). Initial questions were formulated for the semi-structured interviews, and a draft survey was prepared with the help of a focus group (Morgan, 1996), consisting of several clinicians.

Constructive feedback were given that helped with the formulation of the final questions and offered clarity to the definitions of leadership. An example of this were offered as follows:

> "Styles of leadership – we often use collective leadership – should be a shared responsibility. Leadership comes at different levels. Each person has a small element of leadership, and some have a large amount of leadership. Language in the survey may not be relatable to more junior staff. Create short definitions for the different types of leadership to help understand what is being asked." ~ Ramesh, ED Consultant.

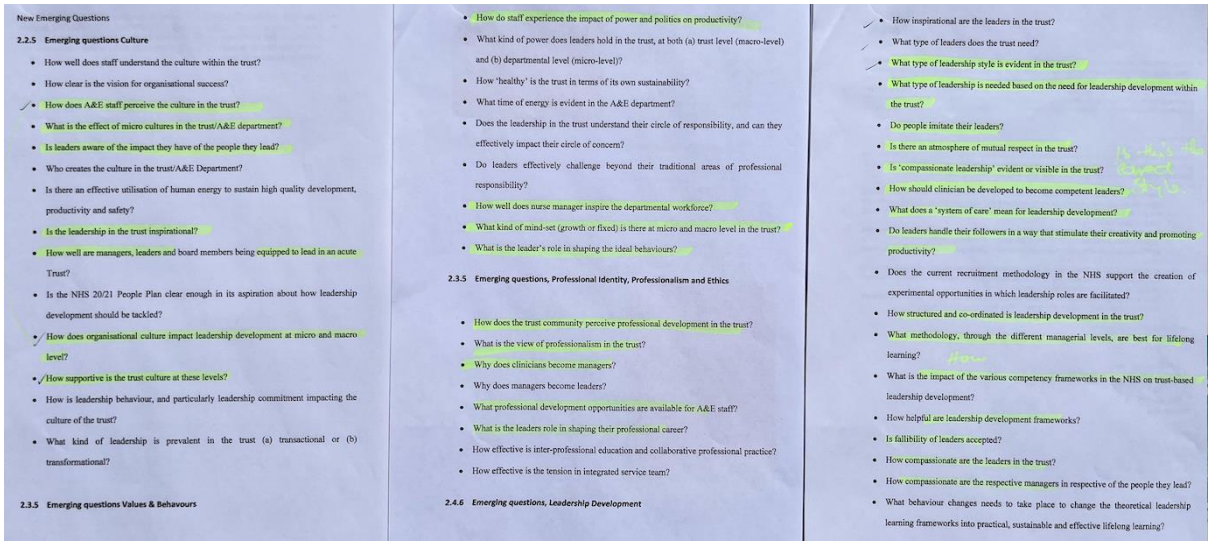
Regarding the specific questions in the survey, the focus group provided helpful insight to clarify wording and structure the questions in a more understandable way. Some examples are:

> **Question 16** ~ Ramesh thinks very difficult to answer – can you add in some guidance? Nina: felt a very deep question and really hit home. Agreed should be ok to leave it in. Or clarifying what is meant by professional identity? What about putting "personal and professional identity". Ensure it says we would like you to elaborate.
>
> **Question 22** ~ What training do you really want? Nina commented that she was never shown how to write a business case for instance / or produce an Excel spreadsheet / QIA / Board reports – how to structure it and what language do you use? Use words like operational support / business case etc.

The above helped with the revision of the conceptual framework (see ***Fig. 2.2***), and a refresh of the survey questions. These were then launched through a pilot of **10** different clinicians from England, the Isle of Man and South Africa. They were sent a link to the pilot survey, with a cover email confirming the purpose of the pilot, asking them to confirm the duration of the survey, (i.e. no longer than 10 min.). They were asked to clarify whether the questions were clear enough, supported the research question, or whether any changes needed to be made. As question 31 invited participants to volunteer to participate in the semi-structured interviews, some of the feedback was the following.

> "Ensuring a diverse range of responders and a reasonable timeframe for responses and perhaps specifying what being interviewed may involve - some may want to help but may be put off if not clear what time will need to be given if they agree." ~ Pilot participant 5.

Following the feedback, a draft set of indicative questions were prepared, under the headings of the survey, being introduction; culture; professional identity; leadership education & training and conclusion (see **Appendix F**).



New Emerging Questions

2.2.5 Emerging questions Culture

- How well does staff understand the culture within the trust?
- How clear is the vision for organisational success?
- How does A&E staff perceive the culture in the trust?
- What is the effect of micro cultures in the trust/A&E department?
- Is leaders aware of the impact they have of the people they lead?
- Who creates the culture in the trust/A&E Department?
- Is there an effective utilisation of human energy to sustain high quality development, productivity and safety?
- Is the leadership in the trust inspirational?
- How well are managers, leaders and board members being equipped to lead in an acute Trust?
- Is the NHS 20/21 People Plan clear enough in its aspiration about how leadership development should be tackled?
- How does organisational culture impact leadership development at micro and macro level?
- How supportive is the trust culture at these levels?
- How is leadership behaviour, and particularly leadership commitment impacting the culture of the trust?
- What kind of leadership is prevalent in the trust (a) transactional or (b) transformational?

2.3.5 Emerging questions Values & Behavours

- How do staff experience the impact of power and politics on productivity?
- What kind of power does leaders hold in the trust, at both (a) trust level (macro-level) and (b) departmental level (micro-level)?
- How 'healthy' is the trust in terms of its own sustainability?
- What time of energy is evident in the A&E department?
- Does the leadership in the trust understand their circle of responsibility, and can they effectively impact their circle of concern?
- Do leaders effectively challenge beyond their traditional areas of professional responsibility?
- How well does nurse manager inspire the departmental workforce?
- What kind of mind-set (growth or fixed) is there at micro and macro level in the trust?
- What is the leader's role in shaping the ideal behaviours?

2.3.5 Emerging questions, Professional Identity, Professionalism and Ethics

- How does the trust community perceive professional development in the trust?
- What is the view of professionalism in the trust?
- Why does clinicians become managers?
- Why does managers become leaders?
- What professional development opportunities are available for A&E staff?
- What is the leaders role in shaping their professional career?
- How effective is inter-professional education and collaborative professional practice?
- How effective is the tension in integrated service team?

2.4.6 *Emerging questions, Leadership Development*

- How inspirational are the leaders in the trust?
- What type of leaders does the trust need?
- What type of leadership style is evident in the trust?
- What type of leadership is needed based on the need for leadership development within the trust?
- Do people imitate their leaders?
- Is there an atmosphere of mutual respect in the trust?
- Is 'compassionate leadership' evident or visible in the trust?
- How should clinician be developed to become competent leaders?
- What does a 'system of care' mean for leadership development?
- Do leaders handle their followers in a way that stimulate their creativity and promoting productivity?
- Does the current recruitment methodology in the NHS support the creation of experimental opportunities in which leadership roles are facilitated?
- How structured and co-ordinated is leadership development in the trust?
- What methodology, through the different managerial levels, are best for lifelong learning?
- What is the impact of the various competency frameworks in the NHS on trust-based leadership development?
- How helpful are leadership development frameworks?
- Is fallibility of leaders accepted?
- How compassionate are the leaders in the trust?
- How compassionate are the respective managers in respective of the people they lead?
- What behaviour changes needs to take place to change the theoretical leadership learning frameworks into practical, sustainable and effective lifelong learning?

List of indicative questions derived from the literature review and focus group discussions

These indicative and initial questions where then grouped based on the research question, and considering which of these are best placed to help sourcing data to fully answer the research question and clarify the supplementary questions. Through a process of review and elimination, a core set of 12 questions were identified, whilst some supplementary questions were used in the discussions to expand, clarify or secure a bit more detail, depending on participant's willingness to share information. All of the above helped to prepare for the launch of the survey and subsequent collection of the research data.

Schematically the research design could be depicted as follows:

Framework for Research Design

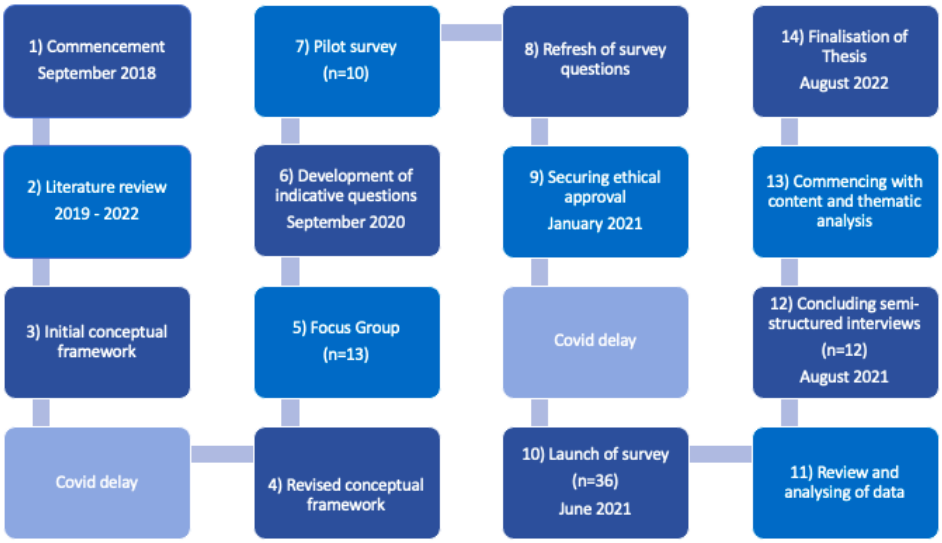


Fig. 3.1 Framework for Research Design

This mixed-method interpretive approach, using both qualitative and quantitative data, helped triangulate and validate the data, reducing the possibility of misinterpretation (Richardson, 2003) and enhancing the quality of knowledge (Kvale, 2007; Kvale & Brinkmann, 2009).

The link to the research question and supplementary questions that follows, from the life histories of the participants, the leadership development and education they have received in their careers, or not as the case may be, and the gap this may create. It relates to the rationality of why they moved from being clinicians to clinical leaders, and the development needs they had or still have, to ensure that they are successful in their contribution to the Trust, and the wider NHS.

3.3 Context

The reality of a Professional Doctorate in Education is that it must be very focused. Cohen (2011) argued that there is "no clear-cut answer" as to sample size (Cohen et al., 2011, p. 144). Although a comprehensive approach could have been explored, looking at leadership development and education across the entire Trust, it was decided to concentrate on the emerging leaders, middle management, and senior leaders within the Trust's Emergency Department (ED) only.

The study was conducted during the second and third wave of Covid-19 that plagued the world during 2020 - 2022. The reality of the pandemic necessitated the researcher being flexible and adjusting timelines for survey reviews, pilots, and the scheduling of interviews, to accommodate the needs of participants, who had as priority the care they provide to patients and the public during these challenging times.

3.4 Participants

Considering there were **203** Hospital Trusts across England (NHSD, 2022b), at the time of this study, a single Trust needed to be selected. Initial consideration was given to the Care Quality Commissioning (CQC) rating of all Trusts in England. It was thought to select a Trust that according to the CQC 'required improvement', but this brought a variety of ethical challenges. Agreement was reached with an English district general hospital that was given a pseudonymised identity.

- The Royal Tudor Hospitals NHS Trust (RTHT)*;
- Commissioned by the Beaufort Integrated Care System (BICS)*;
- Situated in Hampton County*;
- In England.

* Pseudonyms

Once this was achieved and agreement was obtained from the Trust Chief Executive to participate in this study, it was decided to concentrate on a single Department. As the ED of an acute Trust is often seen as the front-door to the hospital, the focus of the research was concentrated in this department, with specific reference to its clinical staff. This was done in line with the arguments of Crow *et al* (2015), who submitted that the selection of participants is largely determined by the research question and took a purposive approach as a result thereof.

Based on the question of this study, the focus is on clinical leaders in the ED only. This provided insight into the experiences, perceptions and realities of these clinicians who hold leadership roles, on their journey from being clinicians to becoming and being leaders. It further explores the development and education they have received, wanted to receive, needed, or needs to ensure that they are as effective as clinical leaders as they could be.

This thesis explores the perceptions and impact of three levels of clinical leaders, based on the NHS job-banding structure, referenced earlier as Agenda for Change (AfC).

Considering the data obtained from the participants in this study, which was achieved through the survey and the subsequent semi-structured interviews, it should be acknowledged that by this time the third wave of Covid took hold of the UK, resulting in ED's across the country

becoming increasingly busy. In fact, the operational demands on ED staff necessitated the rescheduling of several interviews with both middle management and senior management who volunteered to partook in the semi-structured interviews. Equally, candidates from other similar sized Trusts had to be approached to ensure that enough candidates were interviewed, which provided an interesting nuance of different perspectives from three different acute Trusts.

3.5 Sample

The final survey in this study, consisting of 31 questions, was originally sent to a sample population of 235 clinical leaders within one Trust's ED. The composition of these staffing groups was:

- **30** Emergency Medical Technicians;
- **149** Registered Nurses; and
- **56** Medical and Dental staff.

However, several respondents indicated that they did not wish to partake in the study and requested their details to be removed. A few more were on long-term absence, which resulted in an overall potential population of 225, with an anticipation 115 people likely to consider participating in the survey.

The response rate from the survey, calculated on the full distributed population (225) was **16%**. It was anticipated that **115** people were likely to respond and from these, **36** surveys were returned resulting in a response rate of **31%** from the anticipated population.

The survey, was divided into five sections being:

- Demographics (Q1 – Q5);
- Culture (Q 6 – Q12);
- Professional Identity (Q13 – Q17);
- Leadership Development (Q18 – Q23); and
- General (Q24 – Q31).

Following the survey, **17** participants responded to Q 31 following the invite to participate in the semi-structured interviews. However, it became evident that whilst enough participates provided their email addresses to be contacted, not all were keen to participate. Only a couple of volunteers eventually confirmed dates and times for interviews. This necessitated that other ED's were approached to see if any of their clinical staff would be willing to participate in the interviews.

Although the survey was totally confidential and participants could only be identified in terms of how they declared their own sex, pseudonyms were allocated to all participants using the alphabet and a 'name-book' (Astoria, 1997) for ideas of pseudonym names. Names were selected from A – Z and again from A – J to give all **36** survey participants appropriate pseudonym names, see ***Table 3.2*** below.

On completing the survey, it was interesting to note that most of the participants in the survey were in fact emerging leaders, and whilst some of them did provide their email addresses to be interviewed, none responded to the call to be interviewed. On completing the surveys, from the 36 respondents, 5 emerging leaders initially responded positively to the invitation to participate in the semi-structured interview. However, one participant provided an incorrect email address, whilst none of the other 'volunteers' in this category reacted to several emails inviting them to participate in the semi-structured interview process.

As the concepts of leadership and management was regularly used interchangeably by participants in this study, it is acknowledged that they are in fact deferent from each other as articulated by Day (2000) and others. The following is offered in making a distinction.

- **Leadership** ~ 'is as much about developing the self as it is about capacity building in others and such effective leadership requires an intelligent head and in intelligent heart' (Day, 2000, p. 123);
- **Leader Development** ~ is the process of training, education and development or organisational leaders, through succession planning, talent management, ensuring that an organisation is more resilient, having the right competencies and capabilities to grow into the future (Lewis & Heckman, 2006; Powell et al., 2012);
- **Leadership Development** ~ is the development of the leadership to instil that higher sense of purpose, engaging with and empowering team members, taking people with you on the journey, being compassionate whilst holding people to account and enabling followers in being the best they could be (Dalakoura, 2009; Grint, 2010; West, 2021);

- **Management** ~ is those who are responsible for the implementation of policies and procedures, delivery of operational requirements, regulatory and statutory requirements, and holding authority over others (Grint, 2008, 2010; Ham, 2011).

For purposes of this study and based on the comments of participants, leadership and management is used interchangeably, as the same concept, throughout this thesis.

In addition to the Covid demands on operational requirements, the lack of emerging leaders stepping forward, could also be the consequence of the concept of insider research, as some of the participants could have had concerns about the 'continued professional relationship' (Floyd & Arthur, 2012, p. 175), as those participants may have been concerned about participating in an interview with a serving NHS Director. It could also be that they did not see themselves as leaders or were concerned about the possible consequence of their participation. Regardless, the 12 interviewees representing six middle managers and six senior managers, provided interesting insights into different experiences and perceptions on clinical leadership development.

Regarding the **12** semi-structured participants, and whilst none of the emerging leader's participated, the same approach was taken using the alphabetic letters K – V in allocating pseudonyms names to the interviewees. Participants in the semi-structured interviews were recorded as set out in ***Table 3.2*** below and came from three similar sized Trusts. Among the interviewees were **6** Senior Management and **6** Middle Management, which provided an interesting and richer nuance of data, than what would have been the case if all twelve came from the same Trust.

Demographics

The staff groups that took part in the survey were represented as follows:

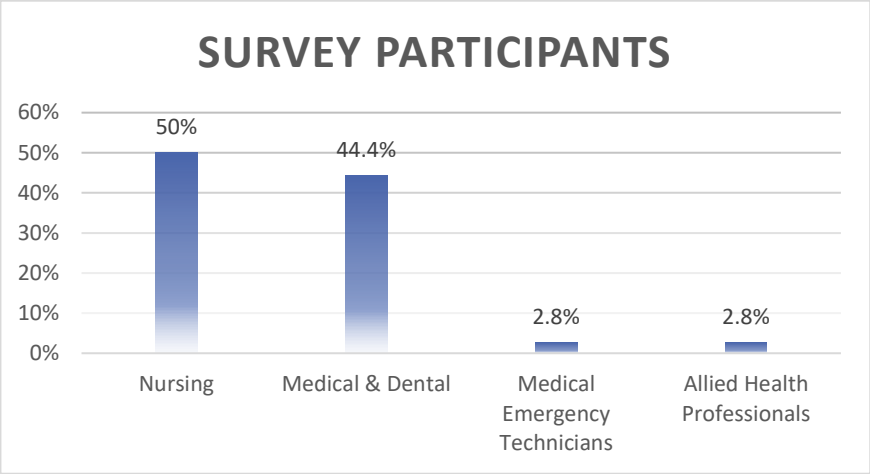


Fig. 3.2 Survey Participants

Figure 3.2 above, confirms that from the 36 participants **18** [50%] were Nursing; **16** [44.4] Medical and Dental; **1** [2.8%] Medical Emergency Technicians; and **1** [2.8%] Allied Health Professional. The survey offered the premise that everyone in the NHS has some form of leadership responsibility. Be it for the public that NHS staff interact with, the patients they care for, or colleagues they work with. With this as backdrop, participants were asked to self-identify as one of three groups of leadership. For ease of reference, these were defined as:

- **Emerging Leader** ~ an individual who shows high potential for future development, currently in AfC band 4 - 6, including someone on a junior doctor's contract;
- **Middle Management** ~ team leaders or intermediate leaders who are on a career path towards senior management, traditionally in AfC band 7 - 8D, or Medical and Dental Staff Grades;

- **Senior Management** ~ the highest level of management, or positions just below the Board, traditionally in AfC band 9, VSM or M&D Consultant Contract.

From the **36** survey participants, **15** identified as emerging leaders with **13** identifying as middle management with **8** participants identifying as senior management.

Table 3.1 Survey Participants [Q1, 2, 3 & 4]

*Name**	*Age Range*	*Grouping*	*Name**	*Age Range*	*Grouping*
Abigail	31 – 40	Middle Management	**Suzanne**	31 – 40	Middle Management
Bastian	51 – 60	Senior Management	**Tina**	31 – 40	Emerging Leader
Carla	21 – 30	Emerging Leader	**Ursula**	31 – 40	Emerging Leader
Dagmar	31 – 40	Middle Management	**Valerie**	41 – 50	Senior Management
Eda	21 – 30	Emerging Leader	**Warren**	21 – 30	Emerging Leader
Feline	21 – 30	Emerging Leader	**Xandria**	41 – 50	Middle Management
Graeme	21 – 30	Emerging Leader	**Yael**	41 – 50	Senior Management
Haley	61 – 67	Middle Management	**Zebrine**	31 – 40	Middle Management
Ida	21 – 30	Emerging Leader	**Andre**	41 – 50	Senior Management
Jacqueline	51 – 60	Middle Management	**Basil**	51 – 60	Senior Management
Kevin	31 – 40	Emerging Leader	**Cailin**	21 – 30	Emerging Leader
Luke	51 – 60	Middle Management	**Dave**	21 – 30	Emerging Leader
Magness	41 – 50	Senior Management	**Enos**	31 – 40	Middle Management
Nadia	51 – 60	Senior Management	**Frida**	21 – 30	Emerging Leader
Octavia	21 – 30	Middle Management	**Gerhard**	51 – 60	Senior Management
Parker	41 – 50	Emerging Leader	**Henry**	31 – 40	Middle Management
Quanah	31 – 40	Middle Management	**Irene**	41 – 50	Middle Management
Rahim	41 – 50	Emerging Leader	**Johan**	21 – 30	Emerging Leader

**Pseudonym names*

Table 3.1 Survey Participants [Q1, 2, 3, & 4]

Table 3.2 identify participates in the semi-structured interviews. Whilst it was originally hoped to interview 12 participants, none of the emerging leaders were willing to be interviewed.

Table 3.2 Semi-structured interview participants [Q 31]

*Name**	*Job Title*	*Grouping*	*Name**	*Job Title*	*Grouping*
Karin	Nurse Practitioner	Middle Management	**Quiana**	ED Matron	Middle Management
Luann	ED Consultant	Senior Manager	**Renate**	Advance Clinical Practitioner	Middle Management
Madeleine	ED Registered Nurse	Middle Management	**Sancia**	Divisional Director	Senior Management
Noran	ED Consultant	Senior Management	**Tara**	ED Registered Nurse	Middle Management
Oriana	Clinical Director	Senior Management	**Uriah**	Managing Director	Senior Management
Prudence	ST 4 Doctor in ED	Middle Management	**Victor**	ED Consultant	Senior Management

Table 3.2 Semi-structured Interview Participants [Q31]

** pseudonym names*

In terms of the survey participants, set out in ***Table 3.1*** above, their demographics are reported in terms of age group, age range, and leadership grouping, of which **19** [52.8%] were Female; **16** [44.4%] were Male; and **1** [2.8%] preferred not to say. For the latter a non-binary name was allocated. Regarding the semi-structured interview participants, as captured in ***Table 3.2*** above, **9** [75%] were Female with 3 [25%] being Male, with an even split [6/6] between middle and senior management. Although the age of the interview participants was not asked, the age range for survey participants was noted as follows:

- 21 – 30 ~ **11** [30.6%];
- 31 – 40 ~ **10** [27.8%];
- 41 – 50 ~ **8** [22.2%];
- 51 – 60 ~ **6** [16.7%];
- 61 – 67 ~ **1** [2.8%].

When asked how many staff participants line-manage, it was noted that nearly half of participants in the surveys or **17** [47.2%] indicted that they did not line manage anyone at all. However, for those that did line manage the following was noted: -

- **5** [13.9%] participants indicated they line manage 1 – 5 staff;
- **4** [11.1%] participants indicated they line manage 6 – 10 staff;
- **3** [8.3%] participants indicated they line manage 11 – 15 staff; whilst
- **7** [19.4%] participants indicated they line manage 16 or more staff.

Interestingly, from the semi-structured interviews it was noted that between the twelve participants, the line management responsibility was reported to be varying between anything

from 5 – 120 people. In addition, hereto, **9** interviewees indicated that their practical ED experiences span periods from 10 – 30 years. Participants interviewed bring ED experience from the United Kingdom, Europe, and Australasia. It should be re-iterated that these participants came from three different Trusts. All three trusts are of a comparable size with multi-site facilities and busy ED's.

The Survey

The survey was developed using the conceptual framework as defined and referred to in Chapters 1 and 2 respectively (see ***Fig. 1.1*** and ***Fig. 2.1*** respectively), focusing on organisational culture, values, and behaviours; personal and professional identity; and leadership development and education. The original survey questions were formulated from the literature review, that resulted in 70 questions, which were refined through a process of iteration and elimination which resulted in the final 30 questions. The eighth version of the survey was reviewed by a focus group consisting of five participants, involving an operations director; clinical consultant; general practitioner; ED consultant; and an ED nurse. The aim of the focus group was to gain a broader insight on the applicability of the survey questions, whilst being mindful of the warning articulated by Freitas *et al*, (1998), that the researcher's own biases, as focus group moderator, could impact the data negatively (Freitas, Oliveira, Jenkins, & Popjoy, 1998). The focus group, which was conducted via MS Teams (a virtual meeting due to Covid-19), was facilitated by explaining the purpose of the focus group, in that participants were asked to take a critical view of the survey questions. These were sent to focus group members prior to the meeting, which enabled a comprehensive discussion focusing on the following questions:

- Are the questions clear enough?
- Was anything missing?
- Were the right questions asked?
- Do they answer the main research question, and the supplementary questions?
- Should anything be changed before the survey is piloted?

The critical review and discussion that followed questioned some of the language in the original questions. It was suggested that these may not be fully understood by participants, that clarifying definitions of terminology like the different types of leadership would be helpful. Questions that were very similar were suggested to be amalgamated, whilst it was suggested to add more options for free text under 'other' at the end of some questions. Some helpful feedback were:-

> **"**Styles of leadership – clinicians like to use collective leadership – it should be a shared responsibility. Leadership comes at different levels. Each person has a small element of leadership and some have a large amount of leadership. Language in the survey may not be relatable to more junior staff. Create short definitions for the different types of leadership to help understand what is being asked." ~ Ramesh* (ED Consultant).

> **"**Band 5-7 covers a huge range. Not sure Band 5 would have an idea of how this survey speaks - even for Band 7s they are terrified of anything "leadership" – words such a collaborative / hierarchical may not be clear. It was suggested that wording could be changed – and to ensure it is clear that all people have a small about of leadership in their roles." ~ Mika* (Clinical Director and Trauma Lead for Emergency Medicine).

Following the focus groups, and the amendments that were suggested, which were actioned, the pre-final survey was loaded onto the University of Reading's survey tool (www.onlinesurveys.ac.uk) before a pilot was run with clinical leaders from a number of different Trusts across England including the Isle of Man and one participant from South Africa. A total of 13 pilot participants were sent an on-line link and were asked to complete the survey whilst offering feedback on several specific questions. These were:

- Please confirm how long it took you to complete the survey, ideally, it should not take more than 10 minutes?

- Were the questions clear and easy to understand?
- Was there any question that made no sense, or that did not add value, which should be removed?
- Is there any obvious question that is missing from the survey, which should have been added, or asked? If so, how would you formulate this/these question(s)?
- Are there any other comments that you feel the researcher should consider before the actual data collection could be commenced?

Ten of the thirteen pilot participants provided feedback on the questions referred to above. Whilst most indicated that they could complete the survey in ten minutes or less, two did indicate that it took them 18 and 20 minutes respectively. Clarity of the question formulation received an overwhelming positive response. Regarding the value of the questions most felt that the questions were relevant and appropriate, with two comments about spelling and the semantics of a couple of words. When asked if there were any questions missing, the majority said 'no' but one challenged about how clinical leaders takes responsibility for their own education and development and testing their understanding of the leadership in the ED.

> "I wonder if there should be any question about how clinical leaders develop themselves as leaders? Each of us have a responsibility for our own development as well, like journaling, or coaching." ~ Ramesh* (ED Consultant).

This was not added to the survey but was captured during the semi-structured interviews. Finally, among 'any other comments' pilot participants felt that they had nothing further to add, other than the concerns of one participant who felt that a single survey may be trying to capture to a diverse group of clinicians.

The survey pilot feedback was very valuable in concluding the final survey before the actual data was collected. The data that was captured from the pilot were reviewed to see if these could be categorised and if any themes could be identified, to ensure that the final data collected would be helpful and appropriate in support of the thesis question(s) and the data reviewed confirmed that this was indeed the case and possible.

The feedback from both the focus group and the pilot were pseudonymised* to ensure an early practice of anonymising the names and places of participants. Following this helpful input from the review and pilot processes, and on completion of the ethical application process, as required by the University of Reading the final survey was developed. The questions were structured using a Likert scale (D. R. Edmondson, 2005) or questions offering multiple choice answers to choose from. These were grouped in the following categories.

- Demographics
- Culture
- Professional Identity
- Leadership Education & Training
- General

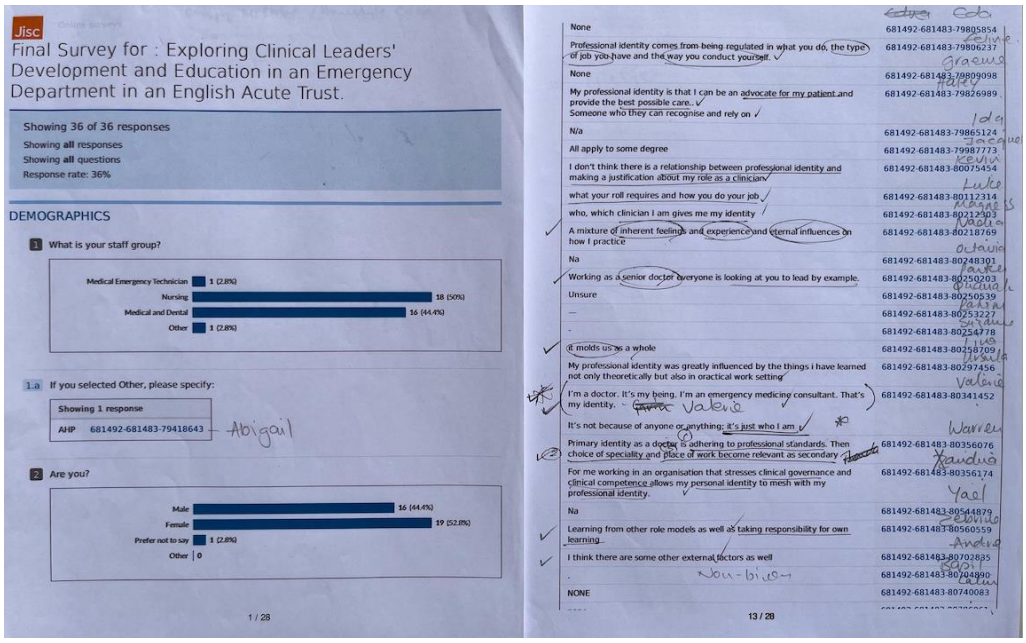
Once the survey was ready (see **Appendix F**), the launch was done with the help of the Medical Director at the RTHT, in that the survey was sent to 235 clinical leaders within the Trust's ED. As stated earlier, the composition of these staffing groups were:

- 30 Emergency Medical Technicians
- 149 Registered Nurses; and

- 56 medical and dental.

However, as mentioned, a few potential participants wrote immediately after the launch of the survey that they did not wish to participate in the research and requested their detail to be removed from the distribution list.

In addition to the initial individuals who declined to participate, it was also noted that there were an additional number of individuals who had left the Trust or were on maternity leave. Their details were removed, resulting in the original distribution list to be 225, with an anticipation population of 115 people likely to consider participating in the survey. The survey was opened on 8 June 2022, for an initial fourteen days, but was extended for a further fourteen days until 9 July 2022, to accommodate operational challenges, due to the Covid pandemic. This was also to give as many participants as possible the opportunity to complete the survey, ensuring a reach and comprehensive data set.



Example of survey results (pg.1 and 13 of 28)

The complete survey, that was sent out to the sample population is available for review (see **Appendix F**), whilst the above example of survey results captures two pages of the completed survey, when the data was being reviewed and pseudonyms were allocated to each participants reference number.

The Semi-Structured Interviews

(Kvale & Brinkmann, 2009) point out that, "An interview is literally an inter-view, an interchange of views between two persons." (p. 2). With this in mind, participants in the survey were asked to identify themselves as volunteers if they wished to participate in the individual interviews, to enhance the quality of knowledge (Kvale, 2007).

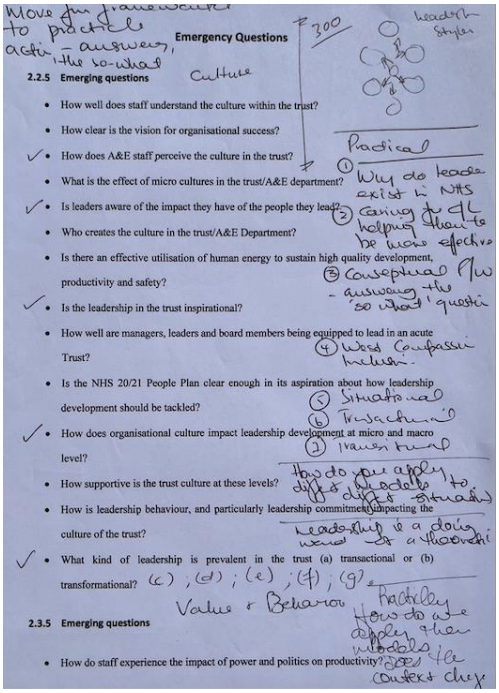
The response rate from the survey, calculated on the full distributed population was 16%, and from the anticipated 115 people that were likely to respond 36 surveys were returned resulting in a response rate of 31% from the anticipated population base. From these it was encouraging that 12 participants provided their contact detail and volunteered to be interviewed as part of this study.

From the 12 volunteers who identified themselves in the returned surveys, it was hoped to conduct semi structured interviews with the three groupings of the workforce, being 4 emerging leaders, 4 middle management, and 4 senior management. However, none of the emerging leaders accepted the invitation to be interviewed, so 12 interviews were conducted with six middle managers, and six senior management.

These included medical, nursing, and allied health professional, who all form part of the multi-disciplinary teams (MDT) offering high quality care to the patients in the ED of the Trust. As was the case with the survey development, the indicative questions for the semi-structured interviews emerged from the literature review and were also grouped in accordance with the conceptual framework. I.e. these were grouped in five categories, being:

- Introduction
- Culture
- Professional Identity
- Leadership Development
- Conclusion

The original list of questions, which were developed following the literature review and before securing ethical approval for this study started with nearly a hundred questions, which were reduced, through a process of iteration and ultimate elimination to about ten overall questions per core-section. However, these were framed as indicative, to help steer the conversation of the interview process, which resulted in twelve overall questions (see **Appendix H)**.



Emergency Questions

2.2.5 Emerging questions

- How well does staff understand the culture within the trust?
- How clear is the vision for organisational success?
- ✓ How does A&E staff perceive the culture in the trust?
- What is the effect of micro cultures in the trust/A&E department?
- ✓ Is leaders aware of the impact they have of the people they lead?
- Who creates the culture in the trust/A&E Department?
- Is there an effective utilisation of human energy to sustain high quality development, productivity and safety?
- ✓ Is the leadership in the trust inspirational?
- How well are managers, leaders and board members being equipped to lead in an acute Trust?
- Is the NHS 20/21 People Plan clear enough in its aspiration about how leadership development should be tackled?
- ✓ How does organisational culture impact leadership development at micro and macro level?
- How supportive is the trust culture at these levels?
- How is leadership behaviour, and particularly leadership commitment, impacting the culture of the trust?
- ✓ What kind of leadership is prevalent in the trust (a) transactional or (b) transformational?

2.3.5 Emerging questions

- How do staff experience the impact of power and politics on productivity?

Example of process of elimination to reduce the long list of indicative questions for the right questions in the semi-structured interviews.

During the semi-structured interviews, the **12** participants, representing the two leadership groups, were all asked the same set of questions (see **Appendix H**). These participants operate as multi-disciplinary teams (MDTs) within their ED's. It is these MDT's that often conflict with one another as the tensions between health-care professional and managerial responsibility is not always in harmony. This, according to Spehar *et al* (2012), is due to the fact that clinicians did not always anticipate a career in management, enter the sphere of management "in order to protect medical practice from interventions by general managers" (p. 11), or joined the healthcare sector to help others, to be clinicians first and foremost (Spehar et al., 2012).

3.6 Data Collection

Considering the polarisation debate on the dichotomy of qualitative and quantitative research (Ercikan & Roth, 2006), and the views on 'triangulation' in research in terms of the benefits in utilising complementary methods to conduct qualitative and quantitative research (Morgan, 1996, 1998) it was felt that the two methodologies should not be mutually exclusive but a combined approach would offer better clarity of the data. This triangulation, combining both qualitative and quantitative research strategies in the same study, was used to validate the data, reducing the likelihood of misinterpretation (U. Flick, 1998). To help in clarifying this concept, Richardson suggests replacing the term 'triangulation' with 'crystallization', to emphasise the multitudes of angles and the infinity of refractions (Richardson, 2003). Following the use of this methodological dualism the study used an integration of both qualitative and quantitative methods.

In considering the qualitative data Hoyningen-Heune (1992) confirms that its aim may vary, depending on the disciplinary background, be it religious, philosophical or phycological in nature (Hoyningen-Huene, 1992). The latter, for example seeks to understand human behaviour. Qualitative research is therefore a good exploratory research methodology, aimed to understand why things happen, and in the case of this study, exploring the data to better understand why clinicians, became clinical leaders, and what education and development they received along the journey, or may require ensuring better leadership, and ultimately improved clinical outcomes. Strauss & Corbin, (1998), defines qualitative research as any type of research that produces outcomes which have been obtained by means other than statistical calculations or quantifications (Strauss, 1998). The collection of qualitative data by its very

nature is time consuming, as it requires the evaluation, interpretation and grouping of data, followed by a process of re-evaluation, to ensure the correct information is explored, the data is accurate, reliable and trustworthy (Elliott, 2008), a journey that enhance the quality of knowledge (Kvale, 2007; Kvale & Brinkmann, 2009).

Quantitative Data

Quantitative data, in contrast to qualitative data is founded in numbers. Malhotra & Dash (2016), described quantitative research simplistically as research methodology that seeks to quantify the data and typically apply some form of statistical analysis (Malhotra, 2016). It is a methodology that relies on data captured through surveys, tests, and checklists (Ercikan & Roth, 2006). It generates data, figures or statistics, and thus, offers a relatively statistical understanding of society, a focus on process (Elliott, 2005). This 'focus' is the concentrated measurement of something rather than its quality, the empirical or practical (represented by natural sciences) and logic (represented by maths) that are viewed as the why and how. Whilst qualitative research considers the world as a social constructed (Easterby-Smith et al., 2002); quantitative research focuses on the what, where and when. One of its greatest benefits is that it could cover large populations groups and its large amounts of numerical data (statistic) on attitudes, opinions or behaviours could offer a wealth of data. This was achieved through the bespoke survey using Likert scales, created by Reniss Likert (1903 – 1981) (D. R. Edmondson, 2005), including some free text to draw out key themes, followed by semi-structured interviews.

3.7 Data Analysis

In interpretating data, Patton (2002) focusses on the impact of patterns, categories and basic descriptive units, (Patton, 2002); whilst the network approach of Bliss *et al*, (1983), focus on categorisation (Bliss, 1983).

Qualitative Data Analysis

In analysing the qualitative data, ensuring its validity and reliably, this exploratory study aimed to understanding why things happen.

The researcher followed Patton (2002), who suggested a naturalistic approach in exploring the phenomenology of participants in a real world setting, where the phenomenon of interest is not being manipulated (Patton, 2002) but interpreted. This was achieved using a bespoke survey, including some free text to test key themes, followed by the semi-structured interviews. During the survey design phase, through the help of the focus groups and the pilot group of pre-survey participants for expert validation (Gehlbach & Brinkworth, 2011), The data from the free text in the first instance offered helpful clarification on the qualitative data, with 17 options to offer free text of qualitative data (see **Appendix F** in particular questions 6, 11, 14, 15, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 29, 30, and 31) whilst the transcripts from the semi-structured interviews were the second method of data production.

Central to the epistemology, the theory of knowledge, and the chosen methodological approach in considering the lived stories, thematic and content analysis were utilised whilst the interaction between interviewer and interviewee elicited personal storylines (Elliott, 2008).

> "Interviewing can inform us about the nature of social life. We can learn about the work of occupations and how people fashion careers, about cultures and the values they sponsor, and about the challenges people confront as they live their lives." ~ (Weiss, 1994, p.1, as quoted in Elliott, 2008).

Following the conclusion of the survey phase of this study, twelve participants identified themselves as being willing to be interviewed. All twelve were written to, with the aim of planning the interview that form the 'analysis continuum' of Crowe *et al* (2015).

It was this 'analysis continuum' (Crowe, Inder, & Porter, 2015), that the researcher used in this study, utilising both thematic analysis (TA) and content analysis (CA), the process of analysis differs. Braun & Clark (2006), as referenced by Crow *et al* (2015), describes this analysis continuum as the "theoretical flexible method" of data analysis as follows:

- **Thematic Analysis** (TA)
    - **Latent** ~ present but not immediately visible, needs exploration to identify;
    - **Interpretive** ~ requires deductive skills to make sense of its meaning;
    - **Inductive** ~ forming a point of view by reaching conclusions, making judgements and inferences from a given set of facts;
    - **Inability to be calculated** ~ does not lends itself to calculation, views are determined by facts, categorisation, and cannot arrived upon by means of numerical calculation.

- **Content Analysis** (CA)
    - **Manifest** ~ data that is readily visible, evident or obvious following some review;
    - **Descriptive** ~ data is explained in terms of its characteristics that gives meaning to it;
    - **Deductive** ~ a process of logical assumptions that defines a logical conclusion;
    - **Ability to be calculated** ~ the results can be achieved by applying a computed calculation (Braun & Clark, 2006 in Crowe et al., 2015).

In this regard, both the CA and TA from the qualitative data obtained from the free text in the survey offered a valuable basis to explore further during the interview phase of the research (see **Appendix F** and **Appendix H**).

Quantitative Data Analysis

Following the final closure of the survey, the researcher downloaded the final survey results into a report form but also into Excel to start creating the tables in this study and to better understand the quantitative data from the survey. In this regard consideration was given to Ercikan & Roth (2006), who describes quantitative data analysis as a process that is considered to be objective and the outcome of the data analysis should be replicable by others (Ercikan & Roth, 2006). Their "interpretation model" was followed as a methodology in understanding the quantitative data better, whilst the researcher analysed the quantitative data, making various interpretive judgements.

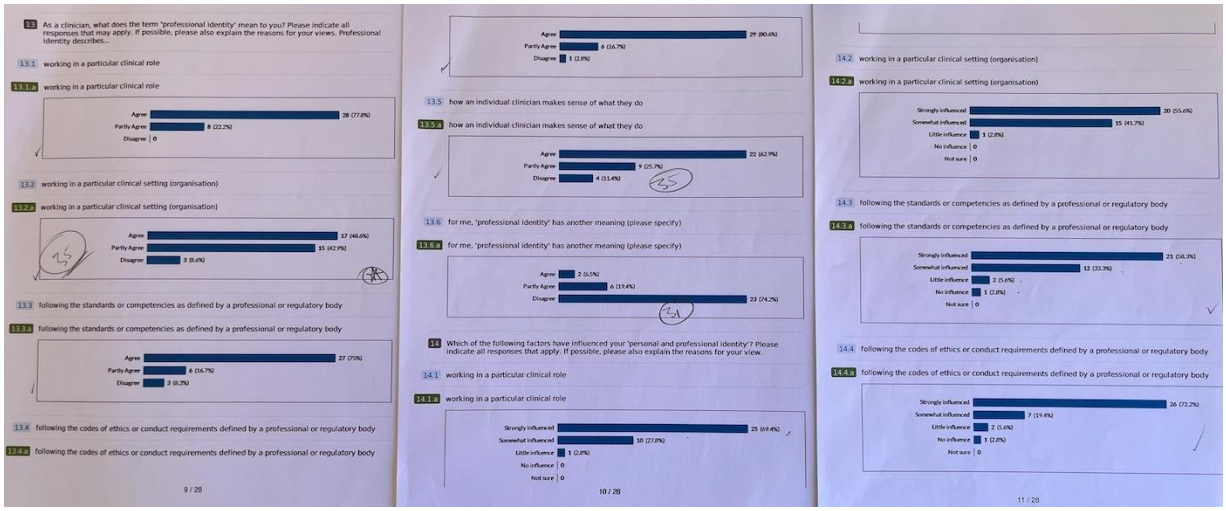
Firstly, it is about the subjective determination of the value of the scoring assigned to questions, and how this may be supportive of the research question. Secondly, it's about the judgement when applying the "scoring rules" and the more consistent the scoring, the more consistent analysis of data would be (Ercikan & Roth, 2006, pp. 16 - 17).

Considering the researcher as narrator and the dichotomy of qualitative and quantitative research, the reflective words of Richardson (1990) was helpful, bearing in mind the influences on and by the researcher, when he confirmed that:

> "We weigh and shift experiences, make choices regarding what is significant, what is trivia, what to include what to exclude. We do not simply chronical what happened next but place the next in meaningful context. By doing so we craft narratives: we write lives" ~ (Richardson, 1990, p. 10).

In interpreting data, (Patton, 2002), focusses on the impact of patterns, categories and basic descriptive units; whilst the network approach of (Bliss, 1983), considers categorisation.

In considering the quantitative data in this study, Cohen *et al* (2011), offers some insights in reading data, understanding its various distribution curves, and defining the mean; the median; the mode; and "the range as a measure of spread" (Cohen et al., 2011, pp. 521 - 532). All of these descriptives were considered in allowing the data "to give up its secrets" (p 544).



Sample of survey responses giving a range of answers to one question. [Q13]

Once the survey was completed the quantitative data was reviewed identifying the highest to the lowest values in the quantitative questions, whilst also considering both TA and CA to identify key themes from the content, which helped shaped the final questions of the interview process. Once the interviews were conducted, each intervention was transcribed and analysed exploring both TA and CA captured in the transcripts (See **Appendix J**).

3.8 Reliability, Validity and Quality Criteria

The researcher drew on the work of Golafshani (2003), who confirmed that reliability, validity, and quality criteria in research is an essential consideration in both quantitative and qualitative paradigms and are based in a 'positivists perspective'. He referenced Watling (as sited in Winter, 200, p. 7) who said: "Reliability and validity are tools of an essentially positivists epistemology." ~ (Golafshani, 2003, p. 598). This was considered in endeavouring that this study is as reliable as possible, i.e., that the results of a subsequent study would be the same, following the same methodology, and that the results would be valid, i.e., if the same

methodology in obtaining the data was accurate to enable the research question(s) to be answered. Did the researcher measured what was intended to be measured? (p. 599).

Patton (2002) employs a naturalist approach when explaining the phenomena of qualitative research as a real world setting where the phenomenon of interest is not being manipulated, but rather being reported as the data is found in its natural state (Patton, 2002, p. 39). However, Golafshani (2003) also referenced Patton (2002), whom he confirmed indicated that both validity and reliability are important factors, when planning and design a research study, analysing results and judging the quality of the study (Golafshani, 2003, p. 601). He concludes that the concepts of reliability and validity are conceptualised based on its repeatability, consistency, precision, and quality in research (p. 604), which is what was used.

It is with this insight in the validity and repeatability of research that this study has been undertaken, but with a clear understanding that there are a variety of external factors (Floyd & Arthur, 2012) that potentially could impact the data, its interpretation and application.

Qualitative Data Quality

Ensuring data quality in this study the work of Rolfe (2006) was followed, who explored the validity, trustworthiness and rigour that is applied to qualitative research, the quality thereof and confirmed that generally there are three views of how reliability, validity and quality could be viewed. In this regard, he submitted that generally, the three positions, are, those who:

- are of the view that qualitative research should be judged and evaluated with the same set of criteria as would be applied to quantitative research;
- believe that a different set of criteria is required; and
- question the suitability of any predetermined criteria for judging qualitative research (p. 304).

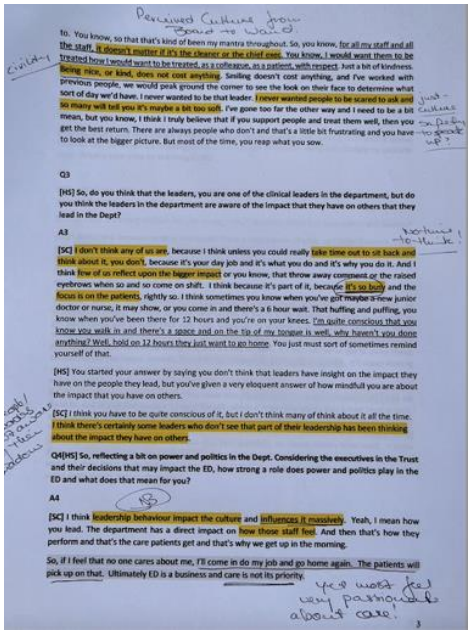
He argues that the second position is the one that causes the greatest deliberation but concludes that the second position should be rejected in favour of the third. This, he suggests is due to the lack of a unified and consensus approach, resulting in the reality that researchers should either accept that the qualitative quantitative dichotomy is a continuum, that requires a range of quality criteria, or that every study is bespoke, distinctive, and individual. Rolfe suggests that attempting to create a predefined set of criteria would be pointless (Rolfe, 2004).

Noble & Smith (2015) on the other hand feel that it is very important that research should be evaluated and focus on its rigour and integrity. In exploring the concepts of reliability and validity that is traditionally associated in quantitative research, explore their applicability to qualitative research. They reference Rolfe (2006) and concur that there are no clear consensus across the research fraternity about the standards by which such research should be judged (Noble, 2015, p. 34). However, they do offer some scope of how researchers could endeavour to ensure that their qualitative research is credible. In this regard they provide a list of strategies, with associated references*, which defines possible strategies. For purposes of this study, the researcher applied the following:

- Be aware of **personal bias** that could influence the findings ~ (Rolfe, 2006*);

- Ensure **careful record keeping** with clear decision trails with consistent and transparent interpretation of data ~ (Sandelowski, 1993*; Long & Johnson, 2000*);
- Including **detailed and verbatim descriptions** of participant's' interpretations to support the research findings ~ (Slevin, 2002*);
- Demonstrating **clarity of thought in analysing and interpreting** the data offered by participants ~ (Sandelowski, 1993*);
- Utilisation of **respondent validation**, by inviting participants to comment on the interview transcripts and whether the final themes and concepts created adequately reflect the phenomena being investigated ~ (Long, 2000*);
- **Data triangulations**, whereby different perspectives help produce a more comprehensive set of findings ~ (Sandelowski, 1993*; Long & Johnson, 2000*; Fraser & Greenhalgh, 2001*; Kuper, Lingard, & Levinson, 2008*); (Noble, 2015, p. 35) [bold added].

Following the semi-structured interviews, detailed transcripts were produced from the 1:1 interview with participants, whilst keeping the above in mind, data were analysed following a systematic approach, in reviewing each question per transcript, and analysing these from both a TA and CA perspective.



Example of content and thematic analysis from semi-structured interview transcripts

Quantitative Data Quality

Ensuring the reliability, validity, and quality of data from the survey, the researcher followed the six descriptive analyses in questionnaire development of Gehlbach & Brinkworth (2011). The six elements consist of the following:

- Step 1: Literature Review;
- Step 2: Interviews and Focus Groups;
- Step 3: Synthesizing the Literature Review with Interview-Focus Group Data;
- Step 4: Developing items;
- Step 5: Expert Validation;
- Step 6: Cognitive Pretesting (Gehlbach & Brinkworth, 2011).

As set out earlier in this chapter, the researcher developed the questionnaire for this study, as follows.

At the commencement of this Professional Doctorate, the literature review commenced, but was intensified as the research question emerged and eventually articulated. This focused the researcher's attention, in considering the previous contributions made by several authors, be it through academic journals, books, papers, national documents, internet links or newspaper articles. This resulted in a library of **334** sources that were available for the development of this study.

Once the research questions were developed, and the conceptual framework designed, a draft survey was prepared, that was shared with a focus group (**n=13**) of clinical staff from England. They were asked for their critical review, and their challenge, input, and comments, which enabled the researcher to clarify definitions, rephrase questions and correct the flow of the survey. This resulted in further reviews of the literature, to clarify aspects in the draft survey and ensuring that the survey supports fully the research question in this study. Which helped with the development of the pre-final survey, which was again circulated to the focus group participants for expert validation. The penultimate litmus test was the distribution of the intended final survey to a pilot group of UEC clinicians (**n=10**) for 'cognitive pretesting' to better understand the interpretation of questions, the utilisation of appropriate descriptive words, and to ensure that the data received would support explaining the research question and supplementary questions that have been developed in this study (Gehlbach & Brinkworth, 2011, pp. 380 - 385).

The process proposed by Gehlbach & Brinkworth (2011) proved very helpful in this study and helped the development of a survey that produce valid and reliable data in support of this study's research question.

3.9 Ethical Issues

In compliance with the University of Reading's ethical requirements and the guidelines of the British Educational Research Associations (BERA, 2018) clarification was sought whether ethical approval should be obtained from the NHS whilst the authorisation was obtained from the University's ethical committee. Contact was made with the NHS medical research council asking whether ethical approval was necessary from the NHS before ethical approval was sought from the University. It was confirmed by the Information Officer of the Medical Research Council, that "if the study involves NHS staff only, then NHS REC review is not required" and as no member of the public was involved in this research, the correspondence substantiate that ethical approval was needed from the University of Reading only.

Elliot (2008) submitted that researchers "as sociologists" enter the world of their research participants on both a personal and moral level and establish a relationship with those they study (Elliott, 2008). Anonymity of participants is of the highest importance, although difficult as the researcher had the challenge what Floyd & Arthur (2012) defined as "external and internal engagement" (p. 171).

- **External ethical engagement** ~ relates to those who seek ethical approval from their own institutional review boards, which in the case of this study, was not a problem, as

the NHS did not require internal ethical approval, as confirmed in e-mail correspondence in this regard.

- **Internal ethical engagement** ~ relates to the greater ethical and moral challenge experienced by internal researchers who 'once in the field' must conduct independent research with participants they potentially have an ongoing personal and professional relationship with post research. This dilemma poses a conflict in both professional and researchers role as it makes full anonymity challenging (Floyd & Arthur, 2012). This has been mitigated by ensuring that the Trust, the Department, and all participants have been anonymised.

Whilst the participants were not known to the researcher at the beginning of this project, as an 'insider researcher' they were known to each other as they were colleagues from within the same Trust. Participants were engaged on a more 'intimate' basis, as both the researcher and participants are from the NHS, al be it from different organisations (Mercer, 2007).

The university's standard 'Ethical Approval Form A' was used to commence with the application for ethical approval. The bespoke ethical application form included the information letter invited clinical staff to complete a survey, and invite them to volunteer to be interviewed, utilising semi-structured interviews. It also made provision for participants to confirm their consent to participate in the survey, whilst participants in the semi-structured interviews were given additional information about the rational, process, their rights, and the data utilisation. The final approval form (see **Appendix D**) confirmed a favourable view from the University's ethical committee enabling the research to be conducted. Participants who were invited to partake in the survey were approached via email, with a covering message setting out the topic,

rationale, and reason for their survey, with a link to the survey where the first page of the survey contained:

- a welcome note (information sheet) to explain the rationale of the survey setting out the intentions, the estimated duration to complete the survey, and how information would be handled; and
- for candidates who volunteered to be interviewed an information sheet was emailed before interviews were scheduled.

The ethical application had several iterations, as the survey questions (stage 1) were evaluated and sharpened. Equally, the indicative questions for the semi-structured questions underwent several iterations before the final ethical application was submitted. It is confirmed that a positive ethical consideration was given to this research before any research commenced, (see **Appendix D**).

3.11 Conclusion

The constructivist and interpretivist nature of this study is captured in the methodology of this chapter, which set a good basis for the collecting, analysing, and interpreting of data. This real-life story gives a valuable insight into the true experience and perceptions of clinical leaders as they embark on their journey.

3.12 Next Steps

The next chapter will report and discuss the data pertaining to the first element of the conceptual framework, being culture.

CHAPTER 4 : RESULTS AND DISCUSSION ~ CULTURE

4.1 Introduction

The purpose of this chapter is to present and discuss the data relating to this study's first research question, with specific reference to the first element of the conceptual framework, being 'culture', and how this impacts the research question, defined as:

What are the experiences and perceptions of leadership education and development for clinical leaders in the Emergency Department (ED) in an English NHS Acute Trust?

In addition to the research question, the supplementary question that will also be addressed in this chapter is:

SQ1. How does the concept of organisational culture influence the experiences and perceptions of leadership, leadership development and education?

Roberts (2005), argues that unless systems, structures and behaviours change, the best intended interventions, or leadership development roadmaps will not change or improve people's behaviour. The findings of this study share parallels with Roberts (2005) as the concept of consciousness of leadership is the reality that leaders inspire, or fail to inspire, the people they lead, to positively choose to use their behaviour constructively in achieving organisational goals. This was illustrated by an interviewee, who offered the following:

> "During the time in ED, working through the bands, you see things, gaining knowledge, how things are done, and then eventually you choose to go into management. All that experiences gives you exposure, helps you to be formed, developed as a better manager to support your workforce in a developmental way." ~ Renate, Advance Clinical Practitioner (Middle Management).

From the analysis of the data from both the surveys and the semi-structured interviews, some clearly articulated themes emerged, which are:

- Perceptions of culture
- Belonging
- Communication
- Accountability

These themes or elements that influenced culture, are expanded on in the following sections.

4.2 Perceptions of Culture

The survey explored perceptions of leadership styles within the ED and in response hereto, just over half of the participants, or **19** [52.9%] described the prevailing culture as '*Hierarchical*' ~ traditionally found in graded or formally structed organisations with '*decisions from above*'.

Table 4.1 below confirms that **15** [41.6%], from the emerging leaders, nearly half or **7** [46.7%] of this group felt that the culture in the department was hierarchical. This was similar for the **13** [36.1%] middle management with **10** [76.9%] of this group reporting that the culture was hierarchical. It was noted that all of the senior management group of **8** [22.2%] was evenly distributed across all the cultural domains with between **1** [12.5%] to **2** [25%] of this group

describing the culture as anything between Collaborative, Collegial, Democratic and Hierarchical. This, according to the data is due to the complexity of emergency medicine, in that at times, the senior management within the ED must apply situational leadership styles. It was said that the ED requires a '*mix of hierarchical and collegial*' culture or leadership style ~ Nadia, (Senior Management); whilst another confirmed that it was a '*combination of* [all the styles] *depending on* [the] *clinical situation*' ~ Gerhard, (Senior Management).

Contrary hereto, the reality of staff on the shop floor is clearly different to that of the senior management, in that **17/28** [60.7%] of both emerging leaders and middle management felt that the culture is '*hierarchical*'. Schein (2004) contends that the transformation within groups, especially in complex organisational structures where different groups are required to work collaboratively in one system that leaders figuratively act as "parent figures" and the team members of the group becomes the "children of that family" (p. 377) who, like different children with parents, will experience the approach of their parents in different styles. In terms of cultural development, Schein (2004) argues that leadership is directly linked to the creation, destruction, evolution, formation, and transformation of workplace culture, as it is formed by the actions or inactions, of the leadership (p. 414). Whilst the experiences of participants on leadership styles clearly differ with most of the emerging leaders and middle management believing that the leadership style in ED is '*hierarchical*', one of the senior manager interviewees offered the following insight.

> "[ED] could not be a democracy, as someone must take charge, to make quick decisions [whilst it was said that] ED is a busy place and not for people who are overassertive or too delicate" ~ Oriana, ED Consultant (Senior Management).

This difference in perception and experience was confirmed by Loke (2001) who argued that although leadership behaviours do not impact employee job satisfaction, productivity, or

commitment independently, but collectively; it influences employee outcomes and experiences, especially in times of work pressures. She argued that although leadership behaviour is key during economic difficult times, or under times of operational pressures, as is the case in an ED; nursing managers and other middle management should focus on their behaviours and what is within their control. Like Covey (2004), who proposed that leaders should focus on their "circle of influence" rather than their "circle of concerns" (p. 81 – 90); nursing and other top administrators should use the five interconnected leadership behaviours confidently to establish the standard for organisational leadership.

Table 4.1 Culture in the Emergency Department [Q6]

	Emerging Leaders		Middle Management		Senior Management		Total	
How would you describe the emergency Department's Culture? [Q6]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Collaborative	2	5.6%	3	8.3%	1	2.8%	6	17%
Collegial	2	5.6%	0	0%	2	5.6%	4	11%
Democratic	4	11.1%	0	0%	1	2.8%	5	14%
Hierarchical	7	19.4%	10	27.7%	2	5.6%	19	53%
Other	0	0%	0	0%	2	5.6%	2	6%
Total	**15**	**41.6%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**

Table 4.1 Culture in the Emergency Department [Q6]

In exploring the circumstances that are likely to impact the perceptions on culture in the ED, it was acknowledged that the perceived culture would be different for different people and will vary in different ED's because of the lack of '*support and empathy from the senior team*' and the '*…time pressures, understaffing, different skill mixes, progress chasers and a broken NHS system'*. – Feline (Emerging Leader) Q11a. This finding is supported by the studies of Yinng *et al* (2009) and Marmaya (2010) who concluded that a supportive leadership who demonstrated their support through their conduct, commitment, and behaviour, played an influencing role on the ultimate experience of staff when it comes to perceived culture in an organisation. Contrary to their findings, an emerging leader argued the following:

> "Managing patients' expectations compared to reality, working while understaffed so doing the work of multiple people, disagreeing with decisions from higher up but having little authority to challenging them." ~ Carla (Emerging Leader) Q11a.

Although the majority, **19** [53%] of survey participants felt that the culture in ED was perceived as hierarchal, from the feedback in the semi-structured interviews, the views were very spread. Three of the twelve [25%] felt that the ED has a '*massive blame culture, with a strong focus on performance targets*'; whilst Luann, ED Consultant (Senior Management), suggested that there is a duality to cultural perception, one being the culture in the Trust and the other that of the ED. He confirmed that in his perception the Trust culture is '*dictatorial*' with a strong focus on '*hierarchical leadership*' whilst in the ED the culture was described as '*not dictatorial, but more of an anarchy*'. Luann suggested, similar to that of the senior management who participated in the surveys, that leadership styles in the department must change according to issues and work pressures in the ED. This 'anarchy' being explained as a perpetual state of disorder (OCD, 2008), not because ED is unorganised, but because it is so busy – (Quiana, ED Matron).

It is this tension between the perception and vision of culture within a Trust, in relation to the reality of what happens in individual departments, and the experiences and perceptions of people on the shopfloor. This was reiterated by an ED registered nurse who argued the culture is '*not very favourable*'. She described it as '*a toxic culture*' with '*bulling in the department*' resulting in a '*despondency in staff*', who '*keep their heads down*', due to very low *'staff morale*' linked to the very high demand on the department ~ Madeleine, ED Registered Nurse (Middle Management), she added:

> "I don't think engagement is very good, staff morale is incredibly low and the demand in the department is unprecedented." ~ Madeleine, ED Registered Nurse (Middle Management).

All of which are contraindicators for a psychological safe culture (Dekker, 2017; A. C. Edmondson, 2003, 2019; West, 2021). That ED staff view themselves as special, should perhaps not be dismissed, as the findings from this study suggests that the pressures and capacity in the ED and the urgency, focus and consequence of flow through the hospital, is different to most other areas within a large complex organisation like an acute Trust.

> The reality is, that irrespective of what happens, we must continue admitting patients through the front door." – Victor, ED Consultant (Senior Management).

ED clearly has defined pressures, to continue accepting and moving patients, but unless the same sense of urgency is followed throughout the hospital, flow through the ED is nearly impossible.

A single approach to culture, leadership style, and behaviours across the Trust is unlikely to be effective as mentioned by a Senior Manager.

> "The perception on culture may be different from the perspective of the Trust Senior Management. This is because they do not understand the pressures that we face. They just look at the targets, pressures at the back door and the reality that we must keep on admitting patients through the front door." ~ Victor, ED Consultants (Senior Management).

The majority, or 9 of the 12 semi-structured interviewees had a positive perception of the culture in the ED. They described the culture in ED as '*a culture of doing what is right for patients*' ~ Noran, ED Consultant (Senior Management); and it was acknowledged that '*ED is a busy place*' ~ Oriana, ED Consultant (Senior Management); whilst a third suggested that there are '*very good relationships in ED*' and did not recognise the allegations that there was a '*blaming culture*' but rather suggested that there was a '*good sense of openness*' in the department. ~ Victor ED, Consultant (Senior Management). This sense of openness was

echoed by another, who confirmed that the culture in ED started with the consultants, but confirmed that there were '*good working relationships, within the multi-disciplinary teams*' ~ Sancia, ED Consultant (Senior Management). However, Edmondson (2019) warns that a '*good sense of openness*' and '*very good relationships in ED*' as not referring to being a 'nice' working environment. It was argued that 'engagement, compassionate candour and accountability' (West, 2021), are key as these multidimensional factors impact organisational norms.

> "ED carries the biggest risk, it receives all or most of the patients into the Trust, yet there is not always a full understanding and support from the wider organisation, and this makes culture difficult to change." ~ Uriah, Managing Director (Senior Management).

It is the willingness to engage to consider different points of view which enables leaders to effectively change organisational culture; their own and employee behaviours; and an effective utilisation of human energy that results in sustained high-quality productivity and safety. Failing in hearing safety concerns, often results in the development of disastrous organisational sub-cultures, even in the best of organisation, which results in poor performance and poor organisation health (Keller & Price, 2011, pp. 6-16), not to mention organisational outcomes.

Other interviewees had a more optimistic perception on the culture in the department, confirming that Consultants play a key role in establishing the culture in the department, but describing the culture as '*collaborative culture*' ~ Prudence, ST 4 ED, (Middle Management). This was echoed by an ED Matron, who also suggested that the senior team plays a vital role in creating the culture, describing the culture in the department as one of inclusion, '*involving staff in decisions, as much as is possible*' resulting in a '*collaborative culture*', with '*lots of respect for each other*' where there were '*generally very good relationships*' ~ Quiana, ED Matron (Middle Management). Another reflected on the diversity in the Trust, and confirmed

that once foreign staff, were integrated and understood the way of doing things in the UK, then the culture could be described as '*being friendly, polite,* [using] *nice works*'~ Renate, Advanced Clinical Practitioner (Middle Management). It could be argued that the culture in the department is influenced by the backgrounds, nationality, and respective experiences of staff within a department, that creates a kaleidoscope of cultures which influences the norms of departmental culture.

In terms of who creates the culture in the ED, it was stated that '*culture is created by the senior team in the department*', that '*staff were involved in decision-making as far as possible*' and that colleagues have '*lots of respect for each other*'. This was contradicted in the surveys, where participants felt that whilst the ED may be a place where people work well together, with staff involvement and respect in an abundance, it was acknowledged that there are also external factors that impact the culture of the ED, and probably also that of the wider Trust, as articulated by a member of the Senior Management.

> "There are external factors that influence the culture in the department, like training or system problems, that people are aware of, but it's often beyond our control. These factors have the greatest adverse impact. This is not an excuse, but culture is impacted by a variety of elements, and it's often factors like the availability of the right levels of staff, training, or time that makes performance management difficult. You have deal with what you have." ~ Noran, ED Consultant (Senior Management).

This could be the gap between developing better work practices and therefore culture in the ED, as at present the majority view is that ED has a hierarchical culture, which some, as referenced above, would defend as essential, others argued that it is not conducive for multi-disciplinary working (MDTs) and not helpful for improved patient outcomes. Which begs the question, whether a more distributed approach to leadership, and in developing the culture within ED, rather than a top-down approach would not be more helpful? Harris (2014) argues that the collaboration and MDT working in an ED by its very nature amounts to '*distributed*

leadership' which she defines as a culture that '*cultivates and co-ordinates*' that is both a '*top-down and bottom-up*' approach for '*leaders at all levels*'. This makes for more flatter structures, with direct access to senior management open transparency and enable innovation and entrepreneurial approaches to be applied. Surprisingly, one survey returned by a senior manager in response to the survey premise that everyone in the NHS is a leader, be it to a colleague, or for patients, however, his view was different.

> "You have stated that everyone is a leader – at least to patients or colleagues, I don't see it that way" ~ Bastian, (Senior Management) Q 17.

This statement on its own is noteworthy, as if senior managers, only see themselves as the leaders, the pathfinders and decision makers, then that behaviour will set the tone for the culture within the department as confirmed by West *et al* (2015), who argues that the most important element that impact organisation's culture is leadership behaviour and this behaviour shape the leadership styles that impact both the climate and culture of an organisation (Roberts, 2005).

Other data offered a slightly different view stating that it was '*not dictatorial but more of an anarchy*'. This 'anarchy' being explained as a perpetual state of disorder (OCD, 2008), not because ED is unorganised, but because it is so busy – (Quiana, ED Matron). It was acknowledged by all interviewees that ED is a very busy place, but interviewees confirmed that the general focus and culture within ED was to ensure that the best possible urgent and emergency care is provided to patients.

It is because of this focus on high quality emergency care, not doing non-emergency work, and the reality of the pace and pressures within the ED, that the department is generally described as the entrance to the hospital, a very busy part of the hospital, because of its demanding

operational essence. This is also used to support the argument why ED could not effectively function as a democracy as one Consultant put it.

Belonging

Another factor that played into the culture within the ED was the sense that not all felt that they belonged. Some respondents indicated that they did not feel part of the ED, this was described as the consequences of the diverse composition of staff employed in the ED, and the wider Trust. It was also said that there is a perceived divide between nursing and medical staff, with a member of the middle management who was concerned about the different groups or '*cliques*' that formed within the ED.

> "There is a large culture of cronyism, with lots of little groups / cliques, with a lack of support to new members of staff from above." ~ Hayley (Middle Management) Q12.

This confirms the perceived disconnect between the senior management in the Trust and the experiences, perceptions, and realities for staff within the ED. It was acknowledged that hospitals generally in the UK employed a wide range of ethnically diverse staff, which have influential implication for both culture and a sense of belonging or diversity, as put by one member of the middle management.

> "The ethnic composition of the ED is very diverse, across all races and cultural backgrounds' [and it was noted that] management were very white [that the Trust was] not diverse in its senior management structures [at all.]" ~ Karin, ED Nurse (Middle Management).

This makes it very difficult for foreign staff, or English second language (ESL) speaking staff to integrate and to feel included within the wider workforce. Most Trusts across the UK employ

'*lots of overseas nurses*' who '*bring very different cultural perspectives to the UK*'. In this regard it was said that native staff, those staff who have been born, raised, and educated in the UK, may consider their foreign counterparts as loud '*arrogant and rude*'. One such clinical migrant confirmed that when it comes to foreign staff, '*there is a gap*' in that '*foreign staff see things differently to UK born staff*'.

It was argued, that this was less of an issue once the foreign staff have been fully integrated and understood the values and behaviours of the Trust and the ED as they adapt to the norms and practices of the organisation in which they work (Schein, 2004). However, it was acknowledged that although '*culture is difficult to change*' '*there is not always a full understanding and support from the wider organisation*' and that the '*culture is shaped by the leadership team and influence by staff experiences*' ~ Uriah, Managing Director (Senior Management) and confirmed by Bourdieu (Swartz, 1997).

The data from this study, suggests that there is a disconnect between what emerging leaders, and middle managers think about culture, in relation to the views of the senior management, especially when it comes to their sense of belonging and professional identity in the ED. The latter will be discussed in Chapter 5, whilst the former will be considered in the first instance.

As stated in Chapter 2, considering that the NHS People Plan contains a 'people pledge' (NHSE, 2020a, p. 14) with its first ambition being 'compassionate and inclusive' and its third ambition ensuring that everyone in the NHS' 'have a voice that counts' which translates to an ability to speak up without fear of consequences (A. C. Edmondson, 2003, 2019). It is also this supportive culture that Yiing *et al* (2009) referred to when they confirmed that a supportive and by extension, an inclusive culture played an influencing role on the relationship between

commitment and satisfaction (Yiing, 2009) in the workplace. In testing how inclusive foreign staff felt within the ED workforce, it was suggested that in other countries, nursing staff '*use a harsher approach*' than what was prevailing in the UK. However, it was acknowledged that once foreign staff '*were integrated, staff learned to be more patient and friendly*' with a realisation that '*ultimately, friendliness, using nice words, being polite costs nothing*'. ~ Renate, Advanced Clinical Practitioner / Nurse Consultant, (Middle Management).

> "When I came to this country, I was surprised about the politeness, the nice words, the compassionate care. That is not the case in the country where I come from, we are much more abrupt, direct and to the point. But then I realised, friendliness and compassion does not cost anything. Saying please and thank you and being nice to patients is important." – Renate, (Nurse Consultant).

Dweck (2017) explains the concept of a growth and fixed mindset and argues that a fixed mindset adversely impacts inclusivity and support of the entire workforce. This sense of belonging is not just about ethnic minority staff feeling part of the organisation, but also impact relationships between medical and nursing staff, or junior doctors and consultants.

However, Schank and Weis (2000) warns that little research has been done to fully understand values across cultures globally and as this global community has ever increasingly interconnectivity, especially in the health sectors, more collaboration towards healthcare education, delivery and research are needed.

Since the earliest reform of Health and Social Care, the evolution and emergence of 'the new public leadership challenge' (Brookes & Grint, 2010), resulted in the need for 'inter-professional education and collaborative professional practice' (Floyd & Morrison, 2014). In this regard the need to work in MDT's, requires different professional teams, from different cultural and ethnical backgrounds to be 'collaborative-practice ready'. Floyd and Morrison

(2014) review this concept in considering Bourdieu's 'field-theory' and describe this as 'inter-professional education' (IPE) and 'collaborative professional practice' (CPP) as a practice where the professionals understand their purpose and function within their 'field', irrespective of their background, culture, or ethnicity. Whilst Floyd & Morrison (2014) focused on higher education in their study, in this context, the same could be applied to health care, resulting in better health-outcomes for patients or end-users. It is this IPE and CPP that plays a vital role between medics and nurses, and inclusivity within the ED, breaking down divides, as indicated by one interviewee.

> 'I think our care is becoming more fluid, interlinked, and inclusive, so we're seeing less and less of the divide. We also have nurse consultants on the shop floor, that helps with bridging the gap" ~ Prudence, ST 4 in ED, (Senior Management).

This progress was challenged by Abigail (Middle Management), who felt that the department was not very inclusive, with a very strong '*medical and nursing divide*'. This was re-iterated by Dagmar, (Middle Management), who suggested that '*there is a strong divide between medical and nursing staff*'. Whilst Tina, (Emerging Leader), felt that '*they* [the medics] *don't talk much to the nurses*, [but they] *just expect us to follow new protocols*'. Zandria, (Middle Management), argued that there is a '*lack of understanding in practices within the ED, with decisions* [being] *made without discussing* [these] *with key stakeholders'*.

All participants in both the survey and semi-structured interviews were clear that they work in the ED for their patients and were committed to emergency care for their patients. This, they argued was only possible through effective MDT working. However, Floyd and Morrison (2014) referenced both Carpenter *et al* (2003) and Adams (2005) who identified the tensions that emerges in 'integrated service teams' and the reality that professional judgement is often

diminished due to the relevant professional's ability to reach agreement on collaboration, which may not always be in the interest of the end-user (p. 39) or the patient.

It was also confirmed that the impact of male dominance, power and politics was a challenge in ED. One ED consultant argued that '*the clinical body within ED are a very close and cohesive group*', they did not have as strong a voice as they should have across the organisation, and '*other voices are still the predominate voice of the trust*'. In addition, hereto it was acknowledged that females across '*very senior leaders are few in number*', which as a female, makes challenge more difficult. ~ Oriana, ED Consultant (Senior Management). Four of the twelve participants in the semi structure interviews or two middle managers, and two senior managers reported that the '*male female share is disconnected*' they were of the view that they work '*in a man's world*' and they attend '*man meetings*'.

> "As female consultant, I am not a shrinking violet…, however, it's still very intimidating even for somebody like me to have that many men in a meeting, and you are the only female voice in the room. The female presence in senior management is good, but the clinical landscape at senior level is still very male dominant.'– Oriana, (ED Consultant).

Considering the feedback from all participants, i.e., that the culture in the ED is predominantly a hierarchical society, the data in this study has parallels with Yosso's (2015) review of CRT and Bourdieu's insights into 'a hierarchical society'. Yosso (2005) challenged Bourdieu's views on 'white culture' and the concept of 'cultural capital', as defined in Chapter 2. This is due to what Bourdieu described as the required 'cultural capital' needed today to ensure acceptance and effective progression. Yosso (2005) critically challenged the concept of culture in asking 'who's culture has capital?'. In her challenge of "Bordieuan cultural capital vs. community cultural wealth" (p.70), Yosso (2005) reflected on the racial insights of the American Sociologist DuBois (1989), and suggest that CRT offers a framework to explore,

challenge and hypothesises on the way that race and racism impacts organisational culture and the social structures of modern society.

In addition to the perception of culture, and the sense of belonging, a senior management argued the following:

> "[It] absolutely plays a part in how people considered me, as a lot of people find it surprising there is a black individual holding this post in the organisation and even when I came into this organisation as senior manager, the Trust definitely had never had a black person in this role. The race issue, for me as a leader and what it means for other people, it confirms 'you can do this, it is possible to achieve it', but also it has made me very open to having conversations that traditionally were difficult for people." ~ Uriah, ED Managing Director, (Senior Management).

It is this continuation of tensions, between the ever-changing demographics of the NHS and the wider UK population; followed by the persistent calls since 2004 for an inclusive and representative workforce that is characteristic of both the people that the NHS lead and the communities it serves, that contributes to participants in this study's perception, of not belonging or not being heard in the NHS.

It should be acknowledged that staff in the ED came across as very passionate about their work and the impact that they have on patients. The ED's composition of staff is clearly multi-disciplined and multi-racial, with a variety of specialities, different roles and bandings across the ED. Participants in both the survey and the semi-structured interviews confirmed that staff in the ED are committed to, and concentrate on the delivery of high-quality emergency care, with a clear focus on doing emergency work. This was irrespective of whether they were nursing, allied health professionals or medical staff.

Communication

The third theme that emerged from the data in this study was the importance of communication, and how this influenced culture both at micro and macro level. It was argued that understanding what needs to be done, and importantly 'why' it was to be done (Sinek, 2009), enabled staff to develop a sense of professional curiosity, asking questions, empowering them to learn. However, it was also indicated that communications underpinned a variety of other elements that contributed to the experiences, perceptions, and realities of staff in the ED.

Pun *et al* (2015) resolved that communication could 'compromise patient safety' it was confirmed that clarity in communication in an ED is essential. This was qualified in a question asking survey respondents to confirm their view about 'the ability to comprehend instructions…', in terms of the clarity in which line managers communicate within the department (Pun, Matthiessen, Murray, & Slade, 2015).

Whilst it was argued that communication is perceived to be poor in the ED, *Table 4.2* below confirms that the majority of survey respondents **30** [83.3%] thought communication in the ED was positive (i.e. between moderately clear to extremely clear).

Table 4.2 Communication, Role Enjoyment and Challenges [Q7, 8 & 10]

	Emerging Leaders		Middle Management		Senior Management		Total	
How clear is communication in the Emergency Department? [Q7]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Extremely clear	2	5.6%	0	0%	1	2.8%	3	8.3%
Quite clear	8	22.2%	5	13.9%	4	11.1%	17	47.2%
Moderately clear	4	11.1%	4	11.1%	2	5.6%	10	27.8%
Slightly Clear	1	2.8%	4	11.1%	1	2.8%	6	16.7%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
How enjoyable is your role? [Q8]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Extremely enjoyable	3	8.3%	1	2.8%	3	8.3%	7	19.4%
Moderately enjoyable	7	19.4%	9	25%	0	0%	16	44.4%
Quite enjoyable	3	8.3%	3	8.3%	4	11.1%	10	27.8%
Slightly enjoyable	2	5.6%	0	0%	1	2.8%	3	8.3%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
How challenging is your role? [Q10]								
	n	***%***	***N***	***%***	***n***	***%***	***n***	***%***
Extremely Challenging	10	27.8%	5	13.9%	5	13.9%	20	55.6%
Quite challenging	4	11.1%	5	13.9%	2	5.6%	11	30.6%
Moderately challenging	1	2.8%	3	8.3%	0	0%	4	11.1%
Slightly challenging	0	0%	0	0%	1	2.8%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**

Table 4.2 Communication, Role Enjoyment and Challenges [Q7, 8 & 10]

Most emerging leaders **14/15** (93.3%) responded positively about communication in the ED. **9/13** (69.2%) of middle management were also in agreement, whilst **5/8** (62.5%) of senior management indicated that communication within the ED was positive. From the semi-structured interviews, it was confirmed that similarly to culture across various EDs, communication will differ from ED to ED as well. The data from the semi-structured interviews confirmed that **5** of the twelve participants talked about communication in their ED's. In this regard **3** of the five were positive about communication, indicating that staff are not shy to speak up.

> "People speak up in the ED my lot come to me all the time for help or advice. Ultimately, I can't fix problems if people don't tell me about them, equally, people need to be willing to speak up, we all carry that responsibility." ~ Oriana, ED Consultant, (Senior Management).

Others indicated that the ED '*leadership is very supportive and compassionate*', confirming that especially during the pandemic communications focused heavily on a constant message of '*look after yourself and look after each other*' ~ Prudence, ST4 in ED (Middle Management); whilst another submitted that '*within the department, I have nothing but positive experiences*' ~ Victor, ED Consultant (Senior Management). **1/5** (20%) made negative comments about communication, in that '*people speak with the matron, but not always to their band 7s*' ~ Quiana, ED Matron (Middle Management), suggested that communication upwards seems good, but sharing the message lower down could be improved; whilst **1/5** (20%) indicated that '*we send out lots of information, but more could be done in informing and updating the team*' ~ Sancia, ED Consultant, (Senior Management).

Sinek *et al* (2017) argues that the best communication strategy or training interventions would not make a significant difference in altering human behaviour, without a clear understanding about why people do what they do. Clarity of communication within the ED is key to enable, empower and inspire staff on the shop floor in responding appropriately in achieving their shared goal of providing emergency care. However, it was argued that '*not all staff have that professional curiosity*', or feel comfortable to challenge in asking '*why?*' ~ Noran, ED Consultant, (Senior Management).

Whilst Roberts (2005) and Scheffer (2018) contends that leadership is 'about choices' and advocates the 'consciousness of leadership' in that leaders inspire the people they lead to 'choose to use their time and energy' constructively in pursuit of and achieving 'a shared goal'.

This proactive and deliberate 'choice', also constructively contribute to improved levels of 'accountability' (Roberts, 2005, p. 113). Roberts (2005) offers seven elements, essential for effective human behaviour. These are, (1) clear and innovative measures in reporting performance; (2) value adding and effective appraisal systems; (3) well designed 360 degree feedback systems; (4) clearly defined process and behavioural standards; (5) effective communication and planning; (6) realistic and appropriate organisational structures, that will enable managers to manage and promote accountability at all levels of the organisation; and (7) clearly defined and communicated, but not overly prescriptive, job roles and responsibilities, that enables managers to be innovative, flexible and creative. Roberts (2005) suggests that to transform organisational culture, it is necessary to change the systems driving behaviour and those systems are defined as 'anything that drives ways of doing things' (Roberts, 2005, p. 115). He concludes that it is essential for leaders to understand their own consciousness, their personal place and purpose in the organisation (Frankl, 2004; Roberts, 2005, pp. 113-119). However, this is not always that simple as stated by one of the ED Consultants.

> "As with all things, there's never enough time in the day, because we have a 24/7 system. Often, it's very difficult to capture everyone to communicate to all in the same room at the same time. Someone will be on days and similarly others on nights." ~ Noran, ED Consultant, (Senior Management).

When asked how enjoyable survey respondents found their job the majority **33** [91.7%] felt their job was moderately to extremely enjoyable. In this regard **13** [100%] of middle management found their roles between moderately to extremely enjoyable, followed by **7** [87.5%] of senior managers and **13** [86.7%] of emerging leaders. However, **3** [8.3%] respondents; or 2 emerging leaders and 1 senior manager, argued that they only find their job 'slightly enjoyable'.

Yiing *et al* (2009) concluded that leadership behaviour played a significant role in organisational culture and if the leaders enjoyed their role, it was likely that the people they lead would find their roles enjoyable as well. Castro & Martins (2010) conducted a South African study that established a positive link between organisational climate and job satisfaction, and concluded that different biographical groups have different needs, which impact the behaviour of staff which translates into the enjoyability of their roles. Whilst another South African study examined the relationship between leadership and how they shaped organisational climate (Eustace & Martins, 2014). Eustace and Martins (2014) made a distinction between 'culture' and 'climate' and argued that 'culture' establish the basis on which management systems are developed, i.e. the 'values, beliefs and principles' that determines how people 'behave'; whilst 'climate' was the enjoyability of coming to work, how it 'feels' to be part of the organisation which are influenced by the 'perceptions of organisational structures' and its impact on the organisational or departmental atmosphere.

In probing what the most enjoyable elements of roles in the ED were, with multiple options for answers, it was noted that the most enjoyable aspect of working in the ED was identified as 'helping people in need', **28** [77.8%]; **27** [75%] indicated that they enjoyed 'making a difference in people's lives'; **22** [61.1%] stated that they enjoyed 'working in a fast-paced environment'; **19** [52.8%] liked 'making a difference to the staff they lead'; **3** [8.3%] confirmed they either enjoyed 'all the options available' or 'the diagnostic challenges', respectively; whilst **2** [5.6%] respondents indicated that 'there [was] no real enjoyable aspects in [their] role'.

When asked how challenging respondents found their job the majority **33** [91.7%] felt their job was moderately to extremely challenging. These were divided as follows: **15** [100%] of emerging leaders; and **13** [100%] of middle management; with **7** [87.5%] of senior management. Investigating the detail of these challenges being experienced in an ED from an operational, developmental and education perspective, the majority or **24** [66.7%] respondents indicated that 'time management' was the most challenging aspect of their role, followed by half of respondents **18** [50%] reporting that the 'unrealistic expectations from Trust Executives' were particularly challenging. **17** [47.2%] confirmed that 'having difficult conversation' were challenging, with **14** [38.9%] submitting that they found 'keeping abreast with best practice' challenging, and **13** [36.1%] considered the 'leading and management of staff' as challenging. **12** [33.3%] felt that 'working both across different medical disciplines' and/or 'working with other ED staff' were equally challenging, whilst **11** [30.6%] submitting that they found 'financial management and budgetary control' challenging; **10** [27.8%] reported that 'strategic leadership' was challenging, whilst **8** [22.2%] indicated that they found both 'coaching and mentoring' [of staff] and 'transformational practice' to be difficult, whilst **7** [19.4%] found 'human resources procedures and systems' challenging. **[5]** 13.9% indicated that 'quality impact assessments' were challenging; whilst the balance of respondents, 4 [11.1%] confirmed that 'the management of patient's expectations', 'understaffing in the department', 'time pressures', and the 'lack of support or empathy form the Trust senior team' was very challenging, with the remaining few feeling that they found 'value adding appraisals' and/or 'emotional intelligence training' and the 'chairing of meetings' as challenging. It was said that more should be done in preparing clinical leaders for their roles and explaining the career path available. This was articulated by one of the senior management.

> "Nobody really sits you down as a consultant and help you plan your next steps as a clinical leader. I think this should start much earlier and maybe someone should sit down with new consultants and help co-design their pathway, it's not clear or easy at the moment." ~ Sancia, ED Consultant (Senior Management).

Considering what participants in the survey said about communication, ***Table 4.3*** *below* confirms that communication or 'interaction' with other clinical leaders across the Trust as positive, with **11/13** (84.6%) of middle management; **12/15** (80%) of emerging leaders and **5/8** (62.5%) of senior management describing their interaction with other clinical leaders across the Trust as positive.

Table 4.3. Interaction [Q24]

	Emerging Leaders		Middle Management		Senior Management		Total	
How would you describe your interaction with other clinical leaders across the Trust? [Q24]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Extremely positive	3	8.3%	3	8.3%	4	11.1%	10	27.8%
Moderately positive	9	25%	8	22.2%	1	2.8%	18	50%
Neither positive or negative	2	5.6%	1	2.8%	2	5.6%	5	13.9%
Moderately negative	1	2.8%	1	2.8%	1	2.8%	3	8.3%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**

Table 4.3 Interaction [Q4]

Most of the survey participants **28/36** (77.7%) confirmed that their interaction with other clinical leaders across the Trust was moderately to extremely positive.

It is this level of communication that is an essential element when it come to the effective and professional functioning required of MDT's to be successful and efficient in the execution of their work. Archer *et al*, (2008) considered the definition of Arnold and Stern (2006) of what professionalism is in a medical setting and argued that the concept is based on (1) clinical competence; (2) communication; (3) skills; and an understanding of both legal and ethical issues (Archer et al., 2008, p. 773), [underlining added]. It is the importance of communication

that was identified as a problem in decision making with its consequence causing a resistance to change.

> "People resist change because they don't' feel they've been involved in the decision making, and that, I think is a big problem," ~ Karin, ED Nurse Practitioner, (Middle Management).

Johan (Emerging Leader) suggested that communication between the ED and the wider Trust could improve, that senior management should '*promote staff initiatives*' as this encouragement, he argues, would also contribute to an update of '*patient responsibility*' to promote the prevention agenda in reducing the demand on ED. It was also suggested by a participant in the semi-structured interviews that communication between consultants and junior doctors could improve, as '*they feel frustrated that they are not lead, managed, or supported by the consultants*' ~ Madeleine, ED Registered Nurse, (Middle Management).

> It is important that management let us know what happens in the department. At present we see 450 patients per day, with the same level of staffing since 2019. There were rumours that an increase of headcount was approved, but we are not sure. One of the consultants asked me if I have had confirmation from management when the new staff will commence, but the reality is that we don't know, communication is that poor.' – Madeleine, ED Registered Nurse, (Middle Management).

However, it was noted that **4** of the 12 [33.3%] participants in the semi-structured interviews reflected on communication with only one [8%] of them indicating that communication was poor. The others confirmed that whilst there have been historic challenges with communications, with various levels of organisational development initiatives being offered, most were of the view that more recently lots of efforts have been made to improve internal development and communication within the Trusts and its respective departments.

From the above, it is evident that communication is a key requirement for leaders and staff, and whilst good progress has been made, with improvements in communication at all levels, there were reports that communication remains poor, be it a perception, fact, or the reality of some, albeit a few.

Accountability

The NHS focus on performance targets has been a theme that was very evident from the qualitative feedback in the survey, whilst participants in the semi structured interviews confirmed their concerns about the performativity and associated accountability of the NHS. In this regard one member of middle management raised her concerns.

> "With a tough focus on task and meeting the four-hour target, rather than doing what is right for patients." ~ Dagmar, (Middle Management).

Performativity or performance matrixes in the NHS and wider public sector is an essential requirement for public services to ensure both politicians, their electorate, and the wider British public, get value for their tax-payers money. It is with this in mind that respondents indicated that there is no criticism against performance targets but felt that the four-hour target was just unrealistic.

> "This is not a criticism of the department but more the unrealistic goal of achieving a target that does not take into account that blood results take 2 hours, imaging sometimes longer." ~ Dagmar, Middle Management, (Q12).

Keller *et al* (2011) contention was that performance focused leaders invest greatly in the effort of delivering organisational targets, but neglect to focus on the position of their organisational health. This, was also confirmed by one interviewee, who stated the following:

> "[Performance targets] is everyone's responsibility, we all have a role to play and so when we don't make these targets everybody feels like they're the ones focused on. It is here that there exists the blame culture, of you guys are not performing and we're not meeting these targets, so you're to blame for that." ~ Karin, ED Nurse Practitioner, (Middle Management).

Six of the twelve participants [50%] in the semi-structured interviews confirmed that there were different aspects to power and politics that impact the performativity of the ED, as '*staff are aware of the politics but don't always relate to it*'. ~ Quiana, ED Matron, (Middle Management).

> "It is challenging when performance decisions are made based on political agendas and you do not agree with these decisions. But, even if I don't agree, if I understand what's been decided and why it needs to happen, then it's easier to share [that] with the team and implement the change…" ~ Quiana, ED Matron, (Middle Management).

It was this 'power' that Somoye (2016) referred to as an important phenomenon in any organisation and defines "the ability to control people or things" (Somoye, 2016, p. 566). The lack of joint ownership of the performance of the ED as a department of the wider Trust was identified as a longstanding problem in acute Trusts, and whilst it has improved in some Trusts, it was submitted that this remains, a significant challenge in other Trusts. An ED Consultant illustrated this as follows.

> "It's ED's problem, it's taken a long time to persuade the whole organisation that it's an organisational target that we can't see people quickly, if we can't physically see them, because they're not moving through. If the back door is closed, the front door will glogg-up." ~ Sancia, ED Consultant, (Senior Management).

Reflecting on the concept of influence, Somoye (2016) suggests that this is the result of exercising power. He referenced Pfeffer (1992, p.30) who drew a distinction between power and politics and define the latter as 'the processes' or 'actions' that influence or direct people's behaviour into a requisite outcome or result. He concludes that the utilisation of power in a professional way, is vital to ensure that organisations are achieving its performance targets and demonstrating its accountability for these performance targets. Irrespective of the views of the four-hour target, it was acknowledged that having performance targets are important and does contribute to positive outcomes for patients.

> "Having performance targets are important, and we continue to subscribe to them. If you don't try to get things done within a four-hour window, you'll just never get anybody out. It keeps you focused and whether we have a four-hour target, or a six-hour target or the anticipated twelve-hour target, it is important to ensure flow through the department." ~ Sancia, ED Consultant, (Senior Management).

ED's still has a four-hour target as a minimum waiting period for patients to be seen. Some reported that it did not matter what ED staff know, but rather how quickly they could get the job done, moving people out of the department, not focusing on quality of care, but rather on the four-hour target. This complexity influenced by internal and external factors creates the climate of the organisation at its various levels (Kazmi & Naaranoja, 2015). This was illustrated by an ED lead nurse and confirmed by an ED Consultant who argued that there is a disconnect between the wider hospital and ED, that could result in a dualism of cultures.

> "In ED, we think we are special, but we are not really; we just feel the wider Trust do not understand our world." ~ Tara, Lead Nurse for ED (Middle Management)

> "Culture is created by the Trust Executives (in theory), but in the department, I think culture starts with us, the ED leadership. Historically, we had a very strong blame culture, about the four-hour target, and flow through the ED, but this was normally done by people who never came into ED, and do not understand the department." ~ Sancia, ED Consultant (Senior Management).

Whilst the staff may feel they are special, it was acknowledged that they form part of the larger focus, ambition, and purpose of the Trust. Regardless of these challenges there were a spectrum of participants from emerging leaders to senior managers who were of the view that the ED was an 'exciting place to work'.

> "The ED is a very exciting place to work, but we need more resources, and interest from senior management to improve not just the 4-hour wait but overall experiences for the staff and patients." ~ Cailon, Emerging Leader, (Q12).

Some of these sentiments were confirmed by Gerhard (Senior Management) who re-iterated that the ED is '*an exciting place to work*' but like his colleague, offered suggestions that the department '*needs more resources, and interest from senior management to improve not just the four-hour wait, but overall experience for the staff and patients*.' ~ Gerhard, (Senior Management). Tara, ED Lead Nurse (Middle Management) suggested that the culture in the Trust is a '*good and supportive one*', whilst she contends that culture is shaped by the team; colleagues; staff shortages; and patient challenges; yet staff return to the ED week in and week out, because to them it's like '*family*'.

> "When it comes to culture, I think the staff will say that it's about the team they come to work with, because of the team and because of their colleagues, that's what keeps them going and that's why they keep coming back. They will tell you about the staffing about how busy it is about some of the less pleasant patients we have, and I think they will say that makes me come back on a Monday morning is my colleagues, my team it is like my work family." ~ Tara, ED Lead Nurse (Middle Management).

4.3 Conclusion

The above confirms that culture is created by the values and behaviours of people and as the behaviours are more supportive of the values, the culture improves (West et al., 2015; Yiing, 2009). Ultimately, the data in this study suggested that the four thematic groups that emerged under culture were leadership behaviours, belonging, communication, and accountability.

Participants all had different views on the culture of their organisation and their department. The emerging leaders, who participated in the survey, but regrettably not in the interviews, were of the view that the culture of the ED was bureaucratic and autocratic, whilst middle managers thought it was compassionate and hierarchical. The senior management from both the surveys and the semi-structured interviews argued that the culture was across the full spectrum including collegiate, compassionate, situational, transformational, hierarchical, and autocratic.

Regardless of the perception of the cultural style employed in the ED, the reality remains that culture is multi-facetted, influenced by values, behaviours, perceptions, and experiences. The organisational purpose is intrinsically grounded in the values and behaviours, and the perceived experiences of staff in this regard is impacted upon by organisational norms at both micro and macro level (Dixon-Woods et al., 2013; Oliver, 2006).

Graphically the influencing factors of organisational culture could be reflected as follows:

Fig. 4.1 Influencing factors on Organisational Culture

It was said that to effect a change in people's behaviour leaders need to be inspirational, clear with their message (Kotter, 1995), and understanding their place and purpose (Frankl, 2004). Communication is key to enable staff at all levels of the organisations to understand what the ask is and why it is important (Sinek, 2009). Organisational culture is shaped by a sense of belonging within the department, of all who works there (NHSE, 2020a). How people are communicated with and how people perceive they are being treated (Dixon-Woods et al., 2013; Hougaard et al., 2022). It is the manner in which they are being held to account for their actions, their delivery of high-quality care, and their contribution within the department, which must be within their circle of control (Covey, 2004), whilst all staff must have a voice with the ability to speak up (A. C. Edmondson, 2003).

Whilst there may be a variety of different indicators to measure culture in an organisation or department, from the data in this study the following framework is offered to measure culture.

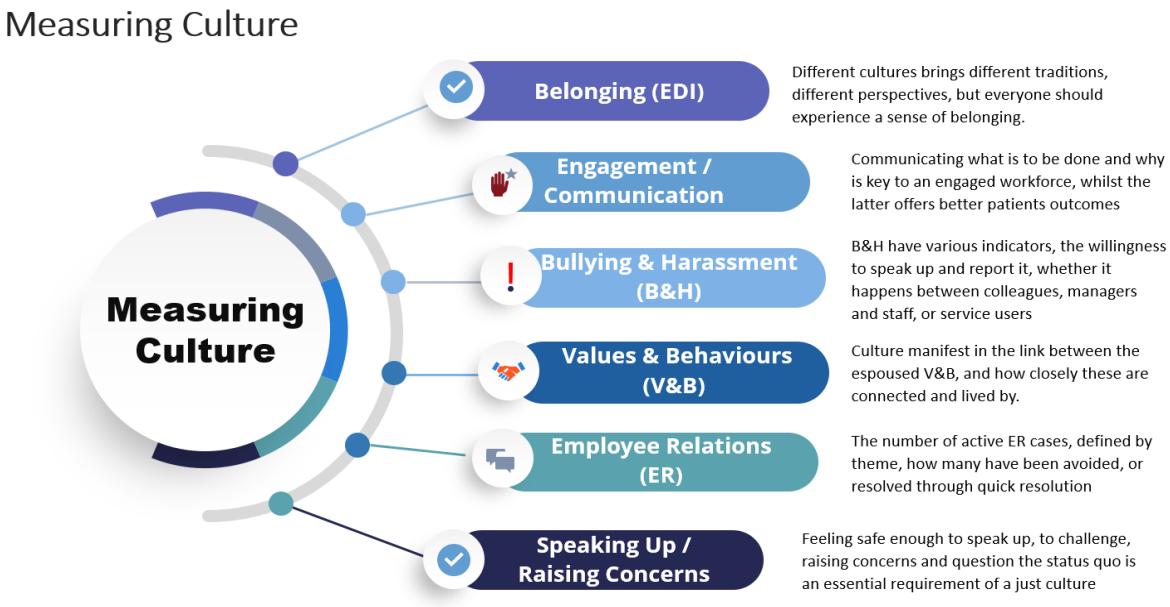


Fig. 4.2 Framework for Measuring Culture

Culture as a concept has little more meaning than a linguistic term, without the supporting values and behaviours to give culture its true purpose. Staff pressures, time pressures, multi-disciplinary teams' functionality, and each individual's purpose of being are all factors that play into the micro and macro level culture of a department and/or organisation (Loke, 2001).

The reality of our global community has made the composition of the modern workforce multinational, multi-cultural, multi-racial, and multi-linguistic, with all its associated diverse values and behaviours (Kazmi & Naaranoja, 2015).

The performativity of the public sector is a fundamental part of government lead services, (Keller & Price, 2011). It is important to measure value adding, and return on investment for stakeholders, be it the wider public, taxpayers, shareholders, or interest groups. This sets the scene for effective accountability, however, the performativity of the public sector, should be influenced and set by suitable and operational experienced clinicians who has the best interest

of the patients at its hart. It should not be shaped by regularity staff, who often have never worked a day in the ED, and who are heavily influenced by the political agenda of the day.

The uniqueness of these frameworks set out in ***Fig. 4.1*** and ***Fig. 4.2*** respectively is because they are created from the literature and data of this specific study. They consider internal and external factors that impacts culture (Brookes & Grint, 2010; A. C. Edmondson, 2003, 2019; Somoye, 2016) and offers a measurement framework to evaluate the culture of a department or organisation (Dixon-Woods et al., 2013; Hougaard et al., 2022; West, 2021). They bring various perspectives together to better understand the influencing factors of organisational culture and offer a methodology to measure culture in an organisation or department.

4.4 Next Steps

The next Chapter will continue to explore the data of this study and the second element of the conceptual framework, being professional identity and how this impact Clinical Leadership.

CHAPTER 5: RESULTS AND DISCUSSION ~ PROFESSIONAL IDENTITY

5.1 Introduction

The purpose of this chapter is to present and discuss the data relating to this study's main research question, with specific refence to the second element of the conceptual framework, being 'professional identity', and how this impact the research question, being :

> What are the experiences and perceptions of leadership education and development for clinical leaders in the Emergency Department (ED) of an English NHS Acute Trust?

In addition to the research question, the second supplementary question that will be addressed in this chapter is:

> SQ 2. How are their personal and professional identities influenced by their experiences of leadership, leadership development and education?

As the world came through Covid, unemployment searched and resulted in large numbers of people having to redefine their personal and professional identity. This was most evident from people who had to consider alternative career paths to secure more sustainable employment. In this regard, the NHS has seen an influx of staff from the aviation industry, retail, hospitality, and voluntary sectors who have all stepped up to support the NHS in these challenging times. Airline pilots reinvented themselves in becoming data analysts, with retail and hospitality staff becoming health care support workers among other roles.

Mullins (2005) suggested that job satisfaction is a complicated and multidimensional concept, and defined it as being "more of an attitude, an internal state" that could be associated with "personal feelings of achievement" (Mullins, 2005). This "complicated multidimensional concept" is influenced by external factors and if there are imbalances to the reality and needs of people, then humanity can go to extraordinary lengths to achieve their personal needs. As if in a state of war. It is this equilibrium that Dartey-Baah & Harley (2007) suggested organisations should endeavour to align, to establish a good balance, between individual needs and organisational goals (Dartey-Baah & Harlley, 2007).

In the survey and from the semi-structured interviews, participants demonstrated a large spectrum of issues, characteristics or perceptions that influenced professional identity, ethical dilemmas, and professional behaviour. It is these themes that will be explored in more detail during this chapter.

5.2 Professional Identity

Beijaard (2004) articulated some of the characteristics of what professional identity is and reference various studies to describe the discourse around perception of what professional identity means to the individual. From the analysis of the data from both the surveys and the semi-structured interviews, some clearly articulated elements emerged, which are:

- Various Perceptions of professional identity
- Ethical dilemmas
- Influencing factors

- Professional behaviours

These themes or elements that influenced culture, are expanded on in the following sections.

Various Perceptions

From the various studies explored by Beijaard *et al* (2004) a variety of perceptions on professional identity were defined as (1) job-satisfaction, where participants consider their role as 'important, attractive and in harmony with other roles' (Moore and Hofman, 1988); participants (2) 'perception of autonomy' (Siraj-Blatchford, 1993); (3) 'dynamic changes over time' impacted by 'relevant features of the profession' (Beijaard, 1995); and issues related to the profession, 'common to all teachers at a general level' (Beijaard, 2000), submitting that 'subject matter, didactic and pedagogical expertise' all contribute to professional identity. Beijaard *et al* (2004) referenced various authors who have tried to described the concept as being 'similar to professional reality' (Goodson & Cole, 1994); that is 'open for continuous redefining' and is not a set of pre-defined characteristics which are common to all professionals (Sugrue, 1997); or a 'complex and dynamic' balance *vis-à-vis* 'personal self-image' and the 'roles one feels obliged to play' (Volkmann & Anderson, 1998). Ultimately, they concluded that professional identity is 'not a fixed' or a stable entity' but a means used by professionals to make sense of the context in which they operate (Coldron & Smith, 1999).

Samuel & Stephens (2000) offered a South African perspective in their attempt to define professional identity as "competing and sometimes contradictory values, behaviours and attitudes grounded in the belief experiences of the self in formation". It is these attitudes and beliefs that an ED Consultant reflected upon when submitting the following:

> "Thinking about delivering the task, be it by nurses or doctors, I think our junior doctors can be challenging. I must remind them that they can do their own bloods and clean up after themselves. My goodness, it's like teaching toddlers. And they are the Consultants of the future." ~ Oriana, ED Consultant (Senior Management).

This was confirmed by Neary (2014) who defined personal identity as "the concept which describes how we perceive ourselves within our occupational context and how we communicate this to others" (Neary, 2014, p. 14).

However, some respondents felt that they haven't really thought much about what their professional identity meant to them and argued that the concept of professional identity has never really been a consideration.

> "I've never really considered the idea of professional identity. I consider identity as much more intrinsic, and don't relate to the externality of a profession as a factor in contribution to my identity." – Bastian (Senior Management) Q14.a.

To understand what professional identity means for clinical leaders, participants were offered a multiple number of options to select, with three potential responses, being, 'Agree'; 'Partly Agree'; and 'Disagree'.

Table 5.1 As a clinician, what does professional identity mean to you? [Q13]

	Emerging Leaders		Middle Management		Senior Management		Total	
Working in a particular clinical role								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Agree	13	36.1%	8	22.2%	7	19.4%	28	77.8%
Partly Agree	2	5.6%	5	13.9%	1	2.8%	8	22.2%
Disagree	0	0%	0	0%	0	0%	0	0%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
Working in a particular clinical setting (organisation)								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Agree	10	27.8%	5	13.9%	2	5.6%	17	47.2%
Partly Agree	5	13.9%	6	16.7%	4	11.1%	15	41.7%
Disagree	0	0%	1	2.8%	2	5.6%	3	8.3%
Blank	0	0%	1	2.8%	0	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
Following the standards / competencies as defined by a professional / regulatory body								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Agree	13	36.1%	9	25%	5	13.9%	27	75%
Partly Agree	2	5.6%	2	5.6%	2	5.6%	6	16.7%
Disagree	0	0%	2	5.6%	1	2.8%	3	8.3%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
Following the codes of ethics / conduct requirements defined by a professional/regulatory body								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Agree	13	36.1.%	11	30.6%	5	13.9%	29	80.6%
Partly Agree	0	0%	0	0%	1	2.8%	6	2.8%
Disagree	2	5.6%	2	5.6%	2	5.6%	1	16.7%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
How an individual clinician makes sense of what they do								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Agree	10	27.8%	7	19.4%	5	13.9%	20	55.6%
Partly Agree	3	8.3%	4	11.1%	2	5.6%	11	30.6%
Disagree	2	5.6%	1	2.8%	1	2.8%	4	11.1%
Blank	0	0%	1	2.8%	0	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
For me 'professional identity' has another meaning								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Agree	1	2.8%	1	2.8%	0	0%	2	5.6%
Partly Agree	1	2.8%	3	8.3%	2	5.6%	6	16.7%
Disagree	11	30.6%	7	19.4%	5	13.9%	23	63.9%
Blank	2	5.6%	2	5.6%	1	2.8%	5	13.9%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**

Table 5.1 What Professionality Identity Means {Q13}

Table 5.1 above confirms that '<u>following the codes of ethics / conduct requirements defined by a professional / regulatory body</u>' is the strongest influencer for personal and professional identity.

In this regard, **29** [80.6%] participates agreed with this statement, represented across the three groups as follows, with the Emerging Leaders the highest at **13** [86.7%], with **11** [84.6%] of

Middle Management and **5** [75%] of Senior Management all confirming that the ethical codes of their professional or regulatory body influenced and shaped their professional identity the most. The other stronger indicators in descending order respectively, were noted as follows:

- **28** [77.8%] indicated that working in 'a particular clinical role' defined their professional identity;
- **27** [75%] confirmed that following 'the standards or competency as defined by [their] professional or regulatory body'; or
- **22** [62.9%] indicated that their professional identity is shaped by and 'how clinicians make sense of what they do'.
- **17** [48.4%] participants confirmed that their professional identity is shaped by 'a particular clinical setting (organisation) they are working in**'**.

Regarding the impact of 'becoming a leader' on professional identity the following were noted:

Fig. 5.1 Becoming a Leader and Personal and Professional Identity

Figure 5.1 above suggests that nearly half of participants, or **15** [41.7%] confirmed that becoming a leader impacted both a '<u>moderate amount</u>' and a '<u>great deal</u>' in terms of their professional identity. Whilst only **5** [13.9%] and **1** [2.8%] reported '<u>a little impact</u>' and/or '<u>no impact at all</u>' respectively. From the semi-structured interviews, it was noted that **9** of the twelve interviewees confirmed that becoming a leader had a positive impact on their professional identity. In this regard, they reported that for them it was '*about recognition and about respect*', a '*process of development*' and an understanding why clinical leaders do what they do. Some have indicated that they have become '*more diplomatic*' ~ Karin, ED Nurse (Middle Management), with other staff looking at them differently and therefore they are much '*more mindful of what* [they] *do and how others perceive* [them] ~ Noran, ED Consultant (Senior Management)'. This perception of others places a huge responsibility on clinical leaders who have describe the transition from clinician to clinical leader as '*a huge jump*', as they no longer have a single individual in front of them who requires their attention, but an '*entire department or section*' for which they hold the responsibility ~ Prudence, ST 4 in ED.

> "Every so often you get imposter syndrome thinking, why am I here; can I do this; and this isn't' really what I signed up for. Because I think when you are at medical school, you only think about diseases and the pathology rather than the system of healthcare." ~ Noran, ED Consultant (Senior Management) Q14.a.

Another reported that it was only when she became a middle manager, that she realised her own potential in comparison to what she believed she was capable of. She '*did not fully realise what potential*' she had to make a difference ~ Quiana, ED Matron (Middle Management). Others describe their ascent to leadership as interesting as they noticed more people '*recognised*' them ~ Luann, ED Consultant (Senior Management), whilst another played it down as a '*natural progression*' but immediately confirmed that '*first and foremost, I remain a nurse*' ~ Tara, ED Lead Nurse (Middle Management).

> "If I write to other Trusts, as a consultant, I think I get more of a response now rather than five years ago, before I became a consultant." ~ Luann, ED Consultant (Senior Management).

Three of the nine clinical leaders, who reported a positive change in becoming a clinical leader were clear that ultimately, irrespective of their title, they remained a nurse at heart. Regardless of the title of these clinical leaders, one lead nurse confirmed that irrespective of what she may be called, she continued to see herself as nurse.

> "Being a leader does not change how I see myself. I remain foremost a nurse. However, I also believe that everyone has leadership abilities. I have a band 3 who does an amazing job in her field, and as far as I'm concerned, she leads the way in her area of responsibility. The role modelling from her is no different, because she's a band three, to me as lead nurse." ~ Tara, Lead Nurse in ED (Middle Management).

Those who were less positive about their professional identity because of their professional or leadership role, reported that they did not find their role as leader coming naturally and confirmed that it was important for them to know what is required of them and importantly why. This, as was confirmed in Chapter 4 enabled them to explain the rational of the ask to their teams (see Sinek, 2009; Sinek et al., 2017). Another reported that she was called in the office and told that it was time for her to be a clinical leader, no discussion, no choice, just told, and then rose to the occasion, although the organisational memory and ability to change with the times remains challenging.

> "Male consultants generally get things done quicker, i.e., their bloods are done much more prompt than their female counterparts, due to the institutional memory. The Trust respect, remember and respond to the male consultants much better than to the female consultants. I have taken over from my male predecessor several years ago, but they still write his name on the requisition. As if he requested the bloods, or tests. So, the organisational memory takes a really long time to change, especially when past personalities have been fairly dominating." ~ Oriana, ED Consultant (Senior Management).

In exploring what professional identity means for survey participants, the data in this study, as set out in ***Table 5.1*** above, confirmed that **28** [77.8%] participants agreed that 'working in a

particular clinical role' was one of the strongest factors impacting this statement. In terms of the three groups of interviewees, the Emerging Leaders were the strongest, with **13** [36.1%] or 86.7% of this group confirmed that they agree most with this statement. They were followed by Middle Management, with **8** [22.2%] or 61.5% of this group, and **7** [19.4%] of Senior Management or 87.5% of this group, all agreeing that 'working in a particular clinical role' meant the most to them when it comes to professional identity. This was confirmed by interviewees who indicated that working in a particular role 'heavily influenced' how they see themselves and defined their professional identity. As one middle manager submitted:

> "As a team leader in the emergency department I am influenced by my role. I have a uniform which depicts my role and often it is reflected in my interactions with others." – Dagmar (Middle Management) Q14.a.

Other interviewees felt that their professional identity comes from their regulatory body, which impacts and defines the type of job they do, with its associated requirements in which post holders should conduct themselves.

Ethical Dilemmas

Although there is a intertwine-ability of the concepts of ethics, values and behaviours, and professionalism, and whilst these are different concepts, they often share the same characteristics. Salloch (2016), however, described a distinction between professionalism and ethics. The former, is the ability for specialised workers with specific skills to organise their work; whilst the latter considers the ethos or character that is expected from specific individuals. Salloch (2016) warns against the narrowing of the gap between ethics and professionalism, especially when it comes to medical education. Whilst the professional nature

of medics enables them to systemise their medical duties, the protection of life as medical professional, as an ethos, which requires professional systems and moral actions to be two very distinguishable concepts (Salloch, 2016). It is this realisation of the reality in assuming a leadership role within the ED, that an ED consultant, who participated in the semi-structured interviews, confirmed that being a clinical leader is not always smooth sailing, and that not all decisions made are liked by everyone, but making difficult decisions, even unpopular one's is part of life.

> "You're a consultant, you must remember not everyone is going to like you and your job is not to be liked by everyone, and there will always be trainees and junior doctors who will not be happy with what they are being asked to do. There will be some that will be fine with what they are asked and there will be others that won't, that's how it is." ~ Oriana, ED Consultant (Senior Management).

Somoye (2016) argues that organisation power is important as it is the ability to control people or things (p. 566). This was acknowledged by an ED Consultant who argued that both power and politics are important, but with the caveat that their interaction should be positive. He submitted the following:

> "Power and politics complement each other within the department, as long as its interaction is positive then it is good." ~ Luann, ED Consultant (Senior Management).

Reflecting on the distinction made by Salloch (2016), the reality remains that values and behaviours of people in organisations are often impacted by the level of authority or power the leaders have over others. It is the ability to influence those under their control to adjust their own values and behaviours, to meet the needs of those who hold the power. Winter (2009) confirmed this dilemma, when he spoke about 'managerial, or public management', (also see Brookes & Grint, 2010) and the realisation that "managerialism has led to an identity schism in the academic workplace". However, whilst the presence of power may be an influential

factor in public management, one registered nurse argued that there was '*no clear power over others*' ~ Madeline, ED Registered Nurse (Middle Management).

Although Winter (2009) wrote about Academic managers and the impact of being managed by academics, and the impact on their identity and values, the same principle could be extended to the ED. In referencing Ibarra (1999), Winter (2009) argues that professional identity is created through the "beliefs, values, motives and experiences that are characteristics of individuals" who work in a similar professional role. The ethical dilemma for participants was striking a balance between patient care and the performativity of the 'new modes of state regulations' (Ball, 2003) and 'the performativity of the service management discourse' (Norgren, 2008, referenced in Brookes & Grint, 2010).

The reality that nursing and medical staff wish to offer the best possible care for their patients, is similar to what academics wish to do for their students. The impact of managerialism or new public management in academia, is not dissimilar to that of the NHS, and adds to the complexity of inter-professional performance (Sommerfeldt et al., 2014). It could be argued that both managerial guidance, and political targets, including their associated ideologies, values, and interests, reshaped the nature of health care. This conflicts with the clinical values of clinical staff in the ED in providing high quality patient care (Winter, 2009). It was these ideologies that caused dilemmas for ED staff, as one articulated it as follows:

> "If we don't meet our performance targets, the Trust gets fined, which seems nonsensical. Surely consideration should be given to the reasons why we are here and why we are not meeting those targets and determine if they are even appropriate." ~ Madeleine, ED Registered Nurse (Middle Management).

These challenges are not unique to the NHS but is a struggle by healthcare systems across the globe (Al-Zaghlawan et al., 2017; Berrio, 2003; Floyd & Fuller, 2016; C. Lane, 2009; Mbigi, 2007). One ED Consultant argued that challenges of spending too much time in an overcrowded ED is adverse for both patient experience and outcomes, whilst she did not recognise the perceived claim of a divide between medical and nursing staff.

> "I think it's more about perception, it's between nursing, the medics and management. Because some things are lost in translation. The fact is, that being in an overcrowded ED for more than four hours is really determinantal to patients, and that's sort of been lost in the target debate." ~ Oriana, ED Consultant (Senior Management).

Summers' (2009) confirmed the basis of medical ethics, which is described as (1) do no harm; (2) ensure anonymity; (3) confirm consent; and (4) ensuring that the end users have the right to withdraw. None of these values are in conflict with the NHS Constitutional Values (DoH, 2015), which confirms that patients come first; everyone is valued; and is included; with a commitment to quality care; through humility and kindness; whilst improving lives; through kindness and compassion. Although it was acknowledged that performance targets are important, high quality patient care remained the key priority.

> "We do need to focus on performance targets, but you know we didn't go into nursing to not be looking after patients. So, the patients' safety is always the first concern, quality is our priority." ~Quiana, ED Matron (Middle Management).

It is with this background that ED clinical staff stated they shaped solutions to any form of problem in ED ultimately ensuring that they provide high quality, emergency medicine, for the benefit of the patient, their service user, first and foremost above anything else which renders their speciality and or place of work as a secondary factor. However, another felt that the political agenda to improve organisational performance, reducing costs, and moving patients through ED enjoys priority and translate in staff feeling de-valued confirming that when staff

don't feel valued within the ED, they will go to work, do a job, and not necessary focus on the best quality of care.

> "So, if I feel that no one cares about me, I'll come in do my job and go home again. The patients will pick up on that, ultimate ED is a business and care not its priority." ~ Tara, ED Lead Nurse (Middle Management).

Ultimately, values, irrespective of how well defined, remains a grammatical discourse unless supported by the associated behaviours that underpins these values. Actions, as the saying goes, speak louder than words.

In this regard the BBC (2014) defined 'ethics' as a 'system of moral principles. A structure of honourable values according to which people live their lives or find honour in what they do (BBC, 2014). According to Mintz (2010), ethical behaviour in philosophical terms described 'that which is good'(Mintz, 2010). Although it was said that the four-hour target specifically has been challenging, and even inappropriate, others felt that it is a good barometer for patient flow and the quality of care, but, acknowledged that some impetus around the four-hour target has been lost. Three participants in the semi-structured interviewees stated the following:

> "Now that we are more focusing on 12-hour breaches, we don't have great patient flow inside the hospitals, so it's hard, but it is important to move patients." ~ Renate, ED Nurse Consultant (Middle Management).

> "The four-hour target remains important. It's still in place, it [was] in place until April 2022, but it is fair to say we have lost a bit of impetus, when it comes to the four-hour target." ~ Sancia, ED Consultant (Senior Management).

> "Whether we agree with it or not, the four-hour target is a thermometer of how we're looking after our patients. We need to consider, when running a department in asking whether we are providing the best possible care to our patients." ~ Uriah, Managing Director of ED, (Senior Management).

Zhao (2016) confirmed that the French Jewish philosopher, Emanual Levinas (1906 – 1995), wrote extensively on education and offered ethics as the first philosophy, positioned in neoliberalism and a desire for "certainty, uniformity and accountability" (p. 325). She contends that Lavina's philosophies of individualism and diversity; and his thoughts on language as the discourse to creating an ethical community; offers a variety of opportunities to develop an ethical and democratic society where 'the other' is more important or prominent than 'the self' (Zhao, 2016). However, Larry (2016) argued that it was the German Philosopher, Immanuel Kant (1724 – 1804), who held very specific views on ethics, against a 'deontological' framework, often referred to as 'Kantian Ethics'. Kant's views on ethics had its origin in the concept of duty, meaning that there is a duty to do what is right no matter the consequence, or what he called a 'categorical imperative'.

The alternative to this imperative, Kant described as the 'hypothetical imperative' which he explained as the things we do, because we have a need or a desire to do them. Kant's ethical framework is based on three elements, being; (1) **Universalability** ~ acting in a way that one would expect everyone across the world to act, all the time; (2) **Duty** ~ a requirement to perform your duty, which meets the maxim of universality; and (3) **Humility** ~ acting in such a way that you treat humanity always as an end, and never as a means to an end or for one's benefit. This philosophy, has a practical methodology that one could apply to everyday work and life (Larry & Moore, 2016).

Influencing Factors

In exploring which factors were likely to have influenced participant's 'personal and professional identity' they were given several multiple options to choose from indicating that they were 'strongly influenced'; 'somewhat influenced'; 'little influenced'; 'not influenced' or 'not sure.

Table 5.2 below offers more data on these factors, that clinical leaders believed 'strongly influenced' their personal and professional identity, with the strongest indicator being 'following the codes of ethics / conduct requirements defined by a professional / regulatory body' for personal and professional identity. In this regard, **26** [72.2%] participants agreed with this statement, represented across the three groups of participants as follows, with Middle Management the highest at **10** [76.9%], followed by Emerging Leaders, with **11** [73.3%] and **5** [62.5%] of Senior Management all agreeing that the ethical codes of their professional or regulatory body influenced and shaped their professional identity the strongest. Reflecting on the impact of personal and professional identity, one participant in the semi structured interviews submitted the following:

> "Other people see me differently now. Nobody else in my family are nurses. I didn't have any nurse friends until I started at university. Personally, and professionally that was a big change, that other people saw me differently and then I saw myself differently." ~ Karin, ED Nurse Practitioner, (Middle Management).

Survey participants reported that 'following the codes of ethics / conduct requirements and standards or competencies as defined by a professional / regulatory body'; or a 'particular clinical setting or organisation they are working in'; and 'how clinicians make sense of what they do'; were the strongest factors that influenced their personal and professional identity.

Table 5.2. Factors that have influence professional identity [Q14]

	Emerging Leaders		Middle Management		Senior Management		Total	
Working in a particular clinical role								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Strongly influenced	10	27.8%	9	25%	6	19.4%	25	69.4%
Somewhat influenced	4	11.1%	4	11.1%	2	2.8%	10	27.8%
Little influence	1	2.8%	0	0%	0	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
Working in a particular clinical setting (organisation)								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Strongly influenced	11	30.6%	6	16.7%	3	8.3%	20	55.6%
Somewhat influenced	3	8.3%	7	19.4%	5	13.9%	15	41.7%
Little influence	1	2.8%	0	0%	0	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
Following the standards / competencies as defined by a professional / regulatory body								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Strongly influenced	10	17.8%	7	19.4%	4	11.1%	21	58.3%
Somewhat influenced	4	11.1%	5	13.9%	3	8.3%	12	33.3%
Little influence	1	2.8%	1	2.8%	0	0%	2	5.6%
No influence	0	0%	0	0%	1	2.8%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
Following the codes of ethics / conduct requirements defined by a professional/regulatory body								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Strongly influenced	11	30.6%	10	27.8%	5	13.9%	26	72.2%
Somewhat influenced	3	8.3%	3	8.3%	1	2.8%	7	19.4%
Little influence	1	2.8%	0	0%	1	2.8%	2	5.6%
No influence	0	0%	0	0%	1	2.8%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
How an individual clinician makes sense of what they do								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Strongly influenced	9	25%	8	22.2%	6	16.7%	23	63.9%
Somewhat influenced	5	13.9%	4	11.1%	1	2.8%	10	27.8%
Little influenced	0	0%	1	2.8%	0	0%	1	2.8%
No influence	0	0%	0	0%	1	2.8&	1	2.8%
Not sure	1	2.8%	0	0%	0	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
For me 'professional identity' has another meaning								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Strongly influenced	1	2.8%	0	0%	0	0%	1	2.8%
Somewhat influenced	1	2.8%	2	5.6%	1	2.8%	4	11.1%
Little influenced	3	8.3%	4	11.1%	2	5.6%	9	25%
No influence	3	8.3%	3	8.3%	0	0%	6	16.7
Not sure	7	19.4%	1	2.8%	3	8.3%	11	30.6%
Blank	0	0%	3	8.3%	2	5.6%	5	13.9%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**

Table 5.2 Factors that Influenced Personal and Professional Identity

The other stronger indicators in ***Table 5.2*** above in descending order respectively, were noted as **25** [69.4%] indicated that working in 'a particular role' influence their 'personal and

professional identity'; **23** [63.9%] indicated that it is influenced by 'how an individual make sense of what they do'; **21** [58.3%] confirmed that following 'the standards or competencies as defined by a professional or regulatory body'; and **20** [55.6%] reported that their personal and professional identity was influenced 'by the clinical setting or organisation' they are working in.

In the qualitative data for this study, participants offered, that in addition to the above, whilst Bastian (Senior Management) indicated that he has '*never really considered the idea of professional identity*' and Dagmar (Middle Management) believed her identity is influenced by the uniform she wears, others indicated that their personal, and professional identity is influenced by '*organisational values and behaviours*' ~ Carla, (Emerging Leader), whilst another felt that there was no '*relationship between professional identity*' and their '*role as a clinician*' ~ Bastian, (Senior Management).

It was also submitted that professional identity is influenced by '*a mixture of inherent feelings, experience and external influences*' ~ Nadia, (Senior Management), that determines how a professional applies his/her craft of practice. An emerging leader said that '*everyone is looking at you to lead by example*' ~ Parker, (Emerging Leader), whilst another was of the view that her professional identity '*moulds us as a whole*' ~ Tina, (Emerging Leader). One participant submitted that their professional identity was greatly influenced not just by the theoretical learning of their profession, but also by the practical experiences in their role.

> "I am a doctor. It's my being. I'm an emergency medicine consultant that's my identity… it is just who I am." ~ Valarie, Senior Management, (Q14.a).

It was acknowledged that often '*there were external factors*' as well ~ André, (Senior Management), but it was equally important to develop one's own practice, by '*learning from other role models*' whilst '*taking responsibility for* [one's] *own learning'* ~ Zebrine, (Middle Management). One participant said that working in ED was '*a privilege to* [be] *able to help patients and upcoming doctors*' ~ Gerhard, (Senior Management), whilst another acknowledged that it was hard to come into the department as a new member of the team but confirmed that their primary ambition is to '*make a difference and develop the skills*' of those coming into the department ~ Enos, (Middle Management).

Participants in the semi-structured interviews, stated that whilst they may have developed from being a clinician to a manager or clinical leader, ultimately, all participants were consistent in that they remained a clinician first and foremost, and places the patients at the heart of what they do. They did not consider the performance targets, the political views on performance targets, or the latest managerial maxim about new public management (Brookes & Grint, 2010; Grint, 2008, 2010) as priority, but the needs of the patients as their first concern.

Professional Behaviour

Considering the data reflected in ***Table 5.2*** above, it is noted that most respondents **35** [97.2%] confirmed that professional identity is mostly influenced by the 'clinical setting (organisation)' in which they function, or by 'working in a particular clinical role'. The second most important factor that influenced participants' personal and professional identity or **33** [91.7%] is any of either 'following the standards / competencies as defined by a professional or regulatory body'; or 'following the code of ethics / conduct requirements defined by a professional or regulatory body'; or finally, 'how an individual clinician make sense of what they do'. Regarding the

latter, **33** [91.7%] participates agreed with this statement, represented across the three groups of participants as follows, with Emerging Leaders **14** [38.9%] the highest, followed by Middle Management at **12** [33.3%], and **7** [19.5%] of Senior Management all agreeing that their personal and professional identity is how they make sense of what they do. It is regretful that none of the Emerging Leaders were willing to participate in the semi-structured interviews, as they are the strongest respondents in several questions, and it would have been interesting to hear their views on these and how they make sense of what they do in relation to their personal and professional identity.

Whilst the quantitative data from this study offered limited insight in the professional behaviour as a factor that influenced professional identity, the qualitative data from the semi structured interviews and from the free text in the surveys did provide some insights. Half of the participants in the semi-structured interviews were very vocal about the professional divide between medical and nursing staff, and how that impacts their behaviour within the ED towards medical staff, towards nursing staff and the allied health professionals (Sommerfeldt et al., 2014). It was noted that **5** of the 12 interviewees reported that they have witnessed clear differences in the behaviours between nursing and medical staff, whilst the same amount, i.e. **5** of the 12 interviewees argued the opposite in that they did not believe there was a divide between nursing and medical staff, but one argued that the divided is outside of ED.

> "I think there is certainly a divide, but the divide is not between the nursing or the medical staff. It is in the behaviours of the directorate management, the directorate clinicians and nursing staff who are caring for patients, that is where the divide is." ~ Luann, ED Consultant (Senior Management).

In clarifying his point Luann, an ED Consultant, explained that management are responsible for the quality and efficiency of the ED, and they drive constantly for better care, but that causes

a divide between the more senior management and the lower grade clinicians, or the nursing staff who are dealing directly with the patients. This manifests in professional behaviours where senior clinicians agree with Trust mantra's (Ball, 2003) as they believe they '*must be on managements side*' and therefore their conduct and behaviour are aligned to that of the Trust philosophy. ~ Luann, ED Consultant, (Senior Management).

> "We could do a better job in bridging the gap to improve communication, but we need more 'time'. Time away from direct patient care to engaged with our teams, to explain why we do what we do. Having that face-to-face, in person conversation, are so much more powerful than doing everything via email or on the run." ~ Noran, ED Consultant, (Senior Management).

One of the ED registered nurses concurred that she believed there was a professional divide between nursing and medics, and the professional behaviour that manifest was described as '*nursing staff consider the entire journey of the patients*', they remain responsible, whilst '*medics refer patients and then do not worry about them any further*' ~ Madeleine, ED Registered Nurse (Middle Management). She submitted that ED nursing staff are required and focus much more on the patient journey from the moment they arrived in ED until they are either discharged or admitted to a ward. The problem according to her was articulated as follows.

> "Emergency medicine is not appropriately recognised as a professional speciality, it is seen as a triage service moving people through the ED to real specialities, as if urgent and emergency care is not a speciality, and that is wrong." ~ Madeleine, ED Registered Nurse, (Middle Management).

It was said that the ED should be run as an emergency medicine centre, a speciality, but because it is so busy, and because of the perception that it is nothing more than triage service, which could be described as a process of determining the urgency and risk of an injury or a condition and then making the decision on what treatment would be best to deploy in treating the injury

or condition. This may be within the ED, or referring to a speciality within the Trust, and the tendency is to always refer to a speciality doctor. This was articulated as follows:

> "The aim is to move patients as quickly as possible, sometimes even before blood results are back, or before imaging for abdominal pains are done, they are just referred. Some patients may even be suitable to go home, but we keep them in ED far too long. I.e., someone coming in with chest pains, but have a regular heartbeat, are always referred to cardiology first. ED doctors will not make the decisions, always referring to their medical colleagues. ED doctors should be more empowered to make decisions without referring to speciality colleagues." ~ Madeleine, ED Registered Nurse, (Middle Management).

Another expressed the view that there was not a strong divide between nursing and medical staff but did confirm that there was a divide between Trust Executives and the ED, with a much bigger disconnect from the ED junior staff and the Executive Team. This manifest in all sorts of behavioural challenges, as people don't always understand why they are asked to do what they do. The availability of time, for team briefings and face-to-face discussion were mentioned as a real problem to '*bridge the gap'*. Especially during the pandemic, but even as systems are moving towards recovery, as the backlogs for patients in hospitals are still immense, it was said that:

> "I don't think we do have a strong divide at all. I think we work very well together; we are all striving to do the right thing for the patients." ~ Sancia, ED Consultant, (Senior Management).

An ED Consultant confirmed that there was a strong historical divide between nursing and medical staff similar to the power and politics describes by Somoye (2016) and Pfeffer (1992) respectively. This was fostered, and to a large extent is still imbedded in current behaviours by the respective professional and regulatory bodies like the Royal College of Nursing (RCN) and the General Medical Council (GMC).

> "If you think about it, how hard it is to get a doctor struck off the register, in comparison to the relative ease a nurses pin could be removed. We are held at different standards, and therefore our professional behaviour will be different, our professional behaviour is reinforced by our Royal Colleges." ~ Oriana, ED Consultant, (Senior Management).

The above, it was argued, also encourages the different professional behaviours between junior doctors and consultants, which add to a divide among medical staff. Junior doctors often remind their senior colleagues that they have 'a right to be trained', they have 'a right to a break', and they don't consider their responsibilities in their own behaviour. It is the balancing of these realities with the needs of patients and the successful functioning of the ED, but at the same time acting as training centre to educate and equipped the current junior doctors, to become consultants and clinical leaders of the future. ~ Oriana, ED Consultant, (Senior Management).

> "I think there is certainly a divide, but the primary identity as a doctor, is adhering to professional standards. Then choice of speciality and place of work become relevant as secondary." ~ Xandria, Middle Management, (Q14.a).

A trainee doctor in year four in the ED did not recognise a strong divide but did acknowledge that there are some in ED who operate within traditional nursing roles and others in traditionally medical roles, but both had a clear focus on clinical outcomes with the best interest of their patients foremost on their mind.

> "I think our care is becoming more fluid, so we're seeing less and less of a divide. We also have nurse consultants on the shop floor, that helps with the bridging of the gap." ~ Prudence, ST 4, (Middle Management).

The two interviewees, who were not sure whether there was a clear divide between nursing and medical staff felt that either there was a minimal divide ~ Victor, ED Consultant, (Senior Management), or there was more of an internal battle within ED, as the longer a patient remains in one part of the ED, the longer another patient must wait in a different part of the ED. It was

reiterated that ED is a very busy place and that impacts people's behaviour, especially if they are under pressure. ~ Quiana, ED Matron, (Middle Management).

As described by French & Raven (1959) one ED registered nurse felt strongly that it is the responsibility of the ED '*leadership in shaping the ideal leadership behaviour*', which is achieved through listening to what people are saying, '*truly listening, not just paying lip service*'. It was said that at times it feels as if the Trust ask for lots of feedback but very little is truly done with this information. The annual national staff survey was used as example, through which feedback is asked on an annual basis, but staff felt that '*nothing was done with the information*'. ~ Karin, ED Nurse Practitioner, (Middle Management).

A lead nurse in ED confirmed that there was a strong divide, but it was between Trust management vs. medics and nurses, rather than between nurses and medics. She confirmed the following:

> "In ED, we try to do everything for everyone, it is very difficult and practically impossible not to work well together, it's about capacity, some Trusts [and EDs] are better than others." ~ Tara, Lead Nurse in ED, (Middle Management).

It was submitted that a patient will not be moved out of ED unless it was safe to do so and that nursing and medical staff would feel very comfortable to go to the Chief Operating Officer (COO) or the Medical Director (MD) to confirm that a patient could not be move due to their acuity. It was equally confirmed that staff believed that they would be supported by both the COO and MD.

Lastly, a more dissatisfied view was offered as it was said that '*there is no working together as a team, there's always professional differences*' ~ Uriah, Managing Director in ED. It was

argued by a couple of interviewees that they consider ED, as a special place to work and that they see themselves as very special. However, it was pointed out that some in ED may think the risk of the department is their sole responsibility, however this was refuted as the risk lies with everyone and the wider Trust. The risk is shared by the wider clinical body. Another point that was raised was that it is difficult to have a single discussion about something in ED, as management felt that they must have discussions with the medics and then must have the same discussion with the nursing leadership and improvement suggestions are not always possible to implement. As example was offered that the Trust management tried to implement 'ward-rounds' for ED to facilitate a collaborative approach between all the clinical staff, i.e., medical, nursing, and allied health professionals to review patients holistically to facilitate better patients flow, and indeed better patient outcomes, but this did not seem to happen, as there is a perception that there was a resistance in ED to do anything suggested by management.

5.3 Conclusion

Professional identity, as a concept is not easily defined, as it has different meanings for different people. People use the term to identify what they do, where they work, or the profession they are in. It is shaped by their professional regulatory bodies, and this resulted in four themes emerging from the data. In this regard, the review of both qualitative and quantitative data indicated that these themes were professional identity, ethical dilemmas, influencing factors and professional behaviours.

Professional identity has clearly different meaning for different people. However, the data from this study confirmed that most participants defined their personal and professional

identity through the 'codes and ethical conduct requirements' as defined by their professional and regulatory bodies. This professional reality is fluid, not pre-defined nor common to all professions (Sugrue, 1997), whilst the "complex and dynamic" balance vis-à-vis "personal self-image" and the "roles [people] feels obliged to play" (Goodson and Cole, 1994; Sugrue, 1997; Volkmann and Anderson, 1998 as referenced by Beijaard et al., 2004) are strong indicators that shape how clinical leaders form their professional identity. This identity is shaped by how others show their deference to clinical leaders, through respect, recognition or responding more positive to the requests or contributions of and from clinical leaders when they assume leadership roles.

Whilst it was acknowledged that there is an intertwine-ability of the concepts of ethics, values and behaviours, and professionalism, a distinction was made between ethics and professionalism (Salloch, 2016). The impact of power and politics (Pfeffer, 1992; Somoye, 2016) and the challenges of the "new public management" (Brookes & Grint, 2010) all contributed to the "schisms" (Winter, 2009) created by the "new model of state regulation" (Ball, 2003) and "the performativity of the service management discourse" (Norgren, 2008 in Brookes & Grint, 2010). These contribute to the ethical dilemma expressed by participants who felt strongly that their professional identity and ultimate purpose is defined by their beliefs in and desire to provide high quality patient care, first and foremost, which is at times, at odds with some of the performance targets, and political directives that impedes their ability to provide such high-quality care. Ultimately, all participants and interviewees could identify with the NHS Constitutional values (DoH, 2015) and the principles of ethics, values and ethical behaviour (Summers & Morrison, 2009). The latter's clarification of 'do no harm'; 'ensure anonymity'; 'confirm consent'; and 'ensuring that the end users have the right to withdraw', captures the ethical parameters for all ED's. Finally, Emanual Levinas' philosophical view

on "certainty, uniformity and accountability" offers a variety of opportunities to develop ethical and democratic society, where 'the other is more important that 'the self'(Zhao, 2016). Whilst Immanuel Kant's "categorical imperative" of "Universal-ability"; "Duty"; and "Humility" offers a very practical methodology that could be applied to every day work and life (Larry & Moore, 2016). From the above, it is acknowledged that there are several elements that influenced professional identity that could be represented as follows:

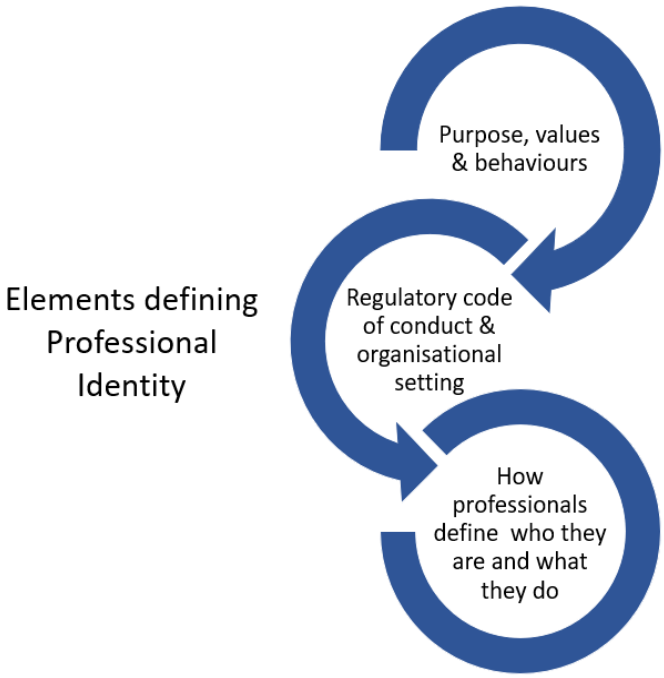


Fig. 5.2 Elements Defining Professional Identity

Current professionalism frameworks in medical education talks about 'competencies' (Archer et al., 2008); 'attitudes and behaviours' (American Board of Internal Medicine, 2011) and 'medical professionalism'. The latter being defined as 'a compilation of attitudes, values, behaviours and relationships that supports the public's trust in doctors' (RCP, 2005). The uniqueness of the framework as describe in ***Fig. 5.2*** above is that it is individual centric, developed from the literature but shaped by the data of this study. It considers the purpose of

participants as clinicians and clinical leaders, and how this influenced their values and behaviours. It is heavily influenced by the expectations of their regulatory bodies and shaped by the realities of the organisational setting in which they find themselves. Finally, it is a key element for clinical leaders to enable them to make sense of who they are and what they do. It brings together different frameworks into one.

Ultimately, whilst personal and professional identity is unlikely to remain statistic, they are consistently defined as philosophical ideologies, with values and ethical dilemmas that differ from ED to ED. It is clear from the above, that the clinicians who participated in this study view their personal and professional identity as a clinician, who set out on their respective journeys to look after, and care for patients, first and foremost, that is who they are, and how they see themselves.

5.4 Next Steps

The next Chapter will review the aspect of Leadership Development and how this impact the experience and realities of clinical leaders in an ED.

CHAPTER 6 : RESULTS AND DISCUSSION ~ LEADERSHIP EDUCATION AND DEVELOPMENT

6.1 Introduction

The purpose of this chapter is to present and discuss the data relating to this study's main research question, with specific refence to the third, and final element of the conceptual framework, being 'leadership education', and how this impact the research question, defined as:

> What are the experiences and perceptions of leadership education and development for clinical leaders in the Emergency Department (ED) of an English NHS Acute Trust?

In addition to the research question, the third and final supplementary questions that will be addressed in this chapter are:

SQ 3. What are their perceptions and experiences of leadership development programmes and/or educational activities to date; and

SQ 4. What are their future development needs that will enable them to be effective in their role?

The literature reviewed in Chapter 2, acknowledged that leadership as a concept has been defined by many, in part, the definition of leadership will continue to advance as scholars develop more insight into the concept (Winston, 2006). However, one definition of leadership is "a person's capacity to be effective in leadership roles" (Van Velsor, 2004).

Education, as a concept has been defined as “the process of teaching or learning; the theory and practice of teaching; information about or training in a particular subject: health education; an enlightening experience’ (OCD, 2008, p. 317).

The hypothesis in the survey of this study suggests that everyone in an ED ‘has some form of leadership responsibilities’ be it for the public they interact with, patients they care for or the colleagues they work with or lead. However, one emerging leader offered a counter argument.

> “You have stated that everyone is a leader – at least to patients or colleagues, I don’t see it that way.” ~ Feline (Emerging Leader) Q17.

Regardless, education, learning and development is something that ‘applies to all ages’ (Blakemore & Firth, 2005, p. 462) whilst it is argued that the human brain has a remarkable capability to adjust, or rewire, which enables humans to behave differently from how they behaved previously. This has also been described as the ‘plasticity’ of the brain, that enables life-long learning, to facilitate the powers of a focused mind, which reduce stress and anxiety (Blackman, 2014; Blakemore & Firth, 2005; Gould & Stevenson, 2008; Pillay, 2017).

From the analysis of the data in this study from both the surveys and semi-structured interviews, some clearly articulated themes emerged, which are:

- Prevailing Leadership Style;
- Leadership Rationale;
- Leadership Education; and
- General.

These themes that influenced leadership education and development, are expanded on in the following sections.

6.2 Leadership Development

The date from this study suggests that a distinction should be made between leader development and leadership development (Day, 2000). This was confirmed by Dalakoura (2000) who defined the former as an essential element for organisational effectiveness (OE) (Dekker, Oates, & Rafferty, 2022) and argues that the latter holds a wider denotation than just the development of leadership talents. It is this development of leadership talents that one ED consultant felt important, to promote in developing his team in submitting:

> "Sometimes, people don't believe in their own talent, and don't go far, as they don't put themselves forward for development. They don't challenge their personal development and don't take personal responsibility. I remind them that there is also a personal responsibility to advance their careers" ~ Victor, ED Consultant (Senior Management).

Prevailing Leadership Style

The data from this study, confirmed that from a cultural perspective, it was argued that the ED was a collaborative, hierarchical department, with a strong focus on compassion and patient outcomes (see ***Table 4.1***). This, however, was contradicted by the senior management, as they felt that the espoused values are more of a situational style, spread across a spectrum of collaborative, collegial, democratic, autocratic, and hierarchical styles, dependant on the

situation and circumstances at the time. However, one advance clinical practitioner, expressed a caveat.

> "How compassionate you are towards your staff to a certain extend depends upon their attitude and behaviours as well. It works both ways." ~ Renate, Advance Clinical Practitioner (Middle Management).

Hougaard *et al* (2022), has a slightly different perspective to this view, in what they call "caring candor" which they defined as "the core of development and growth" (p. 145) as it offers honest feedback required to develop and improve. Hougaard *et al* (2022) defines this as 'being mindful of the setting and context; say it now and do it quickly; bottom line it first (starting with the end first); be firm and decisive; avoid the popularity game and have zero tolerance for value breakers' (pp. 150 – 154).

The word 'compassion' has different meaning for different people, defined as "the intention to be of benefit to others" (Hougaard et al., 2022, p. 2). It could also be described as civility or 'politeness and courtesy' (OCD, 2008, p. 174, p 174), whilst West (2021) defines the four elements of compassion as follows:

- **Attending** ~ paying attention to the other, being present and engaging;
- **Understanding** ~ being cognisance of what is causing the challenge, making an appraisal of the cause through dialogue, and achieving a shared understanding;
- **Empathising** ~ mirroring the other's feelings, having a felt relation without being overwhelmed;
- **Helping** ~ taking intelligent, considerate action to relieve the other's suffering (West, 2021, p. 3).

Hougaard *et al* (2022) requires of leaders to have a higher level of responsibility, to be compassionate in leading, to help, guide and set the direction for their followers, but most importantly to behave in such a way that their followers are enabled to want to follow them. Whilst West (2021) debunked some of the myths of compassionate leadership in arguing that leaders can be both compassionate and committed to high quality performance; putting patients and staff first; having tough performance management conversations; and challenging the status quo. Ultimately, compassionate leadership is not focused on individuals, but relates to institutional behaviour, that impact organisational culture and norms (West, 2021, p. 8). In relation to compassion, Hougaard *et al* (2022) offers helpful and simplistic definitions of sympathy, empathy, and compassion. Sympathy is defined as, 'I feel for you'; empathy 'I feel with you'; and compassion 'I am here to help' (p. 54).

When exploring how compassionate the leadership style is in the ED, the data from the semi-structured interviews confirmed that **8** of the 12 of participants felt that the ED is very compassionate, whilst the remaining four had mixed views. One ED Consultant explained it as follows:

> "It's a question with many variables. I believe the Trust is very compassionate. I don't think there are bad individuals, but the challenge is that bad people are not identified straight away within any organisation. In my ED people are not allowed to run riot with bad behaviour, it is not allowed. So, people know their behaviour has consequences. But people lose that compassion when under pressure." ~ Victor, ED Consultant (Senior Management).

From the above it could be inferred that compassion becomes retributive under pressure. On a 1:1 basis or even within teams, it was confirmed that the prevailing leadership style in the ED overall was very compassionate, '*my manager is very good, I could not ask for more, but there is a disconnect between ED and the Execs*'. The unit of teamwork in the ED is defined '*like a family, when the pressure is on, it does not matter what you are, everyone pulls together*'. It

was acknowledged that as human beings people differ, and at times there are disagreements, but '*like family, we get over it*'. This is achieved through '*a bit of mediation*' but generally staff get over their differences and work as a cohesive team. ~ Karin, ED Nurse, (Middle Management). The disconnect between ED and the Trust Executive was clarified as follows:

> "I think it goes back to a lack of understanding about how the ED function. I don't think this is unique to this Trust. I think generally there is a lack of understanding about the pressures and realities of how the ED operates." ~ Karin, ED Nurse (Middle Management).

Other participants confirming that there is a lot of compassion in ED, acknowledged that there are other leadership styles that emerged, even a combination of some. Regarding the latter it was argued that whilst a compassionate style is prevalent, at times '*some are more transformational*' ~ Quiana, ED Matron, (Middle Management), whilst '*others are more directive*'. The latter is understood as important, based on the situation and the '*reality to flex between different styles depending on the situation*' ~ Noran, ED Consultant, (Senior Management).

Madeleine, an ED registered nurse, also agreed, but with a caveat, in that she argued that the leadership overall is '*compassionate for patients definitely*', but caveat that there is more that could be done for staff within the ED. She argues that the need for a balance in compassion, should be for both patients and staff, it cannot be either one, but need to be both. She offered the following example:

> "A friend of mine was really struggling, when one of the matrons came up to her to ask if she would consider increasing her hours. She said no as she was feeling burnt-out and felt that she was really struggling. The matron just laughed and said, 'it was worth a try', but with no follow-up as to her own personal wellbeing. Especially after being told that she 'felt burnt-out' and 'really struggling'." ~ Madeleine, ED Registered Nurse, (Middle Management).

She explained that she was not of the view that management were uncompassionate but felt that due to the pressures in ED every day, she thought they '*just didn't really listen, they don't pay attention to the people they are supposed to lead*'. ~ Madeleine, ED Registered Nurse, (Middle Management).

According to **5** of the 12 interview participants who had mixed views about the level of compassion in the ED, argued that compassion is impacted by the fact that the senior clinicians are not always on the ED floor and its difficult for ED staff to singlehandedly deal with the operational challenges on their own. This was confirmed by Turnbull (2010) who argued that there is a need for strong collective leadership and asserted that leadership cannot be about individualism, but the ability to allow everyone within a system to have a voice. Emmerson (2019) also supported this view in her argument for a phycological safe working environment when she warned against the risks of '*failing to speak up*' and the consequence this could have for staff, end-users and in this context patients (p. 78).

A key theme that emerged was the fact that mental health patients presenteeism has increased dramatically in the ED, and ED staff are not equipped to deal effectively with these patients. It was argued that the ED is used as a '*place of safety*' by the police, and whilst the ED may be a place of safety, its pressures are such, that it can neither accommodate nor deal with mental health patients who are not in need of emergency medical attendance. A nurse practitioner in ED submitted the following:

> "Fifteen years ago, when I worked in ED, we didn't see any mental health patients because they were taken to a mental health assessment unit, but now they are brought to ED as a place of safety, and we often have them for days in ED, waiting for a bed, and we are not equipped to deal with them." ~ Renate, ED Nurse Practitioner (Middle Management).

A lot has been said about the transformational nature of the NHS at the time of this study (Brookes & Grint, 2010; Grint, 2008, 2010; Kotter, 1995; Lewney, 2017) which was challenged by an ED Consultant, who argued that she did not '*think we are transformational enough*' and consideration should be given more to the impact of the full patient journey, and the role all partners on that journey could play across the ICS, as '*silo thinking is not in the best interest of the patients or service users*' ~ Sancia, ED Consultant (Senior Management). This view was confirmed by Marmaya (2010) who concluded that transformational leaders are more likely to secure employee commitment, whilst Sakire (2013) submitted that it would improve employee effectiveness and Bolden *et al* (2003) arguing that transformational leadership develop, empower, and support their followers to be the best they could be.

Ultimately, when it comes to the leadership styles in ED, it was agreed that compassion is first and foremost the prevailing leadership style in ED, but developmental work needed to be considered to find the balance between the focus on compassion and the circumstances within the ED, dealing with mental health patients, and ensuring that both staff and patients enjoyed the same level of compassion, whilst a wider perspective is needed that goes beyond the ED, to improve the overall patient journey.

Leadership Rationale

In exploring why clinicians became clinical leaders, the following was noted.

Table 6.1. Rational for becoming a clinical leader [Q16]

			Emerging Leaders		Middle Management		Senior Management	
Why did you move from a clinician to a managerial or leadership role? [Q16]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
the longest serving in the department	3	8.3%	2	5.6%	1	2.8%	0	0%
enjoy developing other people's careers	13	36.1%	6	16.7%	4	11.1%	3	3.8%
always wanted to lead others	12	33.3%	5	13.9%	5	13.9%	2	5.6%
wanted a new challenge	19	52.8%	8	22.2%	8	22.2%	3	8.3%
wanted to make a wider impact within the Trust/ED	12	33.3%	6	16.7%	2	5.6% %	4	11.1%
wanted to move away from operational delivery	3	8.3%	2	5.6%	1	2.8%	0	0%
was asked to take on more responsibility	16	44.4%	9	25%	4	11.1%	3	8.3%
a natural division of responsibility	12	33.3%	7	19.4%	3	3.8%	2	5.6%
part of my personal development plan	18	50.0%	9	25%	6	16.7%	3	8.3%
Other	6	16.7%	1	2.8%	2	5.6%	3	8.3%
Number of answers from 36 respondents	**114**		**55**		**36**		**23**	

Table 6.1 Rational for Becoming a Clinical Leader [Q 16]

From the above in ***Table 6.1***, it was noted that **19** [52.8 %] confirmed that they 'wanted a new challenge' and that this level of leadership was their natural next step; **18** [50%] indicated that becoming a clinical leader was part of their 'personal development plan' (PDP); **16** [44.4%] confirmed that they were 'asked to take on more responsibility'; **13** [36.1%] indicated that they 'enjoyed developing other people's careers'.

Three groups of **12** participants, or 33.3%, indicated that (1) it was '<u>a natural division of responsibility</u>'; (2) they always '<u>wanted to lead others</u>'; and (3) they wanted to '<u>make a wider impact on the Department or Trust</u>', respectively.

These reasons of becoming a clinical leader were critically challenged by a participant in the semi-structure's interviews, who indicated that she had no intention to progress as a clinical leader.

> "Becoming a leader in ED is a bit like politicians. They think they go into it because they think they can make a difference, and they can do a really good job. But the reality is that you end up not having much influence and eventually becomes just like them." ~ Karin, ED Nurse Practitioner (Middle Management).

She argued that leaders lost so much of their own individuality, as they had to leave too much of who they are, in favour of being a corporate person. Karin submitted that whilst many leaders start with the best intentions, they end like all the others, they don't truly change the behaviours and practices within the ED. Instead, clinical leaders are changed by the practices in the ED as they adopt more mediocre approaches. Karen felt that '*managers very quickly forget how it was when they ran the floor*', she observed that '*managers become managers, because they think they could be the manager they always wanted*' ~ Karin, ED Nurse Practitioner (Middle Management). This is very challenging as submitted by Blakemore and Frith (2005) who argued that people observe their leaders and imitate their behaviour (p. 463) whilst Gabriel (2016) argued that 'subordinates are quick to reciprocate superiors' toxicity through counter productive work behaviour'. Maxwell (2001) concurred that people adopt the attitude and behaviours of their peers and leaders.

West (2021) confirmed that compassionate leadership in teams is enacted by listening to each team members' contribution, understanding the role each member plays, nurturing a supportive and caring environment, and developing an ethos in which team members support each other (p. 158). However, it was also submitted that not everyone takes up leadership positions when they become available, as it is important to be ready for the responsibility such leadership role brings.

> "I have been asked twice to apply for the nurse consultant job, but I declined, because I was not ready – and I think they respect me for that – today, I am the Nurse Consultant. ~ Renate, Advance Clinical Practitioner (Middle Management).

> "During the time in ED, working through the bands, you see things, gaining knowledge, how things are done, and then eventually go into management. All that experience gives you exposure, help you to be formed, developed as a better manager to support your workforce." ~ Renate, Advance Clinical Practitioner (Middle Management).

Another argued that it was '*important for the clinical voice to be shaping the clinical journey*' and felt that it '*helps the organisation and patients in navigating the changing landscape that is the NHS*'. ~ Uriah, Managing Director of ED, (Senior Management). The effective utilisation of power in a professional way, is confirmed as vital to ensure that organisational goals are met (Pfeffer, 1992).

Education and Development

In exploring how much training participants have received in preparation for their current role, the following was reported.

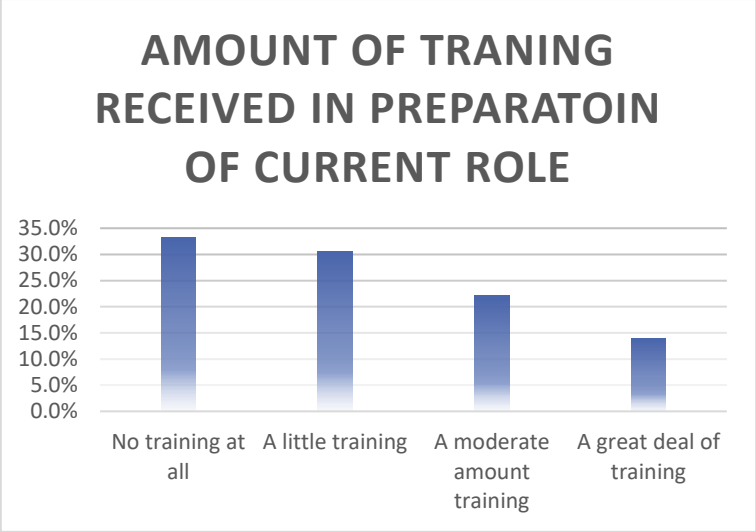


Fig. 6.1 Amount of Training Received in Preparation of Current Role

Figure 6.1 confirms the amount of training participants have received in preparation for their clinical role. In this regard, it was noted that 12 [33.3%] participants indicated that they have not received any training for their current role at all. It was confirmed that this group, received their normal 'mandatory training' as is required in the NHS, but no additional training or development was reported. Eleven [30.6%] participants confirmed that they had 'little training' in preparation for their current role; Eight [22.2%] indicated that they had a moderate amount of training, whilst 5 [13.9%] confirmed that they had received 'a great deal of training'. From this final group, it was not clear what the extend, level of training was that they had received. Contrary to most views, it was argued that there was more than enough training available to choose from, as one ED Consultant submitted.

> "Training and development opportunities is not the problem. There is a long list of training programmes to choose from, but people do not have the time to attend. Availability of time remains a challenge. We must truly protect time for clinical development." ~ Sancia, ED Consultant, (Senior Management).

When enquiring how useful the training was that had been received, **9** [25%] indicated that their training was 'extremely useful'; **8** [22.2%] indicated it was 'slightly useful'; **7** [19.4%]

confirmed their training was 'quite useful'; **6** [16.7%] indicated that the training they had received was 'not useful at all'; with **4** [11.1%] confirming that their training was 'moderately useful'; and finally, **2** [5.6%] participants selected 'other' and indicated that they either received 'no training' at all, or 'none other than mandatory training' respectively. An ED Matron felt strongly that clinical leaders are not sufficiently prepared for their roles.

> "Clinical leaders are not effectively equipped, it's like 'here you go, be a clinical leader' but originally our curriculum did not prepare us for this" ~ Quiana, ED Matron, (Middle Management).

In the quantitative data from the survey, **12** [33.3%] participants, submitted that they received no formal education or development from their trust, other than the traditional mandatory training. These consists of several statutory e-learning modules that all NHS staff must comply with to ensure they remain fit to practice. Some examples of these are information governance; adult safeguarding; child protection; resuscitation (for clinical staff); conflict management; fire safety, fraud awareness, equality, diversity, and human rights, to mention a few. It is this sense of the'keen amateurs' referenced by Ham *et al* (2011) when he challenged the NHS as a system, in that it offered little structure in terms of personal and professional development and preparing clinical leaders for the demanding role of management. During this study, an attempt to capture all the various leadership development frameworks across the NHS was unsuccessful. What was noted is that there is an abundance of generic frameworks (see **Appendix C**), however, one model may not fit all leaders, as different individuals have different developmental needs. Another interview participant confirmed that there is a need for a variety of approaches, in submitting:

> "I don't think we had equipped our clinical leaders enough as its almost like we just expected them to naturally be able to learn how to manage a group of very different specialities, when the interactions between different specialities, and different groups of people, are very different." ~ Uriah, Managing Director (Senior Management).

Wenger's concept of 'community of practice' (CoP) proposes an environment of informal learning (Li et al., 2009). "A useful perspective on knowing and learning" that is defined as "…groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wegner, 2006).

Table 6.2. Type of education or training they had during their career. [Q21]

	Total		**Emerging Leaders**		**Middle Management**		**Senior Management**	
What type of training would help you in your role? (Multiple choice options) [Q22]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Board paper writing	2	5.6%	1	2.8%	0	0%	1	2.8%
Budgetary or financial training	2	5.6%	1	2.8%	1	2.8%	0	0%
Business case development	2	5.6%	0	0%	0	0%	2	5.6%
Chairing of meetings	1	2.8%	0	0%	0	0%	1	2.8%
Coaching skills	12	35.3%	5	14.7%	4	11.1%	3	8.8%
Conducting value adding appraisals	5	14.7%	1	2.8%	4	11.1%	0	0%
Emotional intelligence training	5	14.7%	2	5.6%	2	5.6%	1	2.8%
Excel utilisation (PC skills)	3	8.8%	2	5.6%	1	2.8%	0	0%
Having difficult conversations	8	23.5%	5	14.7%	1	2.8%	2	5.6%
Human resources procedures	6	17.6%	1	2.8%	3	8.8%	2	5.6%
Leading and managing staff	7	20.6%	3	8.8%	2	5.6%	2	5.6%
Quality impact assessments	2	5.9%	1	2.8%	0	0%	1	2.8%
Strategic leadership	3	8.8%	1	2.8%	1	2.8%	1	2.8%
System knowledge	3	8.8%	2	5.6%	0	0%	1	2.8%
Time management	7	20.6%	4	11.1%	0	0%	3	8.8%
University (Academic) modules	6	17.6%	2	5.6%	4	11.1%	2	5.6%
Other	11	32.4%	4	11.1%	5	14.7%	4	11.1%
Number of answers from 36 respondents	**85**		**35**		**28**		**22**	

Table 6.2 Type of Education or Training they had During their Career. [Q 21]

This regular interaction was confirmed by Day (1999) who stated that CoP developed due to collaboration between schools and university in Australia (Day, 1999, p. 184). Development like peer support and collaborative leadership models should be explored further.

Ham *et al* (2011) submitted that clinical leaders reported that the NHS had shown little interest in their career, and they were left to their own creative resources in building their skills in terms of on-the-job development using the methodology of 'see one, do one, teach one' (p. 116).

In exploring the focus of the training that participants did get, a variety of options were offered to select from, whilst it was possible to select multiple responses. ***Table 6.2*** above confirmed that **12** [35.3%] had received '**coaching skills**'; with **11** [32.4%] indicating that there were '**other**' focus areas in the training they received. Regarding the latter, the following were noted. 'Clinical skills' or 'clinical management of patients' and 'important protocols' whilst overseeing night shifts; 'advance life support instructor training', which was obtained overseas, with 'minimal training in current role'; 'conflict management' was offered, whist the remainder of responses were that 'no training' or 'not much leadership training' have been offered thus far. Eight [23.5%] indicating that the focus on training they received was 'having difficult conversations'; whilst two groups of **7** [20.6%] indicated it was 'leading and managing staff'; and 'time management' respectively, with **5** [14.7%] confirmed that 'quality impact assessments' and 'emotional intelligence' were a focus, respectively; and three groups of **3** [8.8%] indicated it was 'strategic leadership'; 'system knowledge'; and 'time management'. Not everyone agreed that there was sufficient training, and even if there were there were other contributory factors that hampered leadership development, as argued by a senior manager.

> "Whilst there is lots to be done to enable people, I do think there are a lot of inhouse particle courses and academic programmes that could sit alongside in-house programmes, however we do not have sufficient staff. The department is busier than ever, but we don't have more staff, we focus on doing a lot of learning on the job but have limited capacity [time] so it's a bit of balancing act." ~ Oriana, ED Consultant, (Senior Management).

During the leadership development section of the survey, participants were asked about their past learning, or development offered, and the benefit of these. They were also asked to reflect on their own needs on what development and education they require to be the best they could be.

Table 6.3. Type of education or training that would be helpful in their role? [Q22]

	Total		Emerging Leaders		Middle Management		Senior Management	
What type of training would help you in your role? (Multiple choice options) [Q22]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Board paper writing	8	22.2%	3	8.3%	1	2.8%	4	11.1%
Budgetary or financial training	14	38.9%	4	11.1%	4	11.1%	6	16.7%
Business case development	11	30.5%	4	11.1%	3	8.3%	4	11.1%
Chairing of meetings	11	30.5%	5	13.9%	3	8.3%	3	8.3%
Coaching skills	24	66.7%	13	36.1%	8	22.2%	3	8.3%
Conducting value adding appraisals	11	30.5%	7	19.4%	3	8.3%	1	2.8%
Emotional intelligence training	18	50.0%	9	25.0%	5	13.9%	4	11.1%
Excel utilisation (PC skills)	10	27.8%	6	16.7%	3	8.3%	1	2.8%
Having difficult conversations	18	50.0%	9	25.0%	7	19.4%	2	5.6%
Human resources procedures	12	33.3%	5	13.9%	3	8.3%	4	11.1%
Leading and managing staff	22	61.1%	13	19.4%	7	19.4%	2	5.6%
Quality impact assessments	17	47.2%	7	19.4%	6	16.7%	4	11.1%
Schwartz rounds training	7	19.4%	3	8.3%	1	2.8%	3	8.3%
Strategic leadership	19	52.8%	9	25.0%	6	16.7%	4	11.1%
System knowledge	13	36.1%	7	19.4%	2	5.6%	4	11.1%
Time management	12	33.3%	10	27.8%	0	0%	2	5.6%
University (Academic) modules	13	36.1%	8	22.2%	3	8.3%	2	5.6%
Working across traditional organisational boundaries	11	30.5%	5	13.9%	3	8.3%	3	8.3%
Other	1	2.8%	0	0%	1	2.8%	0	0%
Number of answers from 36 respondents	**252**		**127**		**69**		**56**	

Table 6.3 Education and Training that would be Helpful

The top responses as capture in ***Table 6.3*** above, confirmed by **24** [66.7%] participants that 'coaching and mentoring skills' would be helpful; followed by **22** [61.1%] 'leading and managing staff'; with **19** [52.8%] indicating that they required 'strategic leadership development'; and **19** [50%] of respondents indicated that 'emotional intelligence' and training in how to 'having difficult conversations' respectively would be helpful.

Regarding the last point it was noted that a participant in the semi structured interviews addressed the issue of having difficult conversation, in submitting that:

> "There is not a single doctor who will stand with a nurse if a patient or a relative is being aggressive. They will stand behind a nurse every single time and let them [the nurse] try and deal with the situation where they just retreat, they don't get involve.' ~ Karin ED Nurse Practitioner (Middle Management).

This may not be due to a reluctance on the part of medical staff to deal with difficult or rude patients, or members of the public, but it takes an acquired skill set in having difficult conversations appropriately (Bond & Naughton, 2011), and if clinical leaders are not sufficient equipped (C. Lane, 2009), then it is likely that they would retreat, rather than dealing with the situation. Regardless, one member of the middle management, felt strongly that there was a clear gap in the leadership development offered to clinical leaders in the ED.

> "There is nothing really, no training that specifically cater for ED leadership, no organised, structured, formal process to develop you into being a leader." ~ Karen, ED Nurse Practitioner, (Middle Management).

In asking participants what type of training or development they would require to be the best in their role, one respondent suggested that he/she '*would like to progress to a more senior clinical role*', however it was also said that this individual '*would not like to progress into a management role*' as it was felt that '*management have little understanding of the day to day issues that affect staff and patients*' and only focus on what needs to happen or change, when a '*major clinical incident' occurs*', and even if change is then facilitated, this was described as '*not always for the best*'. ~ Dagmar, Middle Management, (Q27a).

Participants from the semi-structured interviews submitted a variety of needs, being '*how to have bottom-up difficult conversations*' including '*having difficult conversation with peers or the public*'; '*de-escalation skills*' with some peer support through '*coaching and mentoring*' ~ Karen, ED Nurse Practitioner, (Middle Management). Lee (2022) offered a 'ladder of capabilities' to coaching conversation with five core capabilities, being (1) motivation; (2) self-regulation; (3) self-disclosure; (4) agility; and (5) playfulness. (p. 16). Another participant suggested that the re-introduction of team building, more bespoke away days and simulation training would be beneficial. ~ Luann, ED Consultant, (Senior Management). The latter was confirmed by another in drawing a comparison to the aviation industry in the following:

> "I think we should do lots more simulations, as is done in aviation. Going through various scenarios, to practice like a well-oiled machine. So scenario practice would be very beneficial to make sure that everyone knows their part." ~ Prudence, ST 4 in ED, (Middle Management).

Others suggested '*triage training*'; '*time management*'; '*plastering skills*'; '*wound care*'; '*recognising deteriorating patients*'; '*trauma, including advanced trauma*'. ~ Quina, ED Matron, (Middle Management). '*Give people permission to speak up, irrespective of cultural background, promote a phycological safe environment*' ensuring that '*everyone's voice counts*' ~ Madeleine, ED Registered Nurse, (Middle Management). We need to be '*more compassionate in nature*' whilst it was acknowledged that due to the pandemic, there was a '*big realisation on well-being and mental health*' but it was argued that '*the latter has taken a big toll on ED staff*' as not only is mental health an issue for individual staff in the ED, they have also had '*a lot of mental health patients presenting in ED, whilst* [they] *are not trained to deal with mental health patients*.' ~ Noran, ED Consultant, (Senior Management).

In asking participants whether they have any comments to add about the kind or type of education or leadership development they may need, the following was submitted:

> "An improved leadership programme with an understanding of human factors, management, time management, etc." ~ Feline, Emerging Leader, (Q23).

Others submitted that in their view, the '*trust tends to lead from the top down*' and whilst there are some signs that this is improving, staff don't feel very valued, or are not always involved in the development agenda.

In terms of what would be helpful, from an educational and developmental perspective, one participant suggested that '*debriefings*' would be very helpful, like '*Schwartz rounds*'.

> "Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare." ~ (GMC, 2019).

The pre-final question of the survey [Q30] was the last 'free-text' opportunity where participants were asked about the leadership development and education they have undertaken during their career. Two respondents offered more general feedback which focused on what training they had, rather than what the impact of that training was. Two commented that they had '*mentoring training*' ~ Graeme, (Emerging Leader) and Luke (Middle Management); another suggested that '*life experiences*' ~ Hayley (Middle Management) was most helpful. One emerging leader offered the following perspective:

> "I influence my own development and education by seeking learning opportunities beyond my own scope of practice e.g., asking to watch doctors / practitioners assessing patients, watching doctors interpreting x-rays or scans, taking online courses outside of work on topics that interest me, e.g. ECG interpretation." ~ Carla, Emerging Leader, (Q30).

Three respondents focused predominantly on formal academic programmes, confirming that they partook in the '*Edward Jenner programme*' ~ Quanah, (Middle Management); attended

'*University modules*'~ Suzanne, (Middle Management), or completed a '*Master's in business administration (MBA)*' ~ Henry, (Middle Management), respectively.

However, the overarching message from feedback received from participants, was that the most valued learning comes through experience and working in clinical areas.

6.3 Conclusion

Leadership Development as a concept is not easily defined (Van Velsor, 2004; Winston, 2006). Like Culture and Personal and Professional Identity, as the data and the literature review in this study suggest, it has different meanings and interpretation for different people, with various layers of complexity in defining it as a concept.

The data from this study suggests that leadership development varied for participants and is represented in a spectrum from academic development, including inhouse development programmes, to statutory and mandatory training, coaching, and mentoring, on-the-job training, development through communities of practice (Li et al., 2009) and self-study or self-development.

The key message drawn from the data in this study is that there is not a single model for leadership development that will be suitable for all aspirant leaders. Although there are various leadership development frameworks in practice across the NHS (See **Appendix C**), there is not, or rather cannot be, a single model for leadership development that will be suitable for all leaders. A much more bespoke approach is being advocated based on the individual or group

developmental needs, to ensure that leaders are appropriately developed in being the best they could be (Bolden et al., 2003; Lee, 2022; West, 2021), promoting organisational effective (OE) (Dekker et al., 2022).

It was confirmed that the aspiration for clinical leaders, are to be leaders with a higher level of responsibility, who leads compassionately, and whose followers want to follow them (Hougaard et al., 2022). It was acknowledged that participants were of the view that their trust is very compassionate, and most people come to work to make a constrictive difference to the people in their care, it is not always easy to identify those few individuals who may have less than noble intentions.

Participants felt that their leaders, or they as leaders, are compassionate but did not have the foundational development or headspace, due to the transformational nature of the NHS, to truly listen or pay attention to the people they are supposed to lead (Brookes & Grint, 2010; Grint, 2008, 2010; Kotter, 1995; Lewney, 2017). Ultimately, there was consensus that the prevailing leadership style is based on compassion (Hougaard et al., 2022) with the needs of the patient as key priority. Stability in the executive team was also credited for creating a more compassionate approach, as it provides strength in the leadership, whilst it gives capacity to embed transformational initiatives to the benefit of both patients and staff.

However, participants did confirm that the behaviours of leaders are scrutinised, imitated (Blakemore & Firth, 2005), and responded to (Gabriel, 2016) on an ongoing basis, placing a higher expectation on leaders to lead by example and to be appropriately equipped to do so (Maxwell, 2001). To do this effectively, clinical leaders who are considered exceptional in

their clinical role, do not always have the best people management skills. This is a basic skill that needs to be developed and acquired and is not naturally inborn for everyone.

It was acknowledged that clinicians did not always anticipated a career in management (Spehar et al., 2012), and they have been described as a 'cadre of highly qualified reluctant leaders' (Fulop & Day, 2010) or defined as 'keen amateurs' who have received very little, if any, structured learning to prepare them for the challenges of their leadership roles (Ham et al., 2011).

The increased presenteeism of mental health patients in the ED was discussed at length, in that ED staff are not appropriately skilled or equipped to deal with the complex nature of these patients, which makes them feels vulnerable, devalued and at risk, as whilst the ED is a 'place of safety' it is not equipped to handle the influx of patients with mental health challenges. However, the rational why clinicians became clinical leaders, suggested that most of the respondents argued that it was a natural progression, part of their own development plan or they have been asked or supported to take on a leadership role. However, the complexities of becoming a clinical leader in a federated system like the NHS (Rivett, 1997; Welch, 2018), adds layers of difficulty. Trying to change one of the fifth largest employers in the world (NHSE, 2022) is not an easy task, as much of what they may want to change lies outside of their circle of influence (Covey, 2004, pp. 81 - 85). Whilst the skills of effectively utilising power and politics in a professional and effective way is an art on its own (Pfeffer, 1992). This study confirms that more bespoke management training needs to be wrapped around clinical leaders to manage, lead, support and to develop the people they lead.

Analysing the data from this study confirms that most participants felt that they did not receive sufficient education and or development to perform their roles (Ham et al., 2011). Whilst

others felt that there was plenty of education, training, and development available, but not sufficient time to participate in any of these interventions effectively.

It was argued that there is a need for some structured training (Ham et al., 2011) based on their respective individual needs. The education and development most needed by clinical leaders who participated in this study, was expressed as coaching skills (Bond & Naughton, 2011; D. E. Lane, 2011), how to lead and manage staff, developing strategic leadership skills, having emotional intelligence training, and how to have difficult conversations in an appropriate way (Dekker, 2017; Dekker et al., 2022; Dekker & Schaufeli, 1995; A. C. Edmondson, 2003, 2019; Goleman, 2000; Lee, 2022; Vermeulen, 1999).

To become a competent, compassionate, and inclusive leader, being the best clinician in the room, is not sufficient. Each leader needs the people skills, the basic principles of management, that goes with the role, to ensure that they could lead, support, and motivate the people they are responsible for, to be the best they could be.

Whilst consideration should be given as to how ED staff are either better equipped to deal with mental health patients, or the method of care of mental health patients should be re-considered. Participants also acknowledged that not all development comes from training programmes and development frameworks, but from observing others, which emphasise the importance of ensuring that leaders are fully equipped, with the capability and capacity to lead by example (Blakemore & Firth, 2005; Gabriel, 2016).

The researcher offers the following leadership development framework, which builds on the original conceptual framework (see ***Fig. 1.1***), and the revised conceptual framework (see ***Fig.***

2.2), as flexible option to conduct an individual needs analysis of what might be needed, by current and aspirant clinical leaders, to define their personal needs analysis.

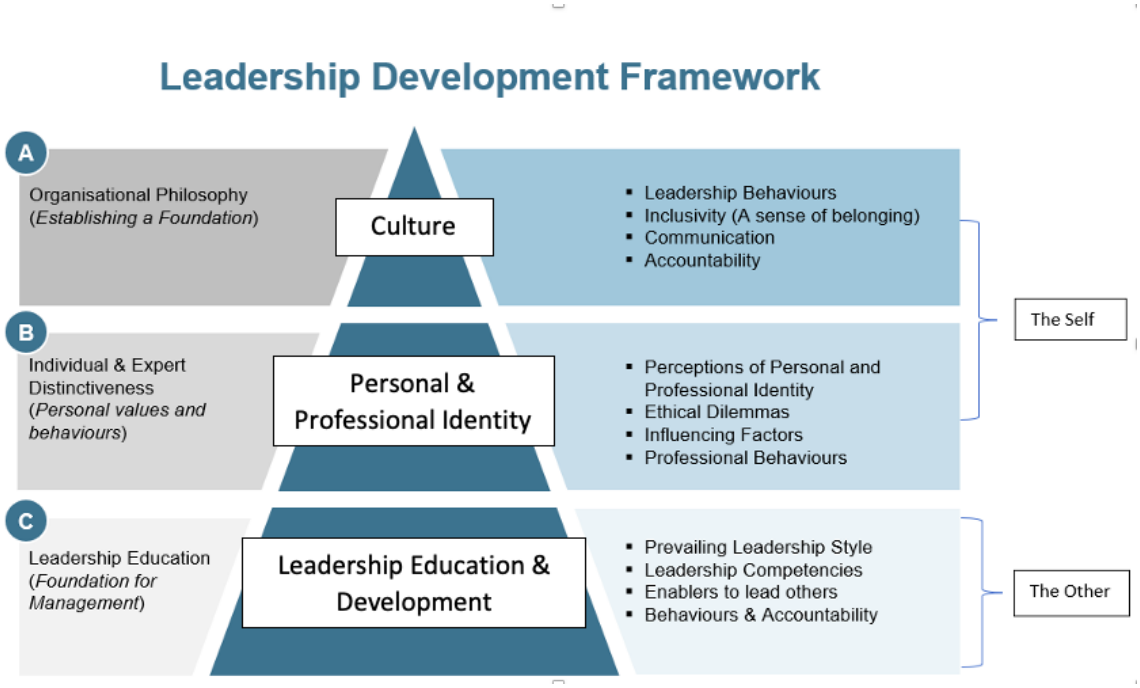


Fig. 6.2 Leadership Development Framework

The uniqueness of this framework is because it is developed from the academic literature (Dekker, 2017; Dekker et al., 2022; Dekker & Schaufeli, 1995; A. C. Edmondson, 2003, 2019; Goleman, 2000; Lee, 2022; Vermeulen, 1999; West, 2021), the data of this study and based on the individual needs of participants. It considers their personal motivation, journey, and developmental needs.

The distinction between the various leadership development frameworks available in the NHS (see **Appendix C**) and the framework as proposed in ***Fig. 6.2***, is that this provides a much more individual centric, flexible approach that could be shaped based on the organisational realities and individual needs.

6.4 General

The final section of the survey asked participants several questions about their interactions with colleagues in the department and the wider Trust; how confident they were in the leadership of the department, whether they would recommend the Trust and or the department as a place to work including what their career plans were for the future. In considering the interaction of participants with clinical leaders across the Trust, confidence about the ED leaders and interaction with clinical colleagues outside of the ED, the following were reported:

Table 6.4. Interaction and Confidence [Q24, 25, 26]

	Emerging Leaders		Middle Management		Senior Management		Total	
How would you describe your interaction with other clinical leaders across the Trust? [Q24]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Extremely positive	3	8.3%	3	8.3%	4	11.1%	10	27.8%
Moderately positive	9	25%	8	22.2%	1	2.8%	18	50%
Neither positive or negative	2	5.6%	1	2.8%	2	5.6%	5	13.9%
Moderately negative	1	2.8%	1	2.8%	1	2.8%	3	8.3%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
How would you describe the general confidence in leadership in the Department? [Q25]								
	n	***%***	***N***	***%***	***n***	***%***	***n***	***%***
Extremely confident	2	5.6%	2	5.6%	4	11.1%	8	22.2.%
Moderately confident	9	25%	6	16.7%	1	2.8%	16	44.4%
Neither positive or negative	3	8.3%	3	8.3%	2	5.6%	8	22.2%
Moderately unconfident	1	2.8%	1	2.8%	1	2.8%	3	8.3%
Extremely unconfident	0	0%	1	2.8%	0	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**
How would you describe your interaction with other non-clinical staff across the Trust? [Q26]								
	n	***%***	***n***	***%***	***n***	***%***	***N***	***%***
Extremely positive	4	11.1%	2	5.6%	5	13.9%	11	30.6%
Moderately positive	9	25%	9	25%	2	5.6%	20	55.6%
Neither positive or negative	2	5.6%	1	2.8%	0	0%	3	8.3%
Extremely negative	0	0%	1	2.8%	0	0%	1	2.8%
Blank	0	0%	0	0%	1	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36.1%**	**8**	**22.2%**	**36**	**100%**

Table 6.4 Interaction and Confidence [Q24, Q25, Q26]

Table 6.4 sets out participants responses in terms of respondents' interaction with other clinical leaders, across the Trust, in this regard, **18** [50%] indicated that it was 'moderately positive';

10 [27.8%] confirmed interactions are 'extremely positive'; **5** [13.9%] indicated that they viewed their interactions with other clinical leaders as 'neither positive nor negative'; whilst **3** [8.3%] respondents reported that they found such interactions as 'moderately negative'. **33** [91.7%] of participants are positive about their interaction with other clinicians. Considering the confidence participants have in the leadership of the ED, respondents submitted that **16** [44.4%] were 'moderately confident'; **8** [22.2%] were 'extremely confident' in the ED leadership; **8** [22.2%] confirmed that they were 'neither confident nor unconfident'.

In exploring respondents interaction with other clinical leaders across the Trust, more than half, or **20** [55.6%] indicated that it was 'moderately positive'; **11** [30.6%] confirmed interactions are 'extremely positive'. Overall **31** [86.1%] are positive in their interactions with other clinical leaders across the Trust. In terms of participants career aspirations, the following were reported:

Table 6.5 Career Aspirations [Q27]

	Emerging Leaders		**Middle Management**		**Senior Management**		**Total**	
What are your career plans within the next five years? [Q27]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Leave the NHS all together	1	2.8%	0	0%	1	2.8%	2	5.6%
Remains in my current post	1	2.8%	3	2.8%	4	11.1%	8	22.2%
Seek another role elsewhere in the NHS	3	8.3%	3	8.3%	0	0%	6	16.7%
Seek a higher leadership and management post in my Trust	6	16.7%	3	8.3%	1	2.8%	10	27.8%
Seek a higher leadership and management post in another Trust or NHS organisation	2	5.6%	2	5.6%	0	0%	4	11.1%
Retire	0	0%	1	2.8%	0	0%	1	2.8%
Undecided	2	5.6%	0	0%	2	5.6%	4	11.1%
Other	0	0%	1	2.8%	0	0%	1	2.8%
Grand Total	**15**	**41.7%**	**13**	**36%**	**8**	**22.2%**	**36**	**100%**

Table 6.5 Career Aspiration [Q 27]

Table 6.5 above confirms respondents, career aspirations during the next five years with **10** [27.8%] respondents indicating that they were 'seeking a higher leadership and management role within their Trust'; **8** [22.2%] indicated that they 'intend to remain in their current post'; **6** [16.7%] confirmed that they are 'likely to seek another role elsewhere in the NHS'; followed by **4** [11.1%] indicating that they would seek 'a higher leadership and management post in another Trust or NHS organisation'.

The final two qualitative questions of the survey asked participants if they would recommend the Trust as a place to work in the first instance, and secondly, whether they would recommend the ED as a place to work. Seven respondents offered reasons why they would not recommend the Trust as a place to work, as '*the culture makes it sometimes an unpleasant place to work*'; there was an '*over emphasis on performance targets*', driven by non-clinical management, to ensure that Trust targets are met, without regard for the '*impact on safety and quality requirements are not being met*'. Others argued that the Trust offers '*little opportunities to develop*' whilst it is expected of one to work in an area for multiple '*years before being accepted to progress*' ~ Q28.

Table 6.6 Recommending your Trust as a place to work [Q29]

	Emerging Leaders		**Middle Management**		**Senior Management**		**Total**	
Would you recommend your Trust as a place to work? [Q29]								
	n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Yes	13	36%	9	36%	7	2.8%	29	81%
No	2	6%	4	11%	0	0%	6	16.7%
If no – please specify why?	0	0%	0	0%	1	2.8%	1	2.8
Grand Total	**15**	**41.7%**	**13**	**36%**	**8**	**22.2%**	**36**	**100%**

Table 6.6 Recommending your Trust as a Place to Work [Q29]

Table 6.6 confirm that **29** [81%] respondents would recommend the Trust and the ED as a place to work, whilst **6** [16.7%] would neither recommend the Trust nor the ED as a place to work.

Some of the general comments offered by participants during this study confirmed that interaction between clinical staff across their trust was positive, whilst most staff had confidence in their ED leadership. Nearly half of participants indicated that they intend to remain within their Trust, seeking a higher position within the department or the wider Trust, whilst a small group indicated that they were likely to seek another role elsewhere in the NHS. Equally, most staff indicated that they would recommend their Trust as a place to work with a small number of staff indicating that they would not recommend their ED as a palace to work. These were due to the prevailing culture, staff shortages and the overwhelming demand from patients on the NHS at present.

6.5 Next Steps

The next and final Chapter will consider the overall research question and all four its supplementary questions in the conclusion of this work exploring the implications of the findings, what the data from this study means for staff in the ED, clinical leadership development and future research.

CHAPTER 7 ~ CONCLUSION

7.1 Introduction

The purpose of this final chapter is to consider the implications of the data, based on the literature and both the data from the survey and semi-structured interviews. It brings all the elements of this study together, whilst offering new definitions for organisational culture, professional identity, and clinical leadership development. It also offers recommendations for basic principles of management, as core essential development elements for future leaders, and considers what future studies could be done because of this study. It also deliberates how the data from this study could be disseminated, whilst it ends with a final personal reflection.

The data from this study, suggests that a different approach should be considered, a different focus to leadership development. Whilst it is acknowledged that there are a good variety of leadership development programmes available, it was argued that not enough has been done to prepare clinical leaders for their roles, enabling them to be the best, they could be.

Thus, a more bespoke approach to clinical leadership development is called for, with less of the traditional approach in offering leadership roles to those who served the longest, who are liked the most, or are the best clinician in the department. The latter is often not be the best leaders of people. A collaborative approach between the organisation and its respective leaders in 'co-designing' a developmental pathway for career planning, talent management and succession planning are called for. This does not suggest a single approach for all but is based on the elements of the conceptual framework and its notion of the inter-relatedness of organisational culture, professional identity, and leadership development. It is proposed that a

process should be considered, that addresses the individual needs of each clinical leader, with clear principles of career planning, talent management and succession planning (Powell et al., 2012).

7.2 Focus of this Study

This study aimed to offer an overview of the rationale and journey that clinicians took in becoming clinical leaders within their organisations. It reflected on the education and training they received (or not as the case may be) and the needs they have, ensuring they could fulfil their roles to their fullest potential. This study has been conducted as "the third paradigm in research" (Johnson & Onwuegbuzie, 2004) within an interpretivist paradigm, utilising a mixed method methodology, ensuring the best of both worlds in research (Uwe Flick, 1998) in considering the experience and actual realities of participants.

This constructivist and interpretative approach of participants' lived reality (Schwandt, 1998) formed the basis of the data in this study, to better understand the 'human experience' (Cohen et al., 2011) of urgent and emergency care participants' leadership journey in an Emergency Department (ED). The methodology employed in obtaining the data was one to one semi-structured interviews for qualitative data (Kvale & Brinkmann, 2009), and a survey to obtain quantitative data (Ercikan & Roth, 2006). This constructivist approach enabled the researcher, as interpretivist, to better understand the participants' experiences, and perceptions regarding clinical leadership development.

The original thesis proposal started with a much wider consideration, which was tempered through the Part A section of this study, and ultimately resulted in the main thesis question, articulated as:

What are the experiences and perceptions of leadership development and education for clinical leaders in the Emergency Department (ED) of an English NHS Acute Trust?

Draft supplementary questions were also refined during this process, which enabled the researcher to shape four supplementary questions to the research question, which emerged as the following.

SQ1. How does the concept of organisational culture influence the experiences and perceptions of leadership development and education?

SQ2. How are their personal and professional identities influenced by their experiences of leadership development and education?

SQ3. What are their perceptions and experiences of leadership development programmes and/or educational activities to date?

SQ4. What are their future development needs that will enable them to be effective in their role?

Finally, Chapter 3 sets out the original intention of conducting research in one hospital, with the semi structured interviews conducted with the same staff. However, due to the operational challenges imposed by the Covid pandemic, it became apparent that this was not going to be possible. Whilst the main survey (see **Appendix F**) was completed by respondents from one Acute Trust, the semi-structured interviews were conducted with participants from three

different acute Trusts. Although not originally planned, this proved very helpful, as it offered different perspectives, which improved the data and discussions held during this study.

Following the literature review, the primary focus of this study was drawing on a conceptual framework based on the inter-related concepts of culture and how it is impacted upon by values, behaviours, a sense of belonging, communication, and accountability. Secondly, it considered various perceptions on personal and professional identity, ethical dilemmas, influencing factors and professional behaviours. Thirdly and finally, it considered leadership development, the prevailing leadership styles, leadership rationale and leadership education. These themes will be reflected on in the next section.

7.3 Original Contribution

It was confirmed in Chapter 1 that the concept of leadership development was important to shape the future leaders of the NHS, which saw the creation of the NHS Graduate Management Trainee Scheme in 1956 (Powell et al., 2012). However, it took some 48 years until 2004 when the principles of 'talent management' was acknowledged whilst the slow progress in the talent gap and inclusivity remained a continuous challenge for the NHS (Calnan, 2017; Carvel & Shifrin, 2004; Powell et al., 2012). The nearly twenty years that followed, saw the publication of several reports, developmental frameworks, and development programmes, (see **Appendix B**, **Appendix C** and **Appendix I**).

However, it may be argued that all of these have had little impact on the respective development needs of individual clinical leaders, as they make their journey from clinician to clinical leader.

It was argued that the creation of leadership development, team development and a supportive working environment is essential for growing leaders of the future (Kazmi & Naaranoja, 2015). It was also argued that a 'one model fit all' approach to cover the developmental needs of senior leaders, middle management, and emerging leaders, in a historical traditional way is inappropriate, as different groups, and individuals, have different needs (Castro & Martins, 2010; Eustace & Martins, 2014). It was acknowledged, that whilst the concept of leadership and management are two different themes, these concepts were often seen by participants as the same. Finally, it has also been said that the NHS showed little interest in clinicians' career development, and they were left to their own creative resources in building their skills in terms of on-the-job development using the practice of 'see one, do one, teach one' (Ham et al., 2011, p. 16). This approach does not take cognisance of the individual's personal developmental journey, strengths, and developmental needs. The individual needs to be or become a compassionate and effective leader.

The original contribution offered by this study, is dealt with under the headings of the concept framework, which also saw some transformation from its original inception to the final elements of a clinical leadership development framework (see ***Fig. 1.1***; ***Fig. 2.2***. and ***Fig. 6.2***). The latter consists of three elements, being culture (***Fig. 4.1*** *and* ***Fig. 4.2***), professional identity (***Fig. 5.2***), and leadership development (***Fig. 6.2***).

However, it was acknowledged earlier, that there are many leaderships development programmes currently in place and available for use across the NHS. Thus, this study offered a leadership development framework for consideration, which provides greater flexibility, based on the individual's needs, as it is proposed that no single programme is suitable for all. Instead, it is proposed that moving forward clinical leadership development would be better

served by exploring bespoke individual needs analysis that would influence the development methodology employed. Rather than having a single leadership development programme, that is imposed on all clinical leaders, the proposed framework presented in ***Figure 6.2*** and discussed in Chapter 6 offers the first elements that could be considered in shaping leadership development interventions for individual clinical leaders.

Culture

SQ1. How does the notion of organisational culture influence the experiences and perceptions of leadership development and education?

From the literature review, surveys, and semi-structured interviews, it became clear that, it was challenging to articulate the culture of an ED, and it was acknowledged that culture would differ from ED to ED, from Trust to Trust, and even within the same department of a single Trust. West *et al* (2015) confirmed that there is no best way to develop leaders, as it is always context sensitive, mostly influenced by the gap analysis and depending on the nurturing of a culture that enables the ED to deliver continuous 'improved high-quality, safe and compassionate care'.

Participants identified the culture of the organisation as 'them and us'. Between the Trust Executive and the ED; between the medical staff and the nursing staff; between management and staff. However, culture is more than hierarchy, it is more than personal or professional identity, culture is about everyone in the group, team, or department. Culture is not something that stands separate, but is created and realised, by the players within. Culture cannot be

changed through the writing of a culture strategy, or a developmental programme, or the appointment of a culture lead, culture is created by people's behaviours. It is the self-reflective inquiry practice, of one's own conduct that impacts on organisational effectiveness (OE) (Dekker et al., 2022). An introspection of personal experiences, and the impact of that learning on altered behaviour (Day, 1999, 2000; Marshall, 2001).

The way people behave, is the bedrock of how culture is perceived and manifests. When leaders' behaviour is aligned to organisational values and the purpose of an organisation, or group of people, then cultural change will manifest itself. It shapes how people communicate with one another and how team members hold themselves and each other to account for their actions, or lack thereof. Culture is not something that stands independent to the role players within the organisation it is complex, interlinked, and interdependent. However, there remained a perceived disconnect that Trust management and staff from outside the ED do not understand the complexity and pressures that are placed on staff within the ED ~ Tara, ED Lead Nurse (Middle Management).

It is also this complex and multi-faceted reality that impacts how people make sense of their role and purpose. This is further impacted by the differences in organisational norms, the behaviours of people inside and outside of the ED that causes tension in defining their own personal meaning with little regard for their external influencing factors (Frankl, 2004).

Culture in the ED has also been explained as the level of 'psychological safety' which 'is about candour and willingness to engage in productive conflict' to ensure various perspectives are heard, creating space for innovation and education. (A. C. Edmondson, 2003, 2019; Lencioni, 2002) that is visible and being practiced within the Trust and or ED.

Much has been said, and written about compassionate leadership and the elements of a 'just culture' (A. C. Edmondson, 2019; Hougaard et al., 2022; West, 2021; West & Bailey, 2019), however from the data in this study, the researcher offers the following as a contribution to the academic record on definitions of organisational culture.

> **Organisational culture is created by the organisation's aspirational purpose; impacted upon by the experience, perceptions, and realities of its staff, regarding its values and behaviours; and influenced by team and organisational norms.**

It is therefore important that clinical leaders are clear about their purpose, the consequence of their own behaviour, their values, the organisational structures, and how they contribute to the actual culture of a department or organisation. How they ensure everyone is included, how communication is done, and how team members hold themselves and others to account.

Each leader cast their own shadow on the culture of an organisation, which is done consciously or unconsciously (Somoye, 2016). It is therefore helpful that they understand that others watch what they say and do, what they pay attention to, how they utilise resources or act in the organisation (Oliver, 2006; Schein, 2004). These are all aspects that is often taken for granted, but directly impacts the culture of a team, department, or organisation, and influence the inter-relationships in multi-disciplinary teams.

The framework for 'measuring culture' proposed in ***Figure 4.2*** will be key in helping organisations or departments, to measure the state of their culture, and the journey of cultural improvement. It is acknowledged that this framework may be amended and would consist of all the factors indicated in the framework, or some, based on the organisation realities. Whilst

all or some of the elements may be used, the key focus should be, how cultural improvement is achieved and measured.

What remains unclear, and could be a subject for further exploration, is how foreign staff are inducted into the UK way of life in an ED or NHS Trust. How to make the transition less traumatic and/or less painful. Equally, to ensure that international recruitment into the NHS remains sustainable, cost effective and not equate to a 'leaking bucket', with the service having a continued revolving door of international nursing and/or medical staff coming and going on an endless basis. As an immigrant researcher, it is not easy to simply adapt to a new country with different cultures, practices, and behaviours. Let alone the added complexity of being an English second language (ESL) user, not to mention the micro and macro-organisational cultures and norms to content with.

Professional Identity

SQ2. How are their personal and professional identities influenced by their experiences of leadership development and education?

Identity as a concept played a big role in this study. Participants talked about their own individual identity, influenced by cultural and religious customs, professional identity, and a lack of a sense of belonging, compounded by bullying behaviours based on their ethnic identity. From a professional perceptive, participants indicated a perception that there was a divide between nursing and medical staff. An affiliation to a specific clinical identity. It was acknowledged that more research is needed (Floyd & Dimmock, 2011; Floyd & Fuller, 2016) on the impact of professional identity and the impact of a more collaborative system approach.

It was also argued that professional identity is similar to professional reality, self-image and the roles people feels obliged to play (Beijaard et al., 2004).

The "system of moral principles" (BBC, 2014) has been described as a structure of honourable values according to which people live their lives. It is this 'universalability', 'duty' and 'humility' of Immanuel Kant (Larry & Moore, 2016) that help shapes the 'moral and ethics' (Wheeler, 2006) of clinical leaders in the ED. However, the professional identity of clinical leaders and the emerging new ways of working results in a threat, perceived or real, to both personal and professional identity. This is a challenge in Health as it is in Higher Education Institutions, as articulated by Floyd (2012) who argued that the professional identity of middle managers in academia is under threat. Although there are some progress with the creation of physician associates, advanced nurse practitioners, and nurse consultants, much more is possible, and should be considered within the health sector.

Unfortunately, the health sector's Royal Colleges are slow, if not reluctant to embrace this change, as they are very protective of their professions, in their belief that doctors should do what doctors were trained to do, and nurses should do what nurses were trained to do, etc. This professional, but narrow view, is out of step with the reality that there is just not sufficient clinical staff available, world-wide, and as such new ways of working, multi-disciplinary team working, and collaborative co-designing of creative new clinical and non-clinical roles should be considered to fill the gap. This will enhance, rather than depreciate the health-care profession.

Considering the art of the possible, new ways of working is going to be key for a sustainable ED and NHS. If the Covid pandemic taught society one thing, it is that when needs must,

people can be very creative in re-inventing themselves. People starting with new careers in new roles, that they never trained for originally, or ever anticipated they could do. Professional identity should not be threatened by new ways of working, but should be embraced, as it enables professions to evolve, individuals to grow and adapt with the times. The principle of life long-learning, enables leaders to accept change and commit to high quality of care for both the people they lead and those in their care (Day, 1999). To define professional identity, based on the literature, and the data from this study, the researcher describes professional identity as follows:

> **Professional identity is the beliefs that defines a professional's purpose, values, and behaviours. It is impacted upon by both the relevant regulatory body's code of conduct, and the organisational setting of the individual, and is the way that professionals define who they are and what they do.**

When it came to professional behaviour, there was a perception that there was a divide between the professional behaviours of medical and nursing staff, with a 50/50 divide, and two participants who were not sure either way. In this regard it was reported that some clinical leaders have seen a significant change since they have stepped up into a clinical leadership role, in that they were recognised more, they got results quicker, or people listen to them more. But the same amount of people argued that for them there was no difference, they were there for the patient first and foremost and they did not believe that there was much of a difference between the various clinical disciplines in the ED, as the nature of the department requires of everyone to play their part, working as a team, to the benefit of the patient.

It was these challenges that impact professional identity for some, and whilst most felt there was no divide between the clinical professions or real challenges within the ED, it was

acknowledged that the ethical dilemmas created between their organisational positions, in terms of power and politics, and their regulatory bodies did lead to conflict between clinical leaders. This conflict impacts how clinical leaders see their role and how they deliver their clinical values of 'doing no harm'; 'ensuring anonymity'; 'confirmed consent' and enabling 'end users have the right to withdraw' (Summers & Morrison, 2009).

Professional identity is nearly as complexed as defining organisational culture. But what was clear from this study is professional identity is defined by a variety of elements including how professionals make sense of what they do (see ***Fig. 5.2***). In addition, and considering that neither the NHS guidance on 'Maintaining High Professional Standards' (MHPS) nor NHS Employer's toolkit on culture defines 'professionalism' as a concept, the question remains, whether clinicians are truly taught, during their forming years, what 'professionalism' and / or 'professional identity' means for them, or what may be expected of future clinicians and clinical leader in this regard. The guidelines articulate what must be done, and may not be done, but is that sufficient?

Leadership Education and Development

SQ3. What are their perceptions and experiences of leadership development programmes and/or educational activities to date?

The participants in this study all confirmed that they did not become clinicians to became leaders and felt that they were not sufficiently supported or developed on that journey. Ham *et al* (2010) described clinical leaders as "keen amateurs" who became leaders as it was felt

that someone had to do, or because there was no one else, whilst it was acknowledged that 'some were interested in being a leader for others'.

Most participants did confirm that they received a variety of education and leadership development during their career, in the ED or their Trust, which included 'mentoring training'; 'life experiences'; 'observing' others; 'Trust approved management courses' or 'experience and working day to day in clinical areas'. However, they confirmed that they have not been sufficiently equipped in the essential principles of management.

The key challenges for clinical leaders were the lack of capacity, bespoke individual development, and availability of time. They articulated personal developmental needs, to have the opportunity to develop and grow, but due to the persistent pressures and challenges facing the NHS this was not possible. These challenges impacted on the prevailing leadership style, communication, and engagement, although it was acknowledged that there was a strong sense of compassion in the ED.

The rationale for clinicians becoming clinical leaders, varied from 'wanted a new challenge'; or being part of their 'personal development plan' to enjoying 'developing other people's careers'. Whilst all acknowledged that some key competencies for leadership development would be essential, there lacked the basic principles of management and an alignment between the different programmes currently available.

The development of clinical leaders was acknowledged in various publications (see **Appendix B**, **Appendix C** and **Appendix I**), which contributed to the development of leadership competencies and behaviours that have been defined as essential for leaders to poses. This

sense of life-long learning was articulated in Chapters 2 and 6 (Blackman, 2014; Blakemore & Firth, 2005; Gould & Stevenson, 2008; Pillay, 2017) and influenced how clinical leaders behave; their leadership styles; the things they pay attention to, and how they develop themselves and others (Oliver, 2006; Schein, 2004). The focus on development of clinical leaders should help them to be comfortable in making difficult decisions. Considering the feedback on different ethnic cultures, it was argued that people should be given 'permission to speak up, irrespective of cultural background, promote a phycological safe environment' ensuring that 'everyone's voice counts', whilst all should feel they belong being more 'compassionate in nature' (Dekker, 2017; Dekker et al., 2022; West, 2021).

Considering the literature review in Chapter 2, and after the review of the data from this study, the researcher offers the following as a definition for clinical leadership development.

> **Clinical Leadership Development is the education of clinical leaders in the art of understanding their own ability (the self), being present, engaging and listening; having an inquiring mind, exploring all the options from others (the other); and offering guidance that enables both 'the self' and 'the other' to benefit in terms of their own development, the people they lead, and ultimately resulting in improved patient outcomes.**

Basic Principles of Management

SQ4. What are their future development needs that will enable them to be effective in their role?

It has been said earlier that often clinicians become clinical leaders because it was part of their own career trajectory, the next step, or because they were the longest serving individual in the department, they served their time, or because someone asked or encouraged them to apply. This does not set the scene for good leaders or managers for the future, as the basic principles of management is often assumed, disregarded, dismissed, or plainly absent.

The data from this study suggests that a foundation level of training for all clinical leaders should be considered, not a tick-box exercise, but real education in the full sense of the word. Whilst e-learning seldom achieve this result, various methods for this education could be considered, but the outcome is more important than the method. The outcome, must enable, empower, offer insight and result in an improved ability to understand 'the self' and lead 'the other'. A society or community where 'the other' is more important than 'the self' (Bettina, 2019; Zhao, 2016).

The core scope is very likely to differ from individual to individual, based on that individual's personal career trajectory and individual needs. However, considering the data of this study, it is proposed that as a minimum, organisations should have in place the following basic principles of management.

To develop 'self'

- Organisational values and behaviours ('the way we do things around here');
- The principles of professionalism (concepts of professionalism and conduct);
- Strategic objective setting, clarity of purpose and the direction of travel (sharing the vision);
- The art of coaching and mentoring (being open for uncomfortable truths, but also being able and willing to enable others to find their best path in a compassionate way);
- Financial management and operating procedures (including procurement arrangements);
- Recruitment authorisation and resource allocation (including values-based, inclusive recruitment);
- Personal accountability (reflective of the organisational strategic objectives);
- Statutory or Regulatory compliance (the importance of regulatory compliance).

To develop 'the other'

- Inclusivity, to accept 'the other' in terms of the multi-ethnicity of the workplace (understanding development needs and how to bring the best out of all they lead);
- Basic principles of employee relations (a sense of belonging, grievances, dignity at work and disciplinary procedures and practises);
- Compassionate conversation, (appraisals, being supportive, focusing on objective setting, delivery, wellbeing, talent management and succession planning);
- Managing performance related conversations (value adding assessments enabling delivery);
- Delivery management (performance) and personal accountability.

The above, which is not an exhaustive list, but is proposed to act as a catalyst to think differently. To consider what is appropriate for each organisation, in ensuring that leaders are appropriately prepared. It may be all of the above, or some of the above. It all depends on the personal needs of the individual and the organisational realities.

Understanding the difference between empathy, sympathy, and compassion. These three concepts could best be defined with the following example of when a boy fell into a well: -

- **Sympathy** ~ to look at the boy, and to express sadness that the boy fell into the well, but gratitude that it was not the case for the onlooker;
- **Empathy** ~ when the onlooker express insight into the experience regarding the anxiety of the boy in the well, as the onlooker might have had the same experience and therefore could understand the fear, anxiety, and experience of the boy;
- **Compassion** ~ disregards whether the onlooker had the same experience as the boy but asks the question 'how could I help' in assisting the boy to get out of the well and enabling him to be in a safe and secure environment.

Compassionate leadership would be to support the people they lead, to be the best they could be, in a safe and just environment, without sacrificing accountability of performance. Thus, not stepping in and doing for 'the other', but rather support, empower, and help 'the other', to be his/her greatest self. Sinek (2009) confirmed that leaders are 'not in charge [of the people they lead but are required to have compassionate conversation with the people] in their charge'.

Whilst everyone may have different and additional personal development needs, the above are defined, from the literature and the data in this study, as essential minimum requirements for

any manger to master. This, it is argued, will enable them to be good leaders and will empower them to develop themselves and the people they lead. Similarly, the competencies defined in the Executive Director's competencies list, (see **Appendix C (5.)**) can equally be used as guide for all leaders as development aspiration. To form the basis, on which they could build their experiences in leadership roles. Practical experience in leadership positions, remains the best method of leadership learning, but essentially, the above should take place under supervision and with appropriate support (Hougaard et al., 2022; West, 2021; West et al., 2015; West & Bailey, 2019).

Implementation & Professional Practice

To implement the basic principles of managements, it is essential that as part of the leadership development process good and value adding appraisal methodology is in place or introduced (Carter, 2016; Kerr, 2018). To have regular compassionate conversation with staff is part of being a compassionate leader (West et al., 2015). This should focus on clearly defined objectives, that is achievable, with measurements for success, and a defined timeframe during which these should be delivered. Any support required to ensure objective delivery should also be defined, whilst regular 1:1 conversations should take place to ensure the appropriate support and accountability is agreed.

A regular, value adding appraisal is essential to ensure people understand their purpose, their responsibility, and their areas of accountability (Frankl, 2004). This will also become the primary source document for talent management, succession planning and an opportunity to have a wellbeing check-in with staff. It is a good process to re-enforce the organisational values and behaviours and reflecting on how staff live the values of the organisation. This

process is essential to help understand and explore the longer-term career aspirations of staff, ensuring that all are clear about their purpose, responsibilities, appropriately valued, and developed where needed, whist offering the support that may be required (Dixon-Woods et al., 2013; West, 2021).

Appraisals in the NHS are traditional conducted annually, with a six-monthly review, but monthly 1:1 conversation should act as supportive discussion to ensure the best possible outcome. Whilst it was stated earlier that each leaders cast their own shadow on the culture of an organisation (Somoye, 2016) poor performance should not be a surprise at an appraisal discussion but something that have been addressed throughout the year's 1:1 discussions. The utilisation of 360 degree anonymous feedback is also essential to ensure a leader understand his/her impact on the perception of others regarding their behaviours, leadership style and ability to lead (Kerr, 2018).

From a professional practice perspective, consideration should be given to local leadership development (see ***Fig. 6.2***) and Higher Education Institution (HEI) curricula changes. Closer relationships with HEI's to better prepare clinical students, i.e., nursing, medical, and allied health professionals, to better understand their role in contributing to organisational culture; how they understand their professional identity, and what leadership development they need. However, the concept of collaboration across both professional and organisational boundaries, adds a new dimension to leadership development as it requires different skills, beyond the obvious, of system working, collaboration, rather than professionally focused, or organisationally introverted. The future is about multi-disciplinary team working, collaboration across organisational boundaries, and system delivery. Leadership development

could play a significant role in expanding these traditional boundaries, resulting in overall better patient outcomes.

Early engagement and curricula review will enable current leaders and students (future leaders) to have insight into the impact of their values and behaviours, on an organisation and system, the requirements of their regulatory bodies, the sense of who they wish to be, from a professional identity perspective. It would help learners, understanding their own developmental areas, whilst asking for help to enable them to develop to be the best they could be. These are all enablers that are required to develop leaders for the future, to work in MDT's, across organisational boundaries and across systems, to provide high quality care to the people they serve and support the people they lead. However, the leadership development is dependent on the personal needs of the individual.

According to Sinek (2009) it is that 'belief in an ideal' that Nelson Mandela expressed in the Rivonia Trail of 1964; that harts-conviction that is needed for leaders to make a constructive contribution. That ability to inspire others, to make people want to get out of bed in the morning, to truly make a difference in the organisation, for the people they lead, or the community they serve (Sinek, 2009).

7.4 Implication and Research Recommendations

Throughout this study a consistent theme expressed was behaviours, which impact culture, personal identity, and leadership development.

Part of being supportive is to understand what individuals need in terms of their personal development, on their journey to becoming clinical leaders, and being the best possible leaders to the people they lead.

Each clinical leader requires their own personal development plan (PDP), which is best achieved by a personal developmental needs analysis, using the appraisal process, aligned to the organisational purpose, strategic objectives, supported by the principles of talent management (Ham, 2011), succession planning and leadership development (Lewis & Heckman, 2006). Some methodology that should be considered is personal coaching, mentoring, with bespoke training interventions (West et al., 2015). This could include self-reflective inquiry practice (Marshall, 2001), individual or team coaching (Augustijnen, Schnitzer, & Van Exbroeck, 2011; Balu, 2017; Bond & Naughton, 2011; Boyatzis, Smith, & Blaize, 2006; D. E. Lane, 2011), mentoring (Lee, 2022; Powell, 2014), community of practice (Li et al., 2009; Sunley, 2010), defined as 'groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly' (Wegner, 2006). Some situational training was called for, as is practiced in the aviation sector, with Schwartz Rounds and dedicated time for in-house experiential and essential learning.

But to achieve this, clinical leadership development is intrinsically linked to objective formulation, personal development plans, talent management and succession planning and the protection of time. This will enable clinical leaders to be heard, to be valued and to be developed to make a meaningful and constructive difference to those they lead and to those in the care.

Limitations of this Study

The fact that this study was originally planned for a single English Acute Trust, renders the data limiting, as an interpretivist study. It cannot be claimed that this study could be generalised nationally, as this study is a case study of effectively one organisation. The fact that three Trust were used for the semi-structured interviews helped with the triangulation or crystallization of data (Richardson, 2003), but it is still not sufficient to claim that the outcome of this study could be generalised across all Acute Trusts in England.

The reality that the researcher is a Director in the NHS, also could have been limiting, as it was difficult to encourage emerging leaders to participate in this study, which could be due to the fear of any consequences from the conversation during the data collection, or that participants just did not identify as being part of the leadership of the organisation. So, the perceptions of participants could have been self-limiting in offering valuable data from especially the emerging leaders.

Whilst insider research is challenging, as confirmed by Floyd & Arthur (2012), it should be noted that the researcher was neither employed nor ever worked in any of the acute Trusts who partook in this study. Information shared was taken at face-value. A neutral approach was taken without any pre-conceived ideas, considering the lived experiences of participants as their reality.

It is regrettably that none of the emerging leaders were willing to participate in the semi-structured interviews. Their participation could have given better insight into the perception of culture; the development of their professional identity; their rational on why they may

become clinical leaders, and what development needs they may require. Sadly, consideration was not given to explore alternative ways to engage with the emerging leaders during the semi-structured interviews. Future research should explore alternative possibilities to engage with emerging leaders, or any other group that may not want to participate. This could include someone else to engage with groups who may feel uncomfortable to engage with the researcher. This will enable data to be collected, for the researcher to review and considered as part of the research project. If this was done, it would have given the researcher additional data to consider, across all three categories of emerging leaders, middle management, and senior leaders.

Regardless of the above, it remains the view of the researcher that the data form this study offers valuable and rich data to start the conversation regarding the art of the possible in leadership development. on how to progress with UEC leadership development. Whilst this study was planned for, and conducted in an Acute setting, it would not be surprising if there are strong similarities with the needs of clinical leaders from the Ambulance Services whose primary duties are around UEC and could be an area for further consideration.

Future Research Recommendations

This study is small in scale but could be replicated across an Integrated Care Board (ICB), with all Trusts across the system participating. This will enable a system approach to talent management, succession planning and leadership development. The inclusion of different hospitals across a system could focus on different specialities. As this study focused on the ED, it could be replicated for Theatres, Intense Care Units (ICU), or maternity units, across the

ICB, or even across a region like the Southwest, Northwest, or East of England, to mention a few.

Following this study, it is recommended that future research, could explore:

- Time management in an ED/UEC, how to ring-fence or maximising limited time, in an urgent and emergency department;
- The induction and integration of foreign staff into the NHS in terms of its practices, regulatory requirements, values, and behaviours;
- Multi-disciplinary leadership development and collaborative system working;
- Exploring the challenges with personal and professional identity, and its impact on health and social care professions;
- Understanding the complexity of UEC, the internal working of operations in an ED/UEC setting, in recognising emergency care as a speciality in own right or not, as the case may be; and
- New ways of working, to support the workforce challenges in the NHS across systems.

7.5 Conclusion and Dissemination

The aim, purpose and content of this study sets out to explore the experience and perceptions of clinical leaders' leadership developmental journey in the ED of an English Acute Trust. The exploration herein, the data from the study and the literature review captured in Chapter 2 established the foundation of how leadership development could or should be handled moving

forward. It focusses on the individual's needs, balanced against the organisational context and within the framework of perpetual change and ever-increasing operational demands.

An unplanned or unforeseen consequence of this study was the creation of, hopefully, a complete chronology of transformation over the past 74 years of the NHS. This revealed that organisational change takes place on average every 3.5 years (see **Appendix B**). The reality of this stark statistic is that if change takes place so often, not only are these very costly, but there is no time to effectively embed the new ideas or ways of working before the next transformation project is launched. This has a massive impact on the tax-payers contribution to the NHS, and the ability of the NHS to provide effective care, free at the point of delivery, which is consistently defined as under-resourced.

A further consideration is that during the collection of data, reference was made about the Aviation sector, and that the NHS should take a leaf from the aviation industry. This was suggested because, according to the UK Aviation Authority, no plane may take off, without ensuring that all essential checks, training, and education has been complied with. These checks are repeated every flight and based on the operational standing orders of each aviation company. Whilst the UK aviation legislation dictates an annual refresh of essential skills training (statutory mandatory training), some companies have internal requirements that necessitate the retake of these tests every six months (UK Civil Aviation Autority, 2022). Ultimately the word "mandatory", is defined as "required by law or mandate; compulsory" (OCD, 2008, p. 618), it should not be optional, or when there is time, it is mandatory.

The question for the NHS, based on the aviation sector's practices, is why healthcare organisations are so unwilling to enforce compliance to its regulatory essential skills training

(statutory mandatory training) policies. The NHS often talks about 'human factors', and lessons learned from the aviation sector. Yet, it allows its staff to operate without 100% (or at the very least 90% considering annual and sick leave) compliance rates for essential skills training or to conduct simulation exercises to ensure that staff operate like a 'well-oiled machine'. Equally important, it appoints clinicians in leadership roles without the appropriate support and essential principles of managing training or development, and the argument is often that there is not 'sufficient time for abstractions'.

It is acknowledged that basic managerial modules could be generic, and would be helpful for emerging leaders, middle management, and senior management, but the key focus for leadership development is the individual gap analysis that is bespoke to every individual leader, as they progress on their journey to becoming a senior leader in the NHS.

Finally, this study, although small in scale, has given new insight into the necessity to consider individual needs as part of the education and leadership development journey. Whilst basic essential skills training will always have its place, coaching, mentoring, experiential learning, community of practice, action learning sets, self-study and external consultant facilitated interventions are key arrows in the armament to support life-long learning (Dalakoura, 2009; Liubchenko, 2016). That will help clinicians to become clinical leaders who are aligned to the organisational culture, vision, and values and who's personal and professional identity enables them to behave in an inspirational way towards those they lead. Leadership development for the future, it is argued, should focus on those elements that each individual leader would benefit from most, to lead by example, to be the best leader they could be and to be as inspirational, engaging, and present for the people they lead as well as for those in their care.

It is confirmed that some of the frameworks and definitions created in this study has already been tested and disseminated with NHS colleagues, resulting in a welcome reception. The more detailed data and content of this study is intended to be shared with ED and UEC colleagues in participating Trusts and systems, but also with the wider NHS, who may be keen to explore clinical leadership development, and ways to improve both its impact and outcome for patients and staff.

7.6 Reflection

Looking back at my notebook of 2018, we started as a group of 12, with students from the United Kingdom, Saudi Arabia, the United Arab Emirates and Belgium. It was a daunting beginning of a process, with self-doubt, and imposter syndrome in abundance. Part A of this study programme helped building my confidence not just in academic research, but also in my own academic ability. Moving to Part B was the truly exciting part, as this enabled the research project to come alive. Consequential to the writing of the thesis, it improved my writing skills, my vocabulary, Excel skills, PowerPoint skills and the ability to use the technology to my disposal better. It forced me to learn new skills that I otherwise would not have acquired.

Five years later, I have been on an academic and personal journey that I never thought would be possible to complete. It has enabled me to be more reflective in what I say and do. It taught me to listen more attentively. I have come to the realisation that it is acceptable not to know everything, and to ask for help when I am struggling. I have learned to apologise more where I have erred and to learn from every culture that have come across my path. This study has

had a fundamental impact on my own leadership style, professional identity, and personal ability.

As a Director in the NHS, I have challenged myself to being better. I have failed many times and am likely to fail many more, but I remain committed to lifelong learning, coaching, self-reflective inquiry practice, and continued personal development.

Ultimately, reflecting on my own leadership development, and in all honesty, if reflecting on my own personal life, I have made many mistakes. I could have done many things differently, I could have handled many situations better, however, I understand that better today, and can learn from those mistakes of the past.

We have no control over the past, but as a leader, as a member of the NHS and as a human being, I have control over today, how I behave, what I say and what I do. The way I act today will influence the consequence for me, and others tomorrow. Finally, it is my submission, that how we act, behave, and perform today determines how people's perceptions will be formed of us today, and how the leaders of tomorrow will behave in time to come.

This has been an incredible enriching, and rewarding journey, both educational and personally, humbling. As the more you learn, the more you realise, how little you know. A journey that encourages a lot of self-reflection, continued life-long learning, but also of challenging the *status quo*, in asking, 'why?'

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APPENDIX A ~ THE IMPACT OF COVID-19 ON THE NHS, AND THIS STUDY

"The values and principles of 1948 remain indelible, but how we make a reality of them in the modern NHS has changed beyond recognition from the starched caps and bedsteads of post-war Britain. The NHS that celebrates its 100th birthday in 2048 will be able to achieve things which today we can scarcely imagine – but only if we, at this moment, take the action necessary to secure the NHS's future." ~ Prime Minister Theresa May (2016 - 2019)

The then Prime Minister Theresa May (2016 – 2019) did not realise how true her words were, when she referred to the memories of the NHS in post-war Britain, as shortly after these comments, the NHS, and the world, faced a new war-like crises in the realisation of Covid-19 (C-19).

The country went into lock-down on 23 March 2020 with a slogan of '*stay at home, protect the NHS, save lives*'. This happened after NHS Digital reported that in February 2020 the NHS had 100,000 vacancies. The pandemic could not have happened at a more challenging time.

Yet, staff were redeployed in mass. Nearly 20,000 retired staff were returned to active duty, whilst surplus staff from both the hospitality and retail sectors volunteered to be retrained as health care support workers. Over 2000 final year medical students were allowed to complete their studies sooner, whilst 20,000 final year nurse students were expedited to become registered nurses responding to the battle against C-19.

Historically, the NHS had lots of duplicating processes, creating inefficiencies and still utilising fax machines as recently as 2020. General Practitioners (GPs) and Consultants had to see people in person and pre-employment checks had to be done by presenting hard copies of documents in person. Culturally, there has been a fundamental shift away from the *status quo*. GP's now don't see people in person but prefer to see them via WebEx, Skype or MS Teams.

From being a competitive system, the NHS had made massive progress towards being more collaborative. Suddenly organisations are talking about a single NHS workforce, creating system support solutions for its vulnerable and in particular for Black, Asian, and Minority Ethnic (BAME) staff.

On 5 April 2022, the then Prime Minster Boris Johnson was admitted to hospital after he contracted C-19 and was moved to the intensive care unit two days later.

The BAME staff in the NHS were severely impacted as a high-risk group of staff. It was reported that nearly 1,000 NHS staff have died (Ford, 2021), of which 64% have been BAME

colleagues (Chaudhry, Raza, Raja, & Ahmad, 2020), compared to a national NHS BAME workforce of 21.4% (NHSE, 2022). By 31 May 2022, the NHS recorded **126,147** deaths because of Covid (NHSD, 2022a), whilst social media suggested nationally the UK deaths were **180,000** by June 2022.

The NHS embraced agile working, collaboration across organisational boundaries, and even across system boundaries, liaising with the Ambulance Trusts, the County Councils, the various Universities across systems, including the voluntary sector, like never before. Best practice was being shared, duplication reduced, and communications have been improved.

It is likely that the NHS will not go back to 'business as usual' post C-19, but that the entire functioning of the NHS would be 're-set' in defining a new dawn in health care services. As ICB's were being established, it is likely that this will develop in time to come, into Integrated Care Organisations (ICO's). New ways of working are being reviewed and reconsidered. Traditional roles are being changed whilst new pathways are being considered and created for people who wish to become a health care professional.

The NHS has seen an immense uplift in prestige. There was a strong sense of belonging that people feel being part of the NHS workforce. Staff from both retail and hospitality all 'reported for duty' when the rest of the country went into lock-down. This has been immensely successful for NHS organisations across England and is likely to remain a key aspect of addressing recruitment needs in future which could provide an injection of new ideas, resulting in a richness of diversity across the NHS.

NHS Organisations had to re-think its human resources processes on agile working, education, training, and leadership development. There is an opportunity to reflect on what has been done in the past. Looking into the future organisations will have to build on the learning of the past. Continue to use technology like MS Teams, WebEx, Zoom and others. Prior to C-19 NHS organisations like The Royal Free Hospital NHS Foundation Trust has been recognised as a leader in HR robotics and has done exceptional work in developing fully computerised recruitment and onboarding processes.

C-19 confirmed that the investment in remote, computer enabled processes and robotics are all opportunities for the future, and it can be envisaged that all organisations in both the private and public sectors will review and re-think its information technology (IT) investment budgets dramatically.

The former Prime Minister survived C-19 and acknowledged with gratitude that: -

"The NHS has saved my life" ~ Prime Minister Boris Johnson (2019 - 2022).

APPENDIX B ~ CHRONOLOGY OF THE HISTORY AND TRANSFORMATION IN THE NHS

		The National Health Service Act, 1946 ~ Confirmed the establishment of the National Health Services - The first implementation of the Beveridge model, which is where the state provides comprehensive health services for all its citizens, 'free at the point of delivery', funded through income tax
1. NHS Reorganisation	1948*	5 July 1948 ~ Creation of the NHS following recommendations made in the Beveridge Report - the NHS employed 144,000 staff - its first-year budget was £437 million
	1949	***The Nurses Act, 1949*** ~ modernised the nursing role leading to reform of nursing education and training
2. NHS Reorganisation	1951*	Charges for dental and optical appliances imposed Removal of Optometry from the NHS as a free service (reducing costs by £22 million) Removal of Dentistry from the NHS as a free service (after demand for dentures in the first year of the NHS reached £66 million)
	1952	Prescription charges of one shilling introduced
	1954	The Percy Commission ~ First Mental Health Review
	1955	The nursing auxiliary / nursing assistant role formally recognised
	1956	Launch of the NHS Graduate Management Training Scheme
	1960	Male nurses are admitted to the Royal College of Nursing
3. NHS Reorganisation	1962*	The Hospital Plan approved the development of District General Hospitals (DGHs) to address the fragmentation of services
	1965	Prescription Charges abolished
	1966	The Charter for General Practice ~ New contract for GPs introduced, improving pay and conditions for GPs
	1967	The Salmon Report ~ Recommends nursing staff structures to be developed and hospital management teams to be created
4. NHS Reorganisation	1968*	Establishment of the Department of Health and Social Security (DHSS) ~ Prescription Charges re-introduced
	1973	***The NHS Reorganisation Act, 1973 (enacted 1974)*** ~ Creation of Area Health Authorities (AHA)
5. NHS Reorganisation	1974*	The Act of 1973 was enacted in 1974 ~ 90 AHAs reporting to 14 Regional Boards were created across England, creating unitary structures responsible for the administration of the NHS - Transferring public health responsibilities from local government to the NHS
	1975	The Merrison Report ~ Concluded that postgraduate medical education and training needed a regulatory framework resulting in the establishment of the Education Committee of the General Medical Council (GMC)
	1980	Healthcare Assistants are introduced

6. NHS Reorganisation	1982*	Abolition of the 1973 AHAs and the transfer of their responsibilities to 192 District Health Authorities (DHAs)
	1983	The Griffiths report ~ Introduction of general management (in place of consensus management)
	1984	Edith Körner Steering Group ~ Six reports on Health Services Information regarding: - Hospital clinical activity - Patient transport services - Manpower in the NHS - Hospital and community services - Community health services - Health services finance ~ Arguably the start of using information and data to review and manage the performance within the NHS
7. NHS Reorganisation	1985*	Creation of the NHS Management Board at the Department of Health and Social Security (estb. April 1985) ~ First Chair was Victor Paige (for 16 months) ~ Followed by Len Peach who became the first Chief Executive (CEO) of the NHS Management Board
	1986	Cumberlege Report ~ Promotion of community nursing and recommending the recognition of nurse prescribers, which was later endorsed in '*The Crown Report*' published by the Department of Health, 1999
	1988	The National Council for Vocational Qualification is established and begins to develop National Vocation Qualifications (NVQs) in healthcare
	1989	Caring for People white paper ~ Local Authorities given lead responsibilities for community care Working for Patients white paper proposed: ~ Creation of a purchaser / provider split (the internal market), GP fundholding and the establishment of NHS Trusts
8. NHS Reorganisation	1990*	The National Health Service Community Care Act ~ Establishment of NHS Trusts ~ New GP Contract with greater financial incentives ~ Creation of GP Fundholding and Commissioning ~ Replacement of FPCs (Family Practitioner Committees) by Family Health Services Authorities FHSA
	1992	The Patients Charter published ~ Setting out patient's rights The Department of Health's publication of "The health of the Nation – a strategy for health in England" ~ Establishment of NHS Performance targets for improving health in five key areas - Coronary heart disease and stroke, - Cancer, - Accidents, - Mental illness and - HIV/AIDS and sexual health
9. NHS Reorganisation	1994*	The 14 Regional Health Authorities (RHA) are proposed to reduce to 8 overseeing 50 Area Health Authorities (AHA) Abolition of FHSAs and incorporation into Health Authorities
10. NHS Reorganisation	1995*	***Health Authorities Act, 1995*** ~ Reconfiguration of Acute Services & Trusts - Setting up NHS Management Executive (later NHS Executive) - The number of Regional Health Authorities is reduced to 8

11. NHS Reorganisation	1996*	Abolition of RHAs, incorporation into the NHS Executive
12. NHS Reorganisation	1997*	The New NHS : Modern, Dependable ~ Abolition of NHS Executive, incorporation into the Dept. of Health - Comprehensive spending review linked money to reform - Proposed abolition of the internal market
	1998	Health Action Zones ~ Locally agreed strategies to improve the health of the population, implemented in around 10 areas, including early attempts at health and social care integration A First-Class Service – addressing concerns over clinical standards and the establishment of NICE and CHI (predecessor to the Health Commission and the CQC and later to NPSA)
13. NHS Reorganisation	1999*	The ***Health Act, 1999*** ~ Establishing joint working between health and social care - The NHS Plan – introduction of specific targets across a wide range of areas focussing on quality and performance - Introduction of 481 Primary Care Groups (PCG)
	2000	NHS Plan, 2000 Recommends the abolition of the NHS Executive, incorporation into the Department of Health
14. NHS Reorganisation	2001*	The ***Health and Social Care Act, 2001*** ~ Shifting the Balance of Power - Structural change to support implementation of the NHS Plan – established Primary Care Trusts (PCTs) and strategic health authorities (SHA), PCGs become PCTs - Optimising performance of the NHS; changes to regulating practitioners; modernised pharmacy and prescribing services; extended direct payments for social services users; changes to funding for long-term care; legislation to abolish CHC (Community Health Councils) [implemented in 2003] - Creation of a Directorate of Health and Social Care at the Department of Health and the abolition of NHS Executive Regional Offices, with a move to regional presence of the DHSC
15. NHS Reorganisation	2002*	The ***NHS Reform and Healthcare Provision Act, 2002*** ~ Creation of NHS Foundation Trusts (greater freedoms) ~ Creation of Care Trusts - Introduction of commissioner and provider-based care trusts, [Primary Care Trusts] to promote health and social care integration - Assistant practitioners in nursing are piloted
16. NHS Reorganisation	2003*	***The Health and Social care (Community Standards) Act, 2003*** ~ New Consultant Contract - Increased earnings and pensions ~ New GP Contract - Introduced new GMS Contract to promote quality improvements and allows GPs to cease to hold responsibility for providing GP out of hour services as part of their service contract ~ Payment by Results - To promote patient choice and incentivise greater activity ~ NHS Foundation Trusts are established
	2004	NHS Improvement Plan – further development of the NHS Plan approach, introducing the 18-week target [with a vision to meet this by 2008] and 48-hour GP access target - Four-hour target for A&E introduced

		- Agenda for Change** – pay system across the NHS - Department of Health, NHS Talent Management Update - Monitor established to authorise and regulate NHS Foundation Trusts ~ Nigel Crisp (NHS CEO) expressed his ambition for an inclusive and fully representative workforce - The beginning of the EDI debate in the NHS ~ Monitor established - NHS regulatory body responsibility for authorising, monitoring, and regulating NHS Foundation Trusts Agenda for Change** pay-scales came into effect on 1 December ~ providing a harmonised pay framework, spanning over 9 job bands, replacing the Whitley Council (or joint industrial council) that was in existence since the creation of the NHS in 1948
17. NHS Reorganisation	2005*	Commissioning a Patient-Led NHS ~ Merger of 303 PCTs into 152 larger PCTs ~ Merger of 28 SHAs into 10 larger SHAs ~ PCTs would no longer have been able to hold provider responsibilities - although implementation of this was delayed until 2009
18. NHS Reorganisation	2006*	Reorganisation of the Department of Health to split the NHS and DH responsibilities ~ Our Health, Our Care, Our Say - Promotion of quality improvements and choice in primary and community care, including more support for long-term-conditions
	2008	High Quality Care for All (Next stage review) ~ 'Transforming community services' & 'World class commissioning' - Improving quality and safety through engaging staff in quality improvement - Identified new priorities to improve access to primary care - Introduced integrated care pilots
19. NHS Reorganisation	2009*	The NHS Constitution is published outlining revised rights and responsibilities for patients and staff ~ Personal Health Budgets: First Steps - Set out policy to pilot personal health budgets ~ Implementation of 'Transforming Community Services' (TCS), moving community care from PCTs into Care Trusts, (Provider organisations)
	2010	Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry ~ The Francis Report - inquiry report into Mid Staffordshire failings, established case that quality and safety responsibilities of hospital leaders should not be secondary to finance responsibilities Equity and Excellence: Liberating the NHS White Paper: abolition of PCTs & SHAs ~ Decentralisation of budgets to GPs & Consortia ~ Sets out reforms which eventually resulted in the Health and Social Care Act, 2012, implemented in 2013 Quality, Innovation, Productivity and Prevention (QIPP) ~ "The Nicholson Challenge" ~ Identified £20bn savings targets for NHS and mechanism to achieve this - features in 2011/2012 and subsequent operating frameworks
	2011	Commissioning clusters ~ White Paper: proposed abolition of PCTs; decentralization of commissioning budgets to GPs & Consortia

		- Transition arrangements between several PCTs established to oversee closedown of previous system and prepare for the establishment of a new system Kings Fund Report ~ The future of leadership and management in the NHS: No More Heroes, by Chris Ham
20. NHS Reorganisation	2012*	***The Health and Social Care Act, 2012*** (The Lansley Reforms) ~ Created CCGs and NHS England (formally National Commissioning Board), along with other new national ("arms-length" bodies (such as Health Education England) - regulation of providers and commissioning only joined at national level - shifted public health responsibilities back to local government Prof Martin Powell *et al*, publish 'Has the British National Health Service (NHS) got talent? A process evaluation of the NHS talent management strategy Second call for Equality, Diversity, and Inclusivity (EDI) in the NHS
21. NHS Reorganisation	2013*	NHS England forms as regulator to oversee commissioning of NHS Services in England ~ Formulate the priorities and giving direction to the NHS ~ Prime Minister's Challenge Fund - Develop models to deliver improved access in general practice through additional funding for innovations in participating areas ~ Better Care Fund - Integration transformation fund ~promote integration and shift funding to local authorities to provide social care services to reduce admissions / support discharges ~ Every Day Counts - Standards for seven-day hospital services (Sir Bruce Keogh Standards) ~ Health Education England (HEE) created - with its mission "*to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place*." NHS Trust Development Authority (TDA) is formed to oversee the management and governance of NHS Trusts
	2014	Five Year Forward View ~ Shift to place-based planning and delivery, integration of care, and renewed focus on prevention, to deliver 'triple aim' - Vanguards and new models of care established, and STPs evolve in some areas to support place-based planning Parity of Esteem ~ Ensure parity of esteem between mental and physical health - Evidence for this required in 2014/2015 planning guidance, and specific target to achieve funding parity by 2020 included in 2015/2016 planning guidance Ian Cummings, CEO of HEE calls for the 'closure of the talent gab' – and spark the second focused debate on BME, especially at executive level
22. NHS Reorganisation	2015*	Lord Rose Report ~ 'Better leadership for tomorrow: NHS Leadership review, Department of Health New Deal for General Practice

		~ Addressed workforce and infrastructure challenges, and plans for seven-day working - became the 2016 'GP Forward View' report NHS Improvement (NHSI) established ~ Simplify regulatory landscape by bringing together Monitor and the NHS Trust Development Authority (TDA) Sustainability and Transformation Fund ~ Additional spending (from 2015 spending review) linked to delivering system goals and supporting the 'Five Year Forward View' transition The King's Fund Report ~ The practice of system leadership – being comfortable with chaos" by Nicholas Timmins The Kings' Fund Report ~ Leadership and Leadership Development in Health Care: The Evidence Base" by Prof Michael West *et al*.
23. NHS Reorganisation	2016*	Lord Carter Report ~ Operational productivity and performance in English NHS Acute Hospitals: Unwarranted variations ~ Creation of Sustainable Transformation Plans (STP) - STPs bring together NHS trusts, commissioners, and councils to plan health and social care joint for local populations
24. NHS Reorganisation	2017*	'Collaborative merging' of CCGs into Joint Structures as next step towards Integrated Care Systems (ICS) ~ Commencement of the 'bottom-up' transformation of the NHS 'at local discretion'
	2018	The Kerr Report – "Empowering NHS Leaders to Lead" by Sir Ron Kerr
25. NHS Reorganisation	2019*	NHS Long Term Plan ~ Create a ten-year vision for the NHS to establish Integrated Care Systems (ICS); through Integrated Care Alliances (ICA) - set out the indicative future of CCGs - proposed a collaborative approach and voluntarily merger of CCGs on a large scale – in the absence of national legislation ~ NHS England and NHS Improvement comes together as NHS E/I on 1 April 2019 ~ The NHS employs nearly 1.4 million people with an anticipated spend of £139.9 billion for 2022/23
26. NHS Pandemic Reorganisation	2020*	***The NHS Funding Act, 2020*** - On 16 March 2020 the NHS Funding Act was approved which made provision for a five-year payment deal until 31 March 2025 with funding arrangements equal to £440 billion (ZAR 8.8 trillion) Simon Stevens, CEO of NHSE calls for the NHS to achieve a 19% BME representative across all bandings by 2025, starting with NHS England, but with an expectation that all NHS Trust will follow ***The Coronavirus Act, 2020*** ~ Emergency redeployment of staff through Mutual Aid Agreements (MAA), in response to the Novel Corona Virus 2019 (Covid-19), which received Royal Assent on 25 March 2020, after it only spent four days in parliamentary sittings ~ COVID-19 and SARS-CoV-2 - gave Government emergency powers to enable public bodies to respond to the C-19 pandemic - during 2021, Department of Health and Social Care announces that NHS E/I will merge into a new NHS England, incorporating Health Education England, and NHS Digital

	2021	Development of Integrated Care Systems HR Technical Guidance for the establishment of Integrated Care Bodies
27. NHS Reorganisations	2022*	***Health and Social Care Act, 2022*** ~ On 28th April 2022 the new Health and Social Care Act, 2022 received Royal Assent, paving the way for the statutory establishments of Integrated Care Boards (ICB), which means the abolishment of - 129 Clinical Commissioning Groups were abolished through this legislation on 30th June 2022, making way for 42 ICBs across England - Although NHS England and NHS Improvement have been working as a single organisation since 1 April 2019 it is anticipated that NHS England (NHSE) will incorporate NHS Improvement (NHSI) and Health Education England (HEE) into a single organisational structure during 2022/2023. ~ 8th June 2022 – Publication of the Independent Report on 'Leadership for a Collaborative and Inclusive Future' by General Sir Gordon Messenger

* Indicates the 27 structural changes that the NHS undertook during the past 74 years, which equates to a major organisational change every 3.6 years. The above was constructed considering a spectrum of literature (Chaudhry et al., 2020; Ford, 2021; NHSD, 2022a; NHSE, 2022; Nuffield-Trust, 2018; Powell et al., 2012; Rivett, 1997; Welch, 2018) and personal conversation with various NHS Colleagues.

APPENDIX C ~ LEADERSHIP DEVELOPMENT FRAMEWORKS IN THE NHS

During the past decade, the NHS created no less than twelve leadership frameworks or development tools, which are:

1. **We are the NHS: The People Plan, 2020/2021** reference the *Interim People Plan* (2019) and sets out actions to support transformation across the entire NHS. The plan provides a framework consisting of four elements, focusing on the wellbeing or the NHS workforce, development of its people, collaboration for better patient outcomes and developing a workforce to deliver the long term needs of the population served by the NHS. The four pillars of the People Plan are:

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future (NHS PP, 2020).

The people promise has seven elements, being:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

The third and final element of the People Plan is the future of the NHS HR and OD the 2030 vision:

- Prioritising the health and wellbeing of our people
- Creating a great employee experience
- Ensuring inclusion and belonging for all
- Supporting and developing the people profession
- Harnessing the talent of all our people
- Leading improvement, change and innovation
- Embedding digitally enabled solutions
- Enabling new ways of working and planning for the future

https://www.england.nhs.uk/ournhspeople/

2. **The Interim People Plan, 2019**, reference The *Developing People – Improving Care* framework which focuses on helping NHS and social care staff to develop four critical capabilities:

- **systems leadership** for staff who are working with partners in other local services on joining up local health and care services for their communities

- **established quality improvement methods** that draw on staff and service users' knowledge and experience to improve service quality and efficiency
- **inclusive and compassionate leadership**, so that all staff are listened to, understood and supported, and so that leaders at every level of the health system demonstrably reflect the talents and diversity of people working in health and care services and the communities they serve
- **talent management** to support NHS-funded services to fill senior posts and develop future leadership pipelines with the right numbers of diverse, appropriately experienced people. (NHS IPP, 2019, p. 14)

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

3. **The NHS Provider and Chair Competency Framework, 2019**
   - Strategic ~ ensuring the board sets the trust's long-term vision and strategic directions, whilst holding the chief executive to account for achieving the trust's strategy
   - People ~ creating the right tone at the top, encouraging diversity, change and innovation, and shaping an inclusive, compassionate, patient centred culture for the organisation
   - Professional acumen ~ leading the board, both in terms of governance and managing relationships internally and externally
   - Outcomes focus ~ achieving the best sustainable outcomes for patients and service users by encouraging continues improvement, clinical excellence, and value for money
   - Partnerships ~ building system partnerships and balancing organisational governance priorities with system collaborations; this role will become increasingly more important as local organisations move to delivering integrated care, prioritising population health in line with the NHS Long Term Plan (NHS PCCF, 2019, p. 6).

   https://www.england.nhs.uk/1sthi5thew4y/wp-content/uploads/sites/54/2020/08/Provider_Chair_Development_Framework_1nov.pdf

4. **The 'Simplified' Knowledge and Skills Framework (KSF), 2019** the KSF was originally published in 2004, but simplified in 2010 and refreshed in 2019 focusing on four levels. The original Knowledge and Skills Framework (KSF) ~ described the knowledge and skills NHS staff (except doctors and dentists) need to apply in their work and focus on six competencies, being:-
   - **Communication** ~ which has various forms but is confirmed as a two-way process. It involves identifying what others are communicating as well as self-communication and the development of effective relationships.

- **Personal and people development** ~ which is about self-development whilst contributing to the development of others through both formal and informal structured methods.
- **Health, safety, and security** ~ focuses on maintaining the health, safety and security of everyone in the organisation and anyone who comes into contact with it. It includes tasks that are undertaken as a routine part of work, such as moving and handling.
- **Service improvement** ~ is about improving services in the interests of the users of those services and the public as a whole. The services might be services for the public (patients, clients, and carers) or be services that support the smooth running of the organisation (such as HR, finance, or estates). The services might be single or multi-agency and or multi-professional.
- **Quality** ~ relates to maintaining high quality in all areas of work and practice, including the important aspects of effective team working. Quality can be supported using a range of different approaches including codes of conduct and practice, evidence-based practice, guidelines, legislation, protocols, procedures, policies, standards, and systems.
- **Equality and diversity** ~ is the responsibility of every person to act in ways that support equality and diversity. Equality and diversity is related to the actions and responsibilities of everyone – users of services including patients, clients and carers' work colleagues; employees, people in other organisations; the public in general. (NHS KSF, 2010, p. 30-31).

https://www.nhsemployers.org/sites/default/files/2021-07/Appraisals-and-KSF-made-simple.pdf

5. **The Aspire Together Competency Framework, 2018** consists of several competencies and personal traits. The competencies are:
   - **Drives for better outcomes** ~ about taking action to improve the organisation's ability to deliver in a sustainable way.
   - **Take people with them** ~ engaging with internal and external stakeholders, about shaping the arguments and rationales that will appeal to the audience, given their concerns, agenda's and needs cross both directorate and organisational boundaries.
   - **Have the ability to speak up** ~ able to speak up to power, even when it might be easier to refrain, raising concerns and engaging others in challenging conversations.
   - **Possesses compassion and humility** ~ empathising with others and seeing one's role as being to support others and ensure they feel heard and valued, whether they be patients, service users, employees, peers, or external stakeholders.
   - **Have a learning a mindset** ~ belief that people can learn, grow and improve, and therefore setbacks are opportunities to learn, and not threats to one's own self image as a competent professional.
   - **Act from a system's mindset** ~ recognising the complexity of the system, and using that understanding to successfully navigate through the system and use the

strengths of the whole system to provide the best possible service to patients/service users and the broader population.

- **Find new solutions** ~ being innovative, creative, and thinking outside the 'box', bringing new insights and thinking to the table.
- **Develops people** ~ enabling others to achieve their full potential, spotting potential, regardless of background, and nurturing it.
- **Creates a culture of inclusion** ~ ensuring the organisation is representative of the community it serves, or the people it leads, whichever is the greatest (ATCF, 2019, p 34). Role modelling inclusion, but also creating a climate in which all participants feel valued and a sense of belongingness, in which diverse perspectives are appreciated by all, and in which ultimately all are able to contribute to their fullest potential.

The traits of an effective and successful executive director are defined as: -

- **Decisive and action orientated** ~ high stamina, likes getting things done, makes quick decisions even when information is short, is willing to take calculated risks and enjoys a fast pace of work.
- **Influence** ~ has a clear point of view and likes selling their idea to others, likes having responsibility of others, prefers leading to following.
- **Flexible** ~ changes behaviour and approach to match new circumstances, thrives on variety and frequently changing environments.
- **Supportive and consultative** ~ enjoys helping and meeting other people's needs, good listener, interested in others' perspectives.
- **Creative problem solvers ~** makes connections, sees the big picture and contributes to the development of strategy, always seeking and generating new ideas, embraces radical ideas and approaches.
- **Resilient ~** optimistic, calm, and able to cope, composed in charged situations, able to accept criticism without becoming overly self-critical.

https://www.leadershipacademy.nhs.uk/aspire-together-the-east-of-england-regional-talent-board/

6. **Developing People, Improving Care, 2016**; ~ a leadership development framework published in response of the 2015 Smith Review, setting out national strategies for both improvement and leadership development (including talent management) alighted to and in support of the NHS Five Year Forward View. The framework offers a variety of improvement and leadership capabilities for staff, including:

- System leadership skills for those managing the integration of local health and care systems
- Quality improvement skills for staff at all levels
- Compassionate, inclusive leadership skills for leaders at all levels
- Talent management to fill senior and leadership vacancies appropriately.

https://www.kingsfund.org.uk/projects/national-improvement-leadership-framework

7. **<u>Public Health Skills and Knowledge Framework</u> (PHSKF, 2016**) ~ describes the range of functions that individuals working in public health perform in their work. A largely theoretical model that could be used to help identify individuals' development needs, either in their current post or with a future career in mind. It was designed in 2016, updated in 2019 but with little support in most NHS organisations. It is aimed at delivering high quality social care services that requires strategic leadership and clear operational management. Managers using National Occupational Standards have found that the standards help to reinforce the link from strategy to operational management and to service standards. There are a variety of uses for the standards, all benefiting from their comprehensive coverage and user focus. In this leaflet we will consider how the standards can contribute to the following seven business areas:

- Business planning
- Workforce management
    - Selection and recruitment
    - Employee development
    - Developing and evaluating training
    - Working effectively with staff, and with education and training providers
    - Benchmarking
    - Change management
    - Contract specification for care services
    - Marketing
    - Risk management

https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf

8. **<u>Healthcare Leadership Model, 2014</u>** ~ underpinned by the research as published in the 2013 'towards a new model of leadership', consisting of three elements: -

- Provide and justify a clear sense of purpose and contribution.
- Motivate teams and individuals to work effectively.
- Focus on improving system performance.

The Healthcare Leadership Model, 2014, consists of nine dimensions: -

- **Leading with care** ~ having the essential personal qualities for leaders in the health and social care, to understand the unique qualities and needs of a team, providing a caring, safe environment to enable everyone to do tehri jobs effectively
- **Evaluating information** ~ using information to generate new ideas and make effective plans for improvement or change making evidence-based decisions that respect different perspectives and meet the needs of all service users
- **Connecting our services** ~ understanding how health and social care services fit together and how different people, teams or organisations interconnect and interact
- **Sharing the vision** ~ communicating a compelling and credible vision of the future in a way that makes it feel achievable and exciting

- **Engaging the team** ~ involving individuals and demonstrating that their contributions and ideas are valued and important for delivering outcomes and continuous improvements to the service
- **Holding to account** ~ agreeing clear performance goals and quality indicators supporting individuals and teams to take responsibility for results, whilst providing balanced feedback
- **Developing capabilities** ~ enable people to meet their future challenges, using a range of experiences as a vehicle for individual and organisational learning, whilst acting as a role model for personal development
- **Influencing for results** ~ deciding how to have a positive impact on others, building relationships to recognise others passions and concerns, whilst using interpersonal and organisational understanding to persuade and build collaboration ~ (HCM, 2014, p. 4).

https://www.leadershipacademy.nhs.uk/wp-content/uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf

9. **Towards a new model of leadership, 2013** ~ this framework offers various elements for a new leadership model with supportive arguments for the elements of this framework, the former is: -

- Provide and justify a clear sense of purpose and contribution
- Motivate teams and individuals to work effectively
- Focus on improving system performance

Whilst the latter is described as: -

- Communicate a clear sense of purpose and contribution
- Motivate teams and individuals to work effectively
- Focus on improving system performance (TNMC, 2013 pp. 8 – 13)

https://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/05/Towards-a-New-Model-of-Leadership-2013.pdf

10. **The Leadership Framework, 2011**

- **Demonstrating Personal Qualities** ~ requires of leaders to draw on their personal values, strengths, and abilities to deliver high standards of service. To achieve this, they are required to demonstrate effectiveness in developing self-awareness, managing themselves, whilst being aware of the needs and priorities of others, continuously developing themselves by learning through participating in continued professional development, from gaining experience and reflecting on the feedback from others and to act with integrity by behaving in an open, honest, and ethical manner.
- **Working with Others** ~ be it in teams or networks to deliver and improve services. To do this, they must demonstrate effectiveness in developing networks by working in partnership with patients, carers, services users, and their representatives, including colleagues within and across systems to deliver and improve services. They must build and maintain relationships, encouraging contribution by all team

members and stakeholders whilst working within teams to deliver and improve services.

- **Managing Services** ~ focusing on the success of the organisation(s) in which they work, through effective planning of activity to achieve service goals, managing resources effectively using their influence in delivering efficient and safe services, whilst reflecting the diversity of needs. They must manage people, by providing direction, reviewing performance, motivating others, and promotion equality and diversity and finally managing performance by holding themselves and others accountable for service outcomes.
- **Improving Services** ~ making a real difference to people's health by delivering high quality services, and by developing improvements to these services. This is achieved by ensuring patients safety, through the management of risk to patients associated with service developments, balanced by economic consideration and the need for patient safety. Critically evaluating by being able to think analytically, conceptually and to identify where services can be improved, working individually and as part of a team. Finally encouraging improvement and innovation through transformation by actively contribution to change processes by creating a climate of continuous service improvements and improving healthcare.
- **Setting Directions** ~ contributing to the strategy and aspirations of the organisation and acting in a manner consistently to its values. This is achieved by demonstrating an awareness of the range of factors to be considered for transformation, whilst applying knowledge and evidence in gathering information to produce an evidence-based challenge to systems and processes in order to identify opportunities for service improvement and making decisions using their values, and the evidence, to make good decisions. Evaluating impact by measuring and evaluating outcomes, taking corrective action where necessary and by being held to account for their decisions.
- **Creating a Vision** ~ creating a compelling vision for the future, and communicating this with in and across organisations. This is achieved by developing the vision of the organisation, looking to the future to determine its direction. Influencing the vision of the wider healthcare system by working with partners across organisations, communicating the vision and motivating others to work towards achieving it. Embodying the vision by behaving in ways which are consistent with the vision and values of the organisation.
- **Delivering the Strategy** ~ by developing and agreeing strategic plans that place patient care at the heart of the service, and ensuring that these are translated into achievable operational plans. This is achieved by framing the strategy by identifying strategic options for the organisation and drawing upon a wide range of information, knowledge, and experience, developing the strategy by engaging with colleagues and key stakeholders. Implementing the strategy by organising, managing and assuming the risks of the organisation and embedding the strategy by ensuring that strategic plans are achieved and sustained.

https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Framework-LeadershipFramework-Summary.pdf

11. The Clinical Leadership Framework, 2010

- **Demonstrating Personal Qualities ~** including the development of self-awareness – learning from experience; managing yourself – and considering the needs of others; continuing personal development – learning through participating; and acting with integrity through open, honest, and ethical conduct (p. 6);
- **Working with Others ~** developing networks – through partnership working and collaboration; building and maintaining relationships – listening to and supporting others; encouraging contribution; working within teams (p. 7);
- **Managing Services ~** planning – with the end goal in mind; managing resources – utilising and influencing available resources for best optimisation; managing people – setting direction, motivating others, and promoting equality and diversity; managing performance – holding self and others accountable (p. 8).
- **Improving Services ~** ensuring patient safety – managing risks, balancing economic considerations with the needs for patient safety; critically evaluating – thinking analytically, conceptually and identifying opportunity for improvement, working individually or as part of multi-disciplinary-teams (MDT's); encouraging improvement – creating a climate of continuous service improvement; facilitating transformation – by actively contributing to change that lead to improved healthcare (p. 9);
- **Setting Direction ~** identifying the contexts for change – taking various factors into account; applying knowledge and evidence – gathering information for evidence-based challenge contribution to service improvement; making decisions – using values and evidence to make good decisions; evaluation impact – considering outcomes, taking corrective action, whilst being held to account for one's decisions (p. 10);
- **Creating the vision ~** developing the vision of the organisation – looking into the future; influencing the vision of the wider healthcare system – working collaboratively with system partners; communicating the vision – leading others; embodying the vision – behaving consistent with the vision and values of the organisation (p. 11)
- **Delivering the strategy ~** framing the strategy – drawing on a wide range of information, knowledge, and experience; developing the strategy – engaging with colleagues and key stakeholders; implementing the strategy – organising, managing and assuming the risk of the organisation; embedding the strategy – by delivering and achieving sustainable implementation of strategic plans (p. 12).
  https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Framework-LeadershipFramework-Summary.pdf [accessed 25/03/2021]

12. <u>Medical Leadership Competency Framework, 2010</u>

Enhancing Engagement in Medical Leadership (Third Edition) July 2010

- **Demonstrating Personal Qualities ~** including the development of self-awareness – learning from experience; managing yourself – and considering the needs of others; continuing personal development – learning through participating; and acting with integrity through open, honest, and ethical conduct (p. 13 - 22);
- **Working with Others ~** developing networks – through partnership working and collaboration; building and maintaining relationships – listening to and supporting others; encouraging contribution; working within teams (p. 27 – 37);
- **Managing Services ~** planning – with the end goal in mind; managing resources – utilising and influencing available resources for best optimisation; managing people – setting direction, motivating others, and promoting equality and diversity; managing performance – holding self and others accountable (p. 41 - 51).
- **Improving Services ~** ensuring patient safety – managing risks, balancing economic considerations with the needs for patient safety; critically evaluating – thinking analytically, conceptually and identifying opportunity for improvement, working individually or as part of multi-disciplinary-teams (MDT's); encouraging improvement – creating a climate of continuous service improvement; facilitating transformation – by actively contributing to change that lead to improved healthcare (p. 55 - 65);
- **Setting Direction ~** identifying the contexts for change – taking various factors into account; applying knowledge and evidence – gathering information for evidence-based challenge contribution to service improvement; making decisions – using values and evidence to make good decisions; evaluation impact – considering outcomes, taking corrective action, whilst being held to account for one's decisions (p. 69 - 79).

  https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf [accessed 15/07/2021]

APPENDIX D ~ ETHICAL APPROVAL FORM A (V. NOVEMBER 2020)

University of Reading

Tick one:

Staff project: _____ PhD ____ **EdD __X__**

Name of applicant (s): Hein Scheffer
Title of project: Experiences, perceptions and realities of leadership development in an Emergency Department within an English Acute NHS Trust.
Name of supervisor (for student projects): Prof. Alan Floyd & Nasreen Majid

Please complete the form below including relevant sections overleaf.

	YES	NO
Have you prepared an Information Sheet for participants and/or their parents/carers that:		
a) Explains the purpose(s) of the project	X	
b) Explains how they have been selected as potential participants	X	
c) Gives a full, fair and clear account of what will be asked of them and how the information that they provide will be used	X	
d) Makes clear that participation in the project is voluntary	X	
e) Explains the arrangements to allow participants to withdraw at any stage if they wish	X	
f) Explains the arrangements to ensure the confidentiality of any material collected during the project, including secure arrangements for its storage, retention and disposal	X	
g) Explains the arrangements for publishing the research results and, if confidentiality might be affected, for obtaining written consent for this	X	
h) Explains the arrangements for providing participants with the research results if they wish to have them	X	
i) Gives the name and designation of the member of staff with responsibility for the project together with contact details, including email. If any of the project investigators are students at the IoE, then this information must be included, and their name provided	X	
k) Explains, where applicable, the arrangements for expenses and other payments to be made to the participants		X
j) Includes a standard statement indicating the process of ethical review at the University undergone by the project, as follows: 'This project has been reviewed following the procedures of the University Research Ethics Committee and has been given a favourable ethical opinion for conduct'.	X	
k) Includes a standard statement regarding insurance: "The University has the appropriate insurances in place. Full details are available on request".	X	
Please answer the following questions		
1) Will you provide participants involved in your research with all the information necessary to ensure that they are fully informed and not in any way deceived or misled as to the purpose(s) and nature of the research? (Please use the subheadings used in the example information sheets on blackboard to ensure this).	X	
2) Will you seek written or other formal consent from all participants, if they are able to provide it, in addition to (1)?	X	
3) Is there any risk that participants may experience physical or psychological distress in taking part in your research?		X

4) Staff Only - have you taken the online training modules in data protection and information security (which can be found here: http://www.reading.ac.uk/internal/humanresources/PeopleDevelopment/newstaff/humres-MandatoryOnlineCourses.aspx Please note, students complete a Data Protection Declaration form and submit it with this application to the ethics committee.	N/A		
5) Have you read the Health and Safety booklet (available on Blackboard) and completed a Risk Assessment Form to be included with this ethics application?	X		
6) Does your research comply with the University's Code of Good Practice in Research?	X		
	YES	NO	N.A.
7) If your research is taking place in a school, have you prepared an information sheet and consent form to gain the permission in writing of the head teacher or other relevant supervisory professional?			X
8) Has the data collector obtained satisfactory DBS clearance?			X
9) If your research involves working with children under the age of 16 (or those whose special educational needs mean they are unable to give informed consent), have you prepared an information sheet and consent form for parents/carers to seek permission in writing, or to give parents/carers the opportunity to decline consent?			X
10) If your research involves processing sensitive personal data[1], or if it involves audio/video recordings, have you obtained the explicit consent of participants/parents?	X		
11) If you are using a data processor to subcontract any part of your research, have you got a written contract with that contractor which (a) specifies that the contractor is required to act only on your instructions, and (b) provides for appropriate technical and organisational security measures to protect the data?			X
12a) Does your research involve data collection outside the UK?		X	
12b) If the answer to question 12a is "yes", does your research comply with the legal and ethical requirements for doing research in that country?			X
13a) Does your research involve collecting data in a language other than English?		X	
13b) If the answer to question 13a is "yes", please confirm that information sheets, consent forms, and research instruments, where appropriate, have been directly translated from the English versions submitted with this application.			X
14a. Does the proposed research involve children under the age of 5?		X	
14b. If the answer to question 14a is "yes": My Head of School (or authorised Head of Department) has given details of the proposed research to the University's insurance officer, and the research will not proceed until I have confirmation that insurance cover is in place.			X
If you have answered YES to Question 3, please complete Section B below			X

- Complete **either** Section A **or** Section B below with details of your research project.
- Complete a risk assessment.
- Sign the form in Section C.
- Append at the end of this form all relevant documents: information sheets, consent forms, tests, questionnaires, interview schedules, evidence that you have completed information security training (e.g. screen shot/copy of certificate).
- Email the completed form to the Institute's Ethics Committee for consideration.

Any missing information will result in the form being returned to you.

A: My research goes beyond the 'accepted custom and practice of teaching' but I consider that this project has **no** significant ethical implications. (Please tick the box.)	X

[1] Sensitive personal data consists of information relating to the racial or ethnic origin of a data subject, their political opinions, religious beliefs, trade union membership, sexual life, physical or mental health or condition, or criminal offences or record.

Please state the total number of participants that will be involved in the project and give a breakdown of how many there are in each category e.g. teachers, parents, pupils etc.
It is anticipated that there would be a research population of 236 clinical staff, who will receive the stage 1 survey. The composition of these staffing groups is 136 nursing; 65 medical and dental; 26 additional clinical services; 9 health care assistants. During the second stage of the research (stage 2), semi structured interviews will be conducted with 12 purposeful selected participants, representing the three groupings of the workforce, i.e. 4 x emerging leaders; 4 x middle management; 4 x senior leaders.

Give a brief description of the aims and the methods (participants, instruments and procedures) of the project in up to 200 words noting:

1. Title of project: **'The experiences, perceptions and realities of leadership development education in an Emergency Department in a NHS Acute Trust in England'.**

2. Purpose of project and its academic rationale: **The purpose of this research project is to explore the experiences, perceptions and realities of leadership development education for clinical staff in an Emergency Department in an English Acute Trust. To analyse a conceptional framework looking at the Context of the NHS; Values, behaviours and culture; Professional Identity; and Leadership Development. To better understand the rational, journey and process of transition from clinicians to clinical leaders; what development and education they have had; what they need; and what gaps could be identified for future clinical leaders. It is known in the NHS that there are a variety of leadership development frameworks that define talent, management and leadership, but fails to address the operational practicality of what needs to be done to ensure that clinical leaders are effectively supported, development, educated and enabled to be the best they could be.**

3. Brief description of methods and measurements: **The data will be collected through a two-stage sequential mixed-methods study. Stage one will include an on-line survey of all clinical staff in the Emergency Department. Once this data has been collected and analysed, semi-structured interviews will be conducted with twelve purposefully selected interviewees form the same department, using the indicative interview schedule for participants in the Emergency Department as set out under 'Stage 2' of this application.**

4. Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria: **It is anticipated that the survey will be sent to all 236 clinical staff in the Emergency Department. As an external researcher, none of the interviewees are particularly known to the researcher. They will be invited to participate in the semi-structured interviews, following the stage 1 part of this project. At the end of the survey staff will be invited to identify themselves if they wish to participate in the interview process. Twelve of these volunteers will be selected to ensure that there are four immerging leaders, four middle management and four senior leaders. The convenience sample of participants will therefore be from a department that the researcher does not work with directly but will be clinical staff who work in the Emergency Department of an Acute Trust in England and whom have been exposed to various forms of leadership development education, or none – as the case may be. The semi-structured interviews will comprise 12 members of staff: 4 from each category of leaders.**

5. Consent and participant information arrangements, debriefing (attach forms where necessary): **Please refer to Participant Information Sheets**.

A clear and concise statement of the ethical considerations raised by the project and how you intend to deal with them: **The main ethical considerations raised by this project relates to the issues around being an 'insider researcher' and the related concerns of power. Whilst the researcher is not a member of the staff of the Trust in question, he is a system Workforce Director within the same system in which the Trust is situated, and therefore may be perceived to have both professional and regulatory authority over the Trust's Human Resources (HR) function. To mitigate against these, he will not be interviewing any members of the HR and OD staff from the Trust. The Trust, its region, and all the participants in this study have been anonymised. Discussions pertaining to this study has taken place with the Medical Director of the Trust, rather than the Interim Chief People Officer. There will thus be no direct link between the HR function of the Trust, and the participants in this study.** 6. Estimated start date and duration of project: **Data Collection (Stage 1) March – June 2021. Intended thesis submission is planned for September / October 2022.**

B: I consider that this project **may** have ethical implications that should be brought before the Institute's Ethics Committee.	**N/A**
Please state the total number of participants that will be involved in the project and give a breakdown of how many there are in each category e.g. nurses, doctors, allied health professionals, etc.	
Give a brief description of the aims and the methods (participants, instruments and procedures) of the project in up to 200 words. 1. Title of project 2. Purpose of project and its academic rationale 3. Brief description of methods and measurements 4. Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria 5. Consent and participant information arrangements, debriefing (attach forms where necessary) 6. A clear and concise statement of the ethical considerations raised by the project and how you intend to deal with then. 7. Estimated start date and duration of project	

RISK ASSESSMENT: Please complete the form below

Brief outline of Work/activity:	**A two-stage sequential mixed-methods study. Stage one will include an on-line survey that will be send to all clinical staff in the Trust's Emergency Department, followed by 12 semi-structured interviews with purposefully selected clinical staff, to see whether the results of stage one is indicative of experiences across specifically selected clinical staff. The interviews will be conducted via MS Teams and will be record and transcribed using MS Teams, additional handwritten notes may be taken.**
Where will data be collected?	**One English NHS Acute Trust.**
Significant hazards:	**None identified. The interviews will take place via MS Teams. Audio recording will be done via MS Teams and the interviews will also be transcribed by MS Teams.**
Who might be exposed to hazards?	**N/A**
Existing control measures:	**N/A**

Are risks adequately controlled:	**Yes**	
If NO, list additional controls and actions required:	Additional controls	Action by:
	N/A	

C: SIGNATURE OF APPLICANT:

Note: a signature is required. Typed names are not acceptable.
I have declared all relevant information regarding my proposed project and confirm that ethical good practice will be followed within the project.

Signed: Print Name: Johann Heinrich Scheffer Date: 29.01.2021

STATEMENT OF ETHICAL APPROVAL FOR PROPOSALS SUBMITTED TO THE INSTITUTE ETHICS COMMITTEE

This project has been considered using agreed Institute procedures and is now approved.

Signed: Print Name…Holly Joseph...
Date…15/02/2021
(IoE Research Ethics Committee representative)*

* A decision to allow a project to proceed is not an expert assessment of its content or of the possible risks involved in the investigation, nor does it detract in any way from the ultimate responsibility which students/investigators must themselves have for these matters. Approval is granted on the basis of the information declared by the applicant.

DATA PROTECTION DECLARATION FOR ETHICAL APPROVAL

This document can be used to provide assurances to your ethics committee where confirmation of data protection training and awareness is required for ethical approval.

By signing this declaration I confirm that:

- I have read and understood the requirements for data protection within the *Data Protection for Researchers* document located here: http://www.reading.ac.uk/web/files/imps/Data_Protection_for_Researchers__Aug_18.v1.pdf
- I have asked for advice on any elements that I am *unclear on* prior to submitting my ethics approval request, either from my supervisor, or the data protection team at: imps@reading.ac.uk
- I understand that I am responsible for the secure handling, and protection of, my research data
- I know who to contact in the event of an information security incident, a data protection complaint or a request made under data subject access rights

Researcher to complete

Project/Study Title: The experiences, perceptions and realities of leadership development education for clinical leaders in an Emergency Department in a NHS Acute Trust.

NAME	STUDENT ID NUMBER	DATE
Johann Heinrich Scheffer		11 February 2021

Supervisor signature

Note for supervisors: Please verify that your student has completed the above actions

NAME	STAFF ID NUMBER	DATE
		12/2/2021

Submit your completed signed copy to your ethical approval committee.

Copies to be retained by ethics committee.

VERSION	KEEPER	REVIEWED	APPROVED BY	APPROVAL DATE
1.0	IMPS	Annually	IMPS	

APPENDIX E ~ CONSENT FORM AND WELCOME LETTER FOR SURVEY PARTICIPANTS

University of Reading

CONSENT FORM

Research Project:

What are the experiences, perceptions and realities of clinical leadership education and training in the Emergency Department of an English NHS Acute Trust?

Name, position and contact address of Researcher	**Name, position and contact address of Supervisor**
Hein Scheffer *Director of Workforce and Organisational Development, NHS* The Forum Dacorum Borough Council Hemel Hempstead Hertfordshire HP1 2YU E: j.h.scheffer@reading.ac.uk P:	**Alan Floyd** *Professor of Education* Institute of Education University of Reading London Road Campus 4 Redlands Road Reading RG1 5EX UK E: alan.floyd@reading.ac.uk Tel: +44 (0)118 378 2720

This application has been reviewed by the University Research Ethics Committee and has been given a favourable ethical opinion for conduct.

		Please initial box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I agree to take part in the above study.	☐

		Please tick box	
		Yes	**No**
4.	I agree to the interview being audio recorded.	☐	☐
5.	I agree to the use of anonymised quotes in publications.	☐	☐

Name of Participant	Date	Signature

WELCOME

Thank you for undertaking this survey which should take no more than 10 minutes to complete. The survey forms part of a study being conducted to better understand clinical leadership education and training in an Emergency Department of an Acute Trust in England.

The aim of the project is to explore the experiences, perceptions and realities of clinical leaders' values and behaviours, the impact of organisational culture, professional identity and the actual education and development of these emerging, middle management and senior leaders.

The survey is completely anonymous, and you will not be asked for any details that will identify you. All data collected will be held in strict confidence and will only be used by the researcher for data analysis and the drafting of a subsequent thesis and relevant publications.

This project has been subject to ethical review, according to the procedures specified by the University Research Ethics Committee and has been given a favourable ethical opinion for conduct.

If you have any questions about this research, before deciding to take part please email either Prof. Alan Floyd (alan.floyd@reading.ac.uk) or Nasreen Majid (n.majid@reading.ac.uk).

By completing this survey, you indicate your consent for your responses to be used for the purposes of research.

APPENDIX F ~ SURVEY

University of Reading

Questionnaire

DEMOGRAPHICS

1. What is your staff group?
   - Nursing
   - Medical and Dental
   - Additional Clinical Services
   - Healthcare Assistant
   - Other (please specify)

2. Are you?
   - Male
   - Female
   - Other
   - Prefer not to say

3. In which age range do you fall?
   - 21 – 30
   - 31 – 40
   - 41 – 50
   - 51 – 60
   - 61 – 67
   - 68 +

4. Everyone in the NHS has some form of leadership responsibilities, be it for the public you interact with, patients you care for, or colleagues you work with. How best would you describe your leadership position?
   - Emerging Leaders ~ an individual who show high potential for future development, currently in Agenda for Change (AfC) band 3 – 5, including someone on a junior doctor's contract
   - Middle Management ~ team leaders or intermediate leaders who are on a career path towards senior management, traditionally in AfC band 6 – 8C, or Medical and Dental (M&D) Staff Grades
   - Senior Management ~ the highest level of management, or positions just below the Board, traditionally in AfC band 8D, 9, M&D Career Grades or M&D Consultant Contract holders

5. How many people do you line manage?

- None
- 1 – 5
- 6 – 10
- 11 – 15
- 16 +

CULTURE

6. How would you describe the Emergency Department's culture?
   - Collaborative ~ where collaboration is done between stakeholders, deliberately, and pro-actively
   - Collegial ~ where responsibility and decision making are shared equally among team members
   - Democratic ~ where decisions are made by a variety of people participating in equal measure for the treater good
   - Hierarchical ~ traditionally found in graded or formally structured organisations with 'decisions from above'
   - Other (please specify)

7. Although communication is important, the ability to comprehend instructions are key. How clear are line managers in communicating in the department?
   - Extremely clear
   - Quite clear
   - Moderately clear
   - Slightly clear
   - Not clear at all - incomprehensible

8. How enjoyable is your role?
   - Extremely enjoyable
   - Quite enjoyable
   - Moderately enjoyable
   - Slightly enjoyable
   - Not at all enjoyable

9. What are the enjoyable aspects of your role?
   - Helping people in need
   - Making a difference in people's lives
   - Making a difference to the staff I lead
   - There are no real enjoyable aspects of my role
   - Working in a fast-paced environment
   - Other [Please specify]

10. How challenging is your role?
    - Extremely challenging
    - Quite challenging
    - Moderately challenging
    - Slightly challenging

- Not at all challenging

11. From an operational, developmental, and educational perspective, what are the challenging aspects of your role? Please indicate all responses that may apply.
    - Budgetary or financial management
    - Chairing meetings
    - Coaching and mentoring
    - Conducting value adding appraisals
    - Emotional intelligence training
    - Excel utilisation (or PC Skills)
    - Having difficult conversations
    - Human Resources procedures and knowledge
    - Keeping abreast with best practice
    - Leading and managing staff
    - Quality impact assessments
    - Strategic leadership
    - Time management
    - Transformation practice
    - University (academic) models and systems knowledge
    - Unrealistic demands from Trust Executives
    - Working across traditional organisational boundaries
    - Working with other ED Staff
    - Other [Please specify]

12. Any other comments you wish to add about the culture of the Emergency Department or at the Trust in general?
    [Please specify]

PROFESSIONAL IDENTITY

13. As a clinician, what does the term 'professional identity' mean to you? Please indicate all responses that may apply. If possible, please also explain the reasons for your view.
    Professional Identity describes…
    (a) working in a particular clinical role [Agree / Partly Agree / Disagree]
    (b) working in a particular clinical setting (organisation) [Agree / Partly Agree / Disagree]
    (c) following the standards or competencies as defined by a professional or regulatory body [Agree / Partly Agree / Disagree]
    (d) following the codes of ethics or conduct requirements defined by a professional or regulatory body [Agree / Partly Agree / Disagree]
    (e) how an individual clinician makes sense of what they do [Agree / Partly Agree / Disagree]
    (f) For me 'professional identity' has another meaning (please specify) [Agree / Partly Agree / Disagree]
    (g) (Optional) Please explain the reason for your view

14. Which of the following factors have influenced your 'personal and professional identity'? Please indicate all responses that apply. If possible, please also explain the reasons for your view.
(a) working in a particular clinical role [Agree / Partly Agree / Disagree]
(b) working in a particular clinical setting (organisation) [Agree / Partly Agree / Disagree]
(c) following the standards or competencies as defined by a professional or regulatory body [Agree / Partly Agree / Disagree]
(d) following the codes of ethics or conduct requirements defined by a professional or regulatory body [Agree / Partly Agree / Disagree]
(e) how an individual clinician makes sense of what they do [Agree / Partly Agree / Disagree]
(f) For me 'professional identity' has another meaning (please specify) [Agree / Partly Agree / Disagree]
(g) (Optional) Please explain the reason for your view

15. How much did becoming a leader impact on your professional identity as a clinician?
- A great deal
- A moderate amount
- A little impact
- No impact at all
- Other [Please specify]

16. Why did you move from a clinician to an emerging leader, middle management or senior manager? (Please select all that apply)
- I am the longest serving in the department
- I enjoy developing other people's careers
- I have always wanted to lead others
- I wanted a new challenge, and this level of leadership was the natural next step up
- I wanted to make a wider impact within the Trust / Department
- I wanted to move away from operational delivery
- I was asked to take on more responsibility as part of my own development
- It was a natural division of responsibility
- It was part of my personal plan
- Other [Please specify)

17. Any other comments you wish to add about the consequences of being a leader on your professional identity and professional code of ethic?
[Please specify]

LEADERSHIP EDUCATION & TRAINING

18. What leadership roles have you held previously either in your current Trust or elsewhere?
- Allied Health Professionals

- Clinical Fellow
- Consultant
- Emergency Nurse Practitioner
- General Practitioner
- Matron / Senior Matron
- Nurse Consultant
- Registered Nurse
- Sister
- Social Worker
- Staff Grade, Associate Specialist or Speciality Doctor
- Other [Please specify]

19. As a leader, how much training have your received for your role?
    - A great deal of training
    - A moderate amount of training
    - A little training
    - I have not received any training for this role

[Note, q.20 will not be available to those who tick 'I have not received any training for this role']

20. How useful was the training that you received?
    - Extremely useful
    - Quite useful
    - Moderately useful
    - Slightly useful
    - Not at all useful
    - Any other comments [Please specify]

21. What was the focus of the training that you had?
    - Board paper writing
    - Budgetary or financial management training
    - Business case development
    - Chairing meetings
    - Coaching skills
    - Conducting value adding appraisals
    - Emotional intelligence training
    - Excel utilisation (PC Training)
    - Having difficult conversation
    - Human Resources procedures and knowledge
    - Leading and managing staff
    - Quality impact assessments
    - Strategic leadership
    - System knowledge
    - Time management
    - University modules
    - Other [Please specify]

22. What type of training would help you in your role?
    - Board paper writing
    - Budgetary or financial management training
    - Business case development
    - Chairing meetings
    - Coaching skills
    - Conducting value adding appraisals
    - Emotional intelligence training
    - Excel utilisation (PC Training)
    - Having difficult conversation
    - Human Resources procedures and knowledge
    - Leading and managing staff
    - Quality impact assessments
    - Schwartz rounds training
    - Strategic leadership
    - System knowledge
    - Time management
    - University modules
    - Working across traditional organisational boundaries
    - Other [Please specify]

23. Any other comments you wish to add about what kind or type leadership development education you and or your staff may need?
    [Free Text]

GENERAL

24. How would you describe your interaction with other clinical leaders across the Trust?
    - Extremely positive
    - Moderately positive
    - Neither positive nor negative
    - Moderately negative
    - Extremely negative
    - Other

25. How would you describe the general confidence in leadership in the department?
    - Extremely confident
    - Moderately confident
    - Neither confident nor unconfident
    - Moderately unconfident
    - Extremely unconfident
    - Other

26. How would you describe your interaction with other non-clinical staff across the Trust?
    - Extremely positive

- Moderately positive
- Neither positive nor negative
- Moderately negative
- Extremely negative
- Other

27. What are your career plans within the next five years?
    - Leave the NHS all together
    - Remain in my current post
    - Seek another role elsewhere in the NHS
    - Seek a higher leadership and management post in my Trust
    - Seek a higher Leadership and management post in another Trust or NHS organisation
    - Seek a transfer on the same level but in another department of the Trust
    - Retire
    - Undecided
    - Other [Please specify]

28. Would you recommend your Trust as place to work?
    - Yes
    - No

    [if no, please indicate why?]

29. Would you recommend your Emergency Department as a place to work?
    - Yes
    - No

    [If no, please specify why?]

30. In terms of all the leadership development and education that you have undertaken during your career, what was the most significant education that you have had, and/or how do you influence your own leadership development and education? Please add any additional comments about your role as a clinical leader that have not been covered in this survey?
    [Please specify]

31. We would like to interview twelve volunteers, i.e., four emerging leaders; four middle management, and four senior managers. If you would be willing to be interviewed about your experience as a clinical leader, place leave your email address below. Thank you.
    [Please specify]

For ease of reference:

- **Emerging Leaders** ~ an individual who show high potential for future development, currently in Agenda for Change (AfC) band 3 – 5, including someone on a junior doctor's contract
- **Middle Management** ~ team leaders or intermediate leaders who are on a career path towards senior management, traditionally in AfC band 6 – 8C, or Medical and Dental (M&D) Staff Grades

- **Senior Management** ~ the highest level of management, or positions just below the Board, traditionally in AfC band 8D, 9, M&D Career Grades or M&D Consultant Contract holders

Thank you very much for completing this survey.

APPENDIX G ~ PARTICIPATION INFORMATION SHEET FOR SEMI-STRUCTURED INTERVIEWS

Participation Information Sheet ~ Interviews

What are the experiences and perceptions of leadership education and development for clinical leaders in the Emergency Department (ED) of an English NHS Acute Trust?

I am an EdD candidate at the University of Reading. You are being invited to take part in the above research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

What is the purpose of the study?

The purpose of this research project is to explore the leadership development that clinical staff are afforded in an Emergency Department to ensure that they are effective in delivering the quality of care required by the patients they serve. This study explores their experiences, perceptions and realities in this regard, within the context of an Emergency Department of a single English Acute Trust, with the aim to inform what training gaps may be identified for other Emergency Departments whilst offering insights to the wider clinical profession.

This aim will be achieved through a two-stage sequential mixed-methods study. Stage one has been a survey to all 263 clinical staff within the Emergency Department. Since these data have been collected and analysed, twelve semi-structured interviews will now be conducted with twelve volunteer members of the ED.

Why have I been invited to participate?

You have been identified to take part as someone who has a clinical role, be it either an emerging leader, middle management or a senior leader, within an Emergency Department in an Acute Trust in England.

What will happen if I take part?

As you have indicated that you would be willing to be interviewed, you are being invited to take part in a semi-structured interview as a group of 12 participants that is evenly spread across the three categories of interest, i.e. emerging leaders (band 5 – 7, and Junior Doctors); middle management (band 8a – 8d, and M&D); and senior management (band 9, VSM, M&D) staff in the Emergency department. This interview is anticipated to take 45 – 60 minutes each.

Do I have 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 asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving reason by contacting me via email on j.h.scheffer@reading.ac.uk

What are the possible disadvantages of taking part?

In agreeing to take part in this study, the semi-structured interview is anticipated to take 45 – 60 minutes. While there will be a time commitment required from participants, it is felt that the benefits of involvement will outweigh the costs: your involvement will allow me to explore key issues related to leadership development for clinical staff and to make recommendations for improved educational practice.

Will what I say be kept confidential?

All information collected will be kept strictly confidential (subject to legal limitations). In order to protect the anonymity of each participant, pseudonyms will be used to ensure participants cannot be identified. The Trust's name and the region in which it is situated will also be changed. All electronic data will be held securely in password protected files on a non-shared PC and all paper documentation will be held in locked cabinets in a locked office.

In line with University policy, data generated by the study will be kept securely in electronic form for a period of five years after the completion of the research project.

The organisation responsible for protection of your personal information is the University of Reading (the Data Controller). Queries regarding data protection and your rights should be directed to the University Data Protection Officer at imps@reading.ac.uk, or in writing to: Information Management & Policy Services, University of Reading, Whiteknights, P O Box 217, Reading, RG6 6AH.

The University of Reading collects, analyses, uses, shares and retains personal data for the purposes of research in the public interest. Under data protection law we are required to inform you that this use of the personal data we may hold about you is on the lawful basis of being a public task in the public interest and where it is necessary for scientific or historical research purposes. If you withdraw from a research study, which processes your personal data, dependant on the stage of withdrawal, we may still rely on this lawful basis to continue using your data if your withdrawal would be of significant detriment to the research study aims. We will always have in place appropriate safeguards to protect your personal data.

If we have included any additional requests for use of your data, for example adding you to a registration list for the purposes of inviting you to take part in future studies, this will be done only with your consent where you have provided it to us and should you wish to be removed from the register at a later date, you should contact either Hein Scheffer or Prof. Alan Floyd.

You have certain rights under data protection law which are:
- Withdraw your consent, for example if you opted in to be added to a participant register;
- Access your personal data or ask for a copy;
- Rectify inaccuracies in personal data that we hold about you;
- Be forgotten, that is your details to be removed from systems that we use to process your personal data;
- Restrict uses of your data;
- Object to uses of your data, for example retention after you have withdrawn from a study.

Some restrictions apply to the above rights where data is collected and used for research purposes. You can find out more about your rights on the website of the Information Commissioners Office (ICO) at https://ico.org.uk. You also have a right to complain the ICO if you are unhappy with how your data has been handled. Please contact the University Data Protection Officer in the first instance.

What will happen to the results of the research?

The data will be analysed and used in an EdD thesis. It may also be used in future publications in appropriate academic journals and/or books. If you would like a summary copy of the research findings, these will be sent to you on request.

Who has reviewed the study?

This application has been reviewed following procedures of the University of Reading Research Ethics Committee and has been given a favourable ethical opinion for conduct. The University has the appropriate insurances in place. Full details are available on request.

Name, position and contact address of Researcher	**Name, position and contact address of Supervisor**
Hein Scheffer *Director of Workforce and OD, NHS* The Forum, Dacorum Borough Council Hemel Hempstead Hertfordshire HP1 2YU, E: j.h.scheffer@reading.ac.uk P:	**Alan Floyd** *Professor of Education* Institute of Education University of Reading London Road Campus 4 Redlands Road Reading RG1 5EX, UK E: alan.floyd@reading.ac.uk Tel: +44 (0)118 378 2720

APPENDIX H ~ SEMI-STRUCTURED INTERVIEW SCHEDULE

Q. 1
[HS] Can I just ask you to introduce yourself, give me a bit of background in terms of your role and your responsibility in the Emergency Department?

Q. 2
[HS] I am interested to understand how the ED staff perceive culture in your Trust, in particularly within the ED?

Q. 3
[HS] Do you think that the staff and the leadership in the emergency department is aware of their impact that they have on others in these circumstances?

Q. 4
[HS] What is your view in terms of the impact of power and politics in the department?

Q. 5
[HS] Can you share with me your view in terms of the leadership's role in shaping the ideal behaviours?

Q. 6
[HS] In becoming a leader, how did that impact your personal & professional identity?

Q. 7
[HS] What is your trust's philosophy pertaining to personal development? Do they invest in people? What is your view on professionalism and how do you demonstrate that on a daily basis?

Q. 8
[HS] Why do you think clinicians like yourself became managers?

Q. 9
[HS] What leadership development is required to ensure that ED staff are well equipped to lead the team in their charge?

Q. 10
[HS] How would you describe your leadership style and what is the leadership style that you think is needed in the ED?

Q. 11
[HS] How compassionate is the leadership first in your Trust and secondly in the ED?

Q. 12
[HS] Anything else you wish to add?

APPENDIX I ~ CURRENT LEADERSHIP DEVELOPMENT PROGRAMMES IN THE NHS

At the time of conducting this research, the following leadership development programmes were available as a central offering across the NHS:

1. **Edward Jenner**
   - Aims at developing NHS staff who are ready to gain more skills to cope with the daily challenges of working in healthcare, being better equipped to care for patients, lead services and provide leadership for others, supporting them to do their job better.
   - The program has been designed as a highly practical and patient-focused program, enabling delegates to better understand the purpose, challenges, and culture of the NHS.
   - The first port of call for health and care staff in building a strong foundation of leadership skills that will help and enhance participants confidence and competence both in their current role and advance their career.

   https://www.leadershipacademy.nhs.uk/programmes/the-edward-jenner-programme/

2. **Mary Seacole**
   - This program encourages participants to be reflective, with increased personal awareness, in search of the right leadership style, that fit their strengths, their emotional intelligence and how best to use these, with increased personal awareness and insight into how their own behaviours might impact on others.
   - It develops the authority, capacity, and motivation to implement change, with tools to transform emotion into assets.
   - A greater self-awareness and emotional intelligence, enabling participants to work with others more effectively.

   https://www.leadershipacademy.nhs.uk/programmes/mary-seacole-programme/

3. **Rosalind Franklin**
   - This program is for clinicians or managers leading from the middle of health and care systems, aspiring to lead large and complex programmes, departments, services, or systems of care.
   - It aims to help shape middle level leaders' knowledge, skills, attitudes, and behaviours to help them become outstanding, compassionate, and inclusive leaders, working at all levels across the health and care system, to help improve services for people who access them.
   - The program encourages participants to ask, and answered, fundamental questions that will support participants to be outstanding innovators, leaders, and team-members.

   https://www.leadershipacademy.nhs.uk/programmes/rosalind-franklin-programme/

4. Elizabeth Garrett Anderson

- Described as a unique healthcare leadership programme delivered as a joint award from the University of Birmingham and the University of Manchester with a mix of internationally renowned healthcare, business, and academic experts, who all brings a comprehensive perspective.
- This fully accredited, world-class, part-residential master's degree programme allows cohorts of participants to develop together, to draw on each other's experiences and build bonds and networks that could span the duration of their careers.
- It enables participants to be more resilient and able to meet the demands of working in often high-pressured healthcare environments, so that patients see improved outcomes and experiences.

https://www.leadershipacademy.nhs.uk/programmes/elizabeth-garrett-anderson-programme/

5. Nye Bevan

- The programme offers supports and learning to build personal resilience, confidence, and capabilities over a twelve-month period.
- Build around self-managed learning and peer assessment, participants will need to include others as active contributors in their learning and demonstrate how behaviours develop and change positively over the period of the programme.
- Delegates are required to work across systems, forming alliances and collaborating across boundaries.
- They will have to demonstrate their knowledge and practice of how structures, systems and behaviours contribute to equity and inequities for NHS patients, and staff.
- They also must understand personal biases, blind spots and beliefs, with insight into the reality of power dynamics and how they us their own personal power.

https://www.leadershipacademy.nhs.uk/programmes/nye-bevan-programme/

6. Accelerated Directors Development Scheme (ADDS)

The purpose of ADDS is to develop potential executive directors to lead organisations across organisations that operates in an Integrated Care System (ICS) to:

- Create a health and care system fit for the future, with services designed and transformed to join up around the people who use them
- Make changes that will be benefit everyone who lives and works in the area
- Align to the four pillars of the NHS People Plan
    - Create a sense of belonging into the NHS and care sector
    - Create new ways of working and delivering care
    - Grow for the future
- Aligned to the Leadership Way
- Delivering inclusive, compassionate, curious, and collaborative leaders

The program traditionally takes 9 months to complete, for candidates who are ready for an executive role within 9 – 24 months.
https://eoe.leadershipacademy.nhs.uk/leadership-development-programmes/east-of-england-programmes/accelerated-directors-development-scheme/

7. The Executive Director Pathway (EDP)

Is an inclusive talent scheme which aims to support aspiring executive leaders progress in their careers through a series of targeted development opportunities. The scheme focuses on preparing participants for any of the following roles, or equivalent in an NHS provider organisation:

- Executive Director of Nursing
- Medical Director
- Chief Operating Officer
- Executive Director of Finance
- Director of Workforce/Human Resources

The EDP – which will take participants between 12–24 months to complete – provides a clear development journey to senior executive leadership, combining best practice in both talent management and leadership development.

The scheme, much of which is self-directed learning, is tailored to individual participants' needs and their level of readiness to undertake an executive director role. Each participant's journey will be different in terms of length of time on the scheme and the development they undertake within it.
https://www.leadershipacademy.nhs.uk/executive-director-pathway-2/

8. The Stepping Up Programme

- The Stepping Up programme is a leadership development programme for aspiring black, Asian and minority ethnic (BAME) staff who work within healthcare (the NHS or an organisation providing NHS care).
- It aims to create greater levels of sustainable inclusion within the NHS by addressing the social, organisational, and psychological barriers restricting BAME staff from progressing.
- It is designed to bridge the gap between where applicants are and where they need to be, to progress into more senior roles.
- Successful candidates will be empowered to drive forward the inclusion agenda and develop skills and abilities in order to grow and progress.

https://www.leadershipacademy.nhs.uk/programmes/the-stepping-up-programme/

9. The Ready Now

- This program from senior BAME (black, Asian and minority ethnic) leaders can help realise potential, as it enables participants to work within the systems.
- Described as an innovative, inspirational positive action programme from the NHS Leadership academy, which enhances skills, knowledge, and an ability to succeed.
- It consists of taught elements, self-taught elements, group work, psychodynamic processes, experiential learning, and a constantly evolving range of approaches to support success.

https://www.leadershipacademy.nhs.uk/programmes/the-ready-now-programme/

10. Training and Development ~ Emergency Management (EM)

- This EM core programme is a three-year core training programme for junior doctors. This includes six months in each of the EM areas, being Intensive Care Medicine, Anaesthetics and Acute Medicine for the first two years and then a further year focusing on trauma and paediatric EM.

https://www.healthcareers.nhs.uk/explore-roles/doctors/roles-doctors/emergency-medicine/training-and-development

11. The Trusted Executive Foundation

An Executive Development programme subscribing to a new standard of leadership defined by trustworthiness

- Direct access to the unique and only academically verified model of trust and it's extensive kit of tools, techniques and metrics.
- Partnership and collaboration with highly skilled and experienced cohort of coaches committed to building a new standard of leadership defined by trustworthiness.
- Thought leadership and practical implementation to maximise the opportunity presented in the post-Covid 'New world of Work' focused on purpose and outcomes, not status and activities.
- Promote, facilitate and support dynamic change as a competitive advantage.
- Challenge leaders to 'step-up' and take responsibility beyond established organisational 'norms' whilst supporting their resilience and well-being.
- Create or increase focus on your 'triple-bottom line'.

https://trustedexecutive.com/

APPENDIX J ~ SAMPLE OF CODING FROM SEMI STRUCTURED INTERVIEW TRANSCRIPTS

[HS] Is there any of those programs that you can name for me? Is there any of the NHS Leadership Academy programs that you had a look at?

[BU] So I did, there's a focused and emergency medicine, so there's an EM leaders' course, which I completed recently and there is also a Quip. So quality improvement program. I guess course as well as my normal role, I'm undertaking quality improvement projects in department.

[HS] Is that also presented by the Leadership Academy?

[BU] So I'm not sure.

[HS] Where would I find them if I want to go look for them?

[BU] The EM program I think was done form the Deanery. I'm not sure about the leadership Academy.

[HS] And the Quip program?

[BU] The Quip one, I think that was the trust.

[HS] thank you.

Q8
[HS] OK, why do you think clinicians become managers?
A8
[BU] I think it's a sense of, you're at the front line and you see the deficits or the positives, in the day to day. So, people feel that they are the best to make the decision, rather than have to put the power into some unknown managers hands, who isn't there and who hasn't experienced the frontline; someone making the decisions in an ivory tower somewhere. So, when you on the shop floor you know what works, know what doesn't work and why things are done in a certain way. So being the leader, you have a greater impact.

[HS] And bitter, do you? Do you think that leaders, clinical leaders are appropriately equipped to be clinical leaders?

[BU] I think, now they are. I have been speaking to consultants who've been doing the job for decades. They kind of came out and it's like 'here you go' be a clinical leader, but our curriculum has changed so much that all these things are embedded into it and trying to do the things expected from you when you become a consultant before you get there. And this is the time to make mistakes. Certain consultants who have become consultants in the last few years are better equipped than their predecessors. So we have a management section of our curriculum where we deal with complaints, writer business case, do a quality improvement project, or things that are expected of us as a clinical leader and kind of learning the process.
Making, as I said, time to, if you make a mistake now if you need to make a mistake and learn from it rather than when you're there, as the one everyone else is looking at.