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**Evaluating Human Capital Investments in Public Services:  
The case of clinical leadership development in NHS Scotland**

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**A thesis submitted in fulfilment of the requirements for the  
Degree of Doctor of Philosophy**

**Business School: Management  
College of Social Sciences  
University of Glasgow**

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## Abstract

Clinical leadership, along with other means such as whole system working and multi-disciplinary teams, has been promoted as an important method of engaging clinicians in reform and improving the efficiency and effectiveness of healthcare. Consequently, a key human resource strategy within NHS Scotland has been to invest in training and development to build clinical leadership capacity across the organisation. However, clinical leadership is a contested concept, with no readily accepted definition and is subject to debate between competing professional and managerial logics and identities. As such there has been little investigation into how clinical leaders' identities are developed at an individual, relational and collective level, how such identity construction affects the development of clinical leaders, and how learning from such development can be transferred back into healthcare organisations. Thus, this thesis investigates the impact that development programmes can have on participants' identities, through their human capital and social capital, and the organisational factors that influence the degree of learning transfer.

Focusing on a phenomenological case study of an eighteen-month 'flagship' leadership development programme for senior clinical leaders across NHS Scotland, the thesis explores the notion of development programmes as 'identity workspaces' (Petriglieri, 2011) where participants can step back from their daily routines to reflect and work on their identities and examines whether such workspaces are seen as useful by participants and their managers. Data were gathered through semi-structured interviews, observation of key events and analysis of relevant policy, programme and participant documents. The longitudinal study, undertaken between December 2008 and May 2011, examines the processes, practices, and tensions underpinning leader and leadership identity development. It highlights the importance of studying not only how identities are constructed, maintained and regulated, but also how past identities are deconstructed and unlearned, and the emotional and psychological effects that these processes can have on clinicians.

These data supported the view that identities are formed within social and discursive contexts and evolve and change over time in relation to an individual's experiences and changes in the wider environment. They also provided support for the claim that leadership programmes can play an important role in the social construction of a leader's identity as they initiate bonding, brokering, bridging, and legitimising activities which enhance their social capital and reaffirm their identity at a relational and collective level. However, for this identity to be embedded and sustained over time, individuals require a degree of autonomy to implement change as this both reinforces their own sense of self as a leader and encourages others to act reciprocally. Furthermore, developmental support was seen as necessary by participants to encourage a common understanding of leadership which enables the construction of leadership identities at a relational and collective level. Lastly, by examining how clinicians participating on the programme understood and enacted their dual-role, the thesis explores the diverse meaning attributed to the notion of clinical leadership. It considers the internal and external challenges facing clinical leaders and proposes that it is important for clinical leaders to assume a dual-professional identity that allows them to move from being a clinician to a professional clinical leader who combines clinical and leadership expertise. Thus, the thesis provides a contribution to the relatively limited academic literature on clinical leadership and professional leadership development more generally and adds to research on identity work, social identity theory and intellectual capital. In particular, it emphasises that working on and changing ones' professional

identity is not an easy process as it involves first deconstructing and unlearning past notions, beliefs and behaviours before a new sense of selves can be reconstructed.

The research took place within a dynamic policy context that encompasses recent work on engaging clinicians in leadership, embedding strong clinical governance and accountability, and overcoming the economic challenges facing public services both in Scotland and the UK. The thesis makes a contribution to practice by informing ongoing policy relevant debates on leadership development and the value of clinical leadership as well as other dual-professional identities in the Scottish National Health Service and the Scottish Government.

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## **Author's Declaration**

I declare that, except where explicit reference is made to the contribution of others, that this thesis is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature \_\_\_\_\_

Printed name STACEY BUSHFIELD

## **Abbreviations**

DTF – Delivering the Future

HC – Human Capital

OC – Organisational Capital

SC – Social Capital

IC – Intellectual Capital

PC – Psychological Capital

EI – Emotional Intelligence

HRD – Human Resource Director



## Chapter 1: Introduction and Background

### 1.1: Introduction

The development of leaders who can drive forward reform and engage others in change is a key priority for healthcare systems across the world (Ham and Dickinson, 2008; Swanwick and McKimm, 2011). Particular emphasis has been placed upon developing clinical leaders who can lead in areas such as service change, quality improvement, patient safety, and clinical research; as without the engagement of clinicians in these topics initiatives can face resistance and delays (Berwick, 1994; Dickinson and Ham, 2008). The National Health Service (NHS) in the UK is a good example of this trend as its size and complexity has led many to suggest that effective, in particular transformational, leadership is required not only at the top, but also across professions and at multiple levels of the organisation (Dickinson and Ham, 2008; The Kings Fund, 2011; Scottish Government, 2009). However, clinicians who take on strategic leadership roles face a number of challenges due to the ambiguity surrounding the dual-role, the need to balance their time between clinical and leadership responsibilities, and the potential for peer resistance (Llewellyn, 2001; Kippist and Fitzgerald, 2009; NHS Confederation, 2007).

Professionals such as doctors, nurses, lawyers, and accountants have strong occupational identities underpinned by shared norms, logics, belief systems and associated practices (Gunz and Gunz, 2007; Greenwood *et al.*, 2011). These identities are firmly embedded within the profession's community of practice; individuals define themselves in relation to their membership and non-membership of particular groups (Wenger, 1998). At any given time individuals may be members of more than one community of practice and have multiple identities that they activate in different situations (e.g. doctor, parent, patient etc). However, in terms of professional identities, conflicts may arise when an individual plays two different roles within an organisation (Robertson, 2011). For example, in a healthcare setting it has been suggested that a clinician's professional values may sometimes be at odds with the organisation's managerial objectives (Kippist and Fitzgerald, 2009). Thus, those who take on hybrid professional-leadership roles can find it difficult to move outside their professional community to construct a coherent dual-identity that is authentic to both

the individual and others (Fitzgerald *et al.*, 2006; Ham *et al.*, 2011; Watson, 2009; Witman *et al.*, 2011).

Relevant to this is the current focus on self-perception and social identity construction within the leadership development literature (Carroll and Levy, 2010; Day and Harrison, 2007; Petriglieri, 2011). It is proposed that leadership identities are dynamically co-constructed at three levels: individual (i.e. leadership becomes part of their self-concept), relational (i.e. leader is relationally recognised by important others), and collective (leader works for collective good and are collectively endorsed) (DeRue and Ashford, 2010). However, despite significant investment in various leadership training and development initiatives there remains uncertainty as to how a clinical leader's identity is developed at an individual, relational and collective level and how learning from training is transferred back into the organisation (Cheng and Hampson, 2008; Day and Harrison, 2007; Day, 2011). Thus, drawing on both leadership and intellectual capital theory, this thesis examines accounts of the individual and organisational impacts of leadership development. It explores how development programmes can act as 'identity workspaces' (Petriglieri, 2011) where participants can co-construct their personal and social leadership identities and considers the individual and organisational factors that influence the degree of learning transfer and identity development.

Funded by a joint ESRC Scottish Government studentship, this phenomenological research used an embedded case study design to examine clinical leadership development in the context of the Scottish NHS. Data was collected in three phases between December 2008 and May 2011. The longitudinal design incorporated a range of methods, including in-depth interviewing, document analysis and observation to explore the views and accounts of a range of stakeholders at an organisational and development programme level. The research took place within a dynamic political context, both in Scotland and the UK as a whole, that emphasises the importance of engaging clinicians in management and leadership, the need for strong clinical governance and accountability, and the challenges involved in delivering quality services with limited resources (Giordano, 2011; Hamilton *et al.*, 2008; Ploch and Klazinga, 2005). Clinical leadership is a relatively new discourse within academic research; however theorists have considered the interdisciplinary nature of leadership in a healthcare setting (McCallin, 2003; Millward and Bryan, 2005), the issues

around engaging clinicians in leadership (Forbes *et al.*, 2004; Dickinson and Ham, 2008; Martin *et al.*, 2011), the dilemmas and developmental needs of those who hold hybrid professional-leadership roles (e.g. Edmonstone, 2009; Forbes *et al.*, 2004; Ham *et al.*, 2011), and the advantages and disadvantages of focusing on ‘soft bureaucracy’ and ‘leaderism’ in the public sector (Brookes and Grint, 2010; Martin and Learmonth, 2010; O’Reilly and Reed, 2010; Sheaff *et al.*, 2003). The thesis also draws on a rich body of knowledge surrounding leadership in a professional setting (Gordon, 2010; Gosling, Bolden and Petrov, 2009; Mulec, 2006; Spillane, 2006). Furthermore, underpinning this is a vast multidisciplinary literature on leadership (Jackson and Perry, 2008) and a growing academic interest in how leadership is developed and the effects of development (Day, 2011; Grint, 2010).

Nonetheless, there remains conceptual confusion; in particular, there is uncertainty as to how individual and organisational factors influence leadership development effectiveness (Day, 2011; Grint, 2010; Ladshewsky and Flavell, 2011). An individual’s prior orientations, experiences, and work identity as well as their motivations and dispositions towards learning may influence the way they process, make sense of and re-contextualise learning (Combs, Luthans and Griffith, 2009; Day, Harrison and Halpin, 2009; Evans, Guile and Harris, 2011; Weick, 1995). Moreover, organisational factors such as culture, hierarchical structures, political frameworks, role complexity, competing demands, workload strain, managerial support and sense of community have been found to shape leadership behaviour and impact learning application and the benefits that can arise from development (Costley, 2011; Currie, Lockett and Suhomlinova, 2009; Ladshewsky and Flavell, 2011; Mumford *et al.*, 2002; Porter and McLaughlin, 2006). Thus, as recommended by Hiller *et al.* (2011), this thesis brings together areas of micro, meso, and macro research on leadership to explore both the personal and organisational outcomes of development. This complements and builds on previous academic literature relating to leadership development and the co-construction of leadership identity at an individual, relational and organisational level.

This opening chapter outlines the context in which the research for the thesis has taken place. It begins by describing how the empirical study was developed and designed. The focal research question and objectives are then outlined. This is followed by a discussion

of the existing literature and the conceptual framework that guided the empirical study. The research context is then introduced. The chapter concludes by providing an overview of the structure and content of the thesis.

## **1.2: Developing the Empirical Study**

The current research originated from a policy request from the Scottish Government to investigate the role of human capital investment in public sector reform. This was a fairly broad and open request, which allowed me to develop and design a research study with implications for both practice and theory. Following the advice of Blaikie (2009), I began by asking myself a number of conceptual questions including: what was the purpose of the study; what were the primary questions or issues; who were the key stakeholders; what approach, model, or framework will be used to provide direction for the study; what political considerations should be taken into account; and what resources were available for the study? The answers to these questions helped to focus the research and formed the basis for the conceptual framework that guided the study (Blaikie, 2009; Hart, 1998; Patton, 1987). This section provides a brief overview of this study's development. The research purpose and the conceptual framework are then discussed.

Combining inductive and deductive approaches, the study evolved as it progressed rather than following a deliberate plan. To situate the study within existing theory, I began by completing a comprehensive review of the human capital and public value literature (Bushfield, 2008; see appendix A for a mind-map of the key themes from this review). This revealed that the relationship between human capital and organisational value creation is mediated by an organization's stock and flow of intellectual capital, and so is subject to a number of other causal variables, including social capital and organisational capital (Bontis and Fitz-Enz, 2002; Lepak, Smith and Taylor, 2007). In addition, it showed that although there exists a plethora of measurement approaches that aim, to a greater or lesser extent, to synthesise the financial and non-financial aspects of an organisation (e.g. Bontis 2001; Roos *et al.* 1997) there are several difficulties involved in reporting and measuring intangible resources as they are context specific, their worth differs for different people and value is created in relation to the organisation's wider strategy and other assets (e.g. Bennington, 2011; Cinca *et al.*, 2003; Marr and Moustaghfir, 2005; Nunmaker *et al.*,

2001). Much of the existing work has been completed in the private sector and has been positivistic in nature, often using large scale questionnaires and structural equation modelling or regression techniques to show that firm specific intellectual capital factors lead to value creation (e.g. Bontis and Fitz-Enz, 2002 or Subramaniam and Youndt, 2005). Although such research has enhanced the discipline by revealing specific causal connections between different dimensions of intellectual capital and various performance outcomes, there remains terminological confusion around the concept and its antecedents as authors have used different terms to denote similar knowledge resources and processes (Schiuma, Carlucci and Lerro, 2012). Moreover, the underlying mechanisms through which human, social, and organisational capital combine to create intellectual capital are by no means clear (Bowman and Swart, 2007; Lepak *et al.*, 2007; Prajogo and Ahmed, 2006).

Due to the context-bound meaning of value (e.g. Grint, 2005b; Groysberg *et al.*, 2008) it was felt that basing the research across the entire Scottish public sector would be too broad. Thus, the focus of the research was narrowed to the Scottish National Health Service (NHS). An embedded qualitative case study design that centred on one strategic development investment in the Scottish NHS was selected. A full discussion of the rationale for the design and sampling procedures is provided in chapter five. Adopting a case-study approach allowed the role of context on development outcomes to be examined and facilitated the inclusion of multiple stakeholder views. During the first phase of data collection key policy documents were sourced and exploratory interviews were completed with twelve HR Directors (or managers) from nine health boards across Scotland. These interviews provided insight into the complex workings of the Scottish NHS, its political and economic environment, and the organisation's current HR priorities (see chapter six). An overarching theme to emerge from these interviews was a strong emphasis on developing the organisation's leadership capabilities (in particular those of clinical leaders) as a means of engaging employees in change and encouraging collaborative working. Consequently, a second more focused review of the leadership, leadership development, and training evaluation literature was completed (see chapter two). In addition, *Delivering the Future* (DTF), a development programme targeted at senior clinical leaders from across NHS Scotland, was identified and selected as the primary research context. The

evolutionary nature of the study ensured that the research focus was relevant to policy and practice. The research purpose, questions and objectives are now discussed.

### **1.3: Research Purpose, Focal Questions and Objectives**

Drawing on the enduring debate over whether leadership outcomes can be measured, the purpose of the study was to explore leadership development in NHS Scotland from the perspective of programme providers, clinical participants as well as selected colleagues and managers. By examining experiences of leadership development, identity change, learning application and re-contextualisation the study sought to understand how different individual and organisational factors contribute to the creation of collective knowledge resources in health sector organisations. The research was guided by the following focal question:

*In a healthcare context, how do clinicians who participate in a leadership programme account for the programme's impact on their identity, through their human and social capital, and what organisational factors influence their accounts?*

This question gave the study direction and coherence but was sufficiently open to allow participants to explain their ideas. However, the study evolved as it progressed (see chapter five). The initial interviews highlighted that identity change is a complex process and that clinical leadership can take many forms. Thus, after reflecting on these interviews and revisiting the literature two further research questions relating to the role of development programmes as identity workspaces and to the special case of clinical leadership were developed:

- (a) What role can leadership development programmes play in shaping participants' leadership identities at an individual, relational and collective level?
- (b) What do we mean by clinical leadership and how do clinical leaders construct this concept in action?

Together the focal question and sub-questions provided the basis for the research design and led to the formation of the six specific objectives that guided the study:

- To critically evaluate the literature on leadership, particularly focusing on social constructionist approaches, with a view to enhance the leadership development literature.
- To explore participants' accounts of the leadership development programme in terms of learning content, applicability and human capital development.
- To examine how leadership development programmes can provide a forum for social capital creation through group-based learning and the establishment and maintenance of networks.
- To investigate the perceived role of policy and organisational context on accounts of learning effectiveness, transfer, and intellectual capital development.
- To evaluate how leadership development programmes can act as identity workspaces, connected to, yet removed from, participants' organisational contexts and daily routines, which facilitate the revision and consolidation of individual and collective identities.
- To assess the special case of clinical leadership: what makes it different from other forms of management and leadership in healthcare and what are the unique challenges involved in occupying such a dual-role.

## **1.4: The Study's Theoretical Foundations**

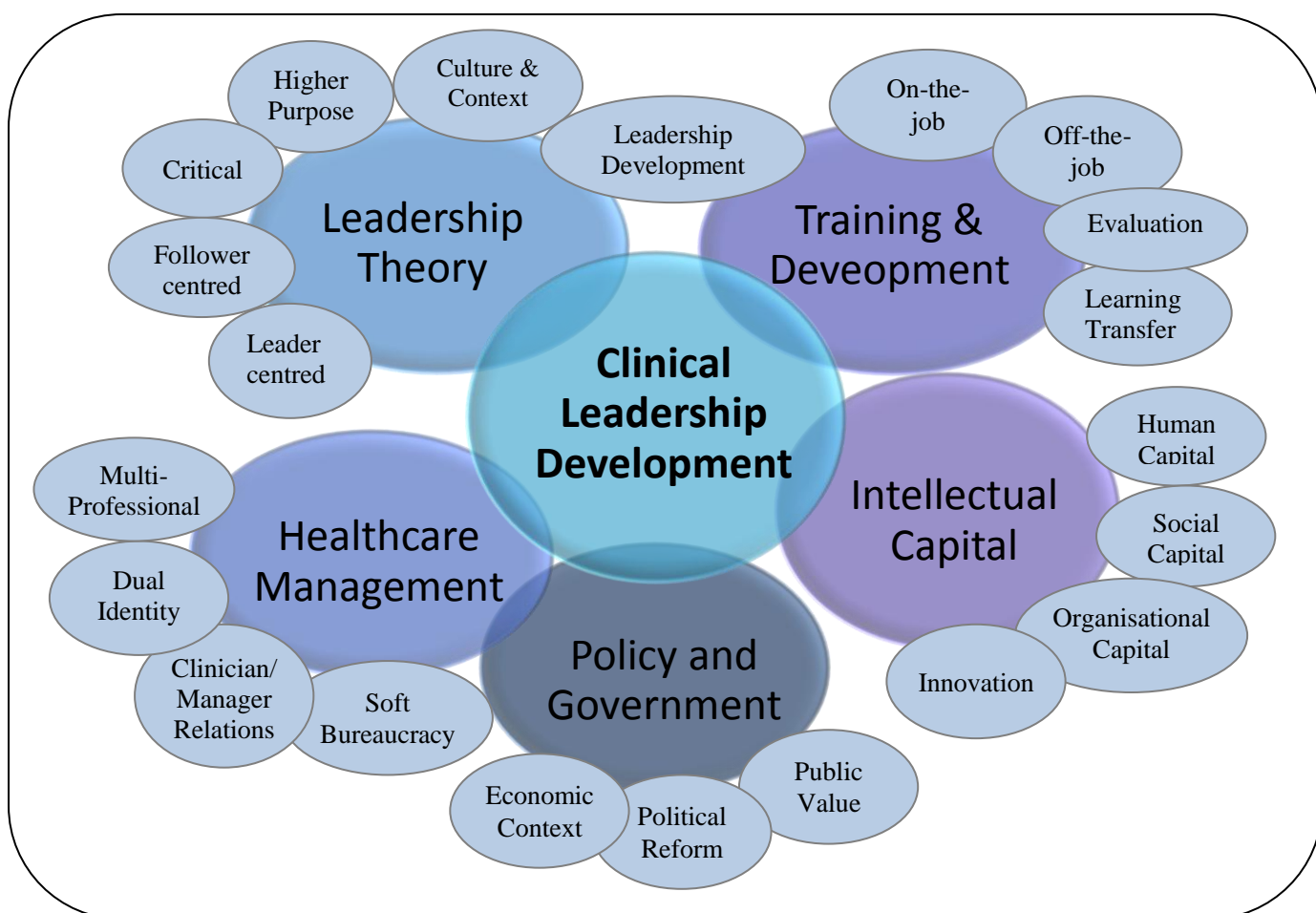
The first objective of the study involved reviewing the relevant leadership, leadership development and intellectual capital literature. The following discussion provides a brief introduction to the review's focus and the key themes that emerged. Section 1.5 then introduces the conceptual framework underpinning the empirical study.

### ***1.4.1: Focusing the Review***

Over the last twenty years leadership has become one of the most popular and rapidly growing fields of organisational research (Cohen and Titchy, 1997; Coswill and Grint, 2008; Jackson and Perry, 2008; Morrell, 2010; Wright *et al.*, 2001a). Academics from a wide range of business, economics, politics, psychology, sociology and other social

science disciplines have explored leadership within various contexts resulting in a substantial and interdisciplinary body of literature relating to the phenomena (Kellerman and Webster, 2001). When embarking upon a literature review it is necessary to find a balance between breadth and depth (Saunders *et al.*, 2003). Reviewing the leadership literature in its entirety is beyond the scope of this research, so following the advice of Hart (1998) the review focused on literature relating to the research question. Specifically, I sought to critically evaluate literature relating to leadership development and intellectual capital. Preliminary scoping searches were completed to establish the size and range of the literature. This allowed me to map the main areas of literature (see figure 1.1), set the parameters for the review, and identify potential keywords for further searches. Following this a comprehensive and explicit methodology was developed to locate, select and synthesise relevant literature. This methodology is discussed in chapter 2.

**Figure 1.1: Initial Guide to Research Areas Relating to Clinical Leadership**



Source: Author's Diagram



### ***1.4.2: Situating the Current Study in Existing Theory***

Figure 1.1 demonstrates that the research was informed by multiple overlapping strands of literature. The development of clinical leaders and leadership is a growing area of academic research. Literature in the field has been informed primarily by three established fields of research relating to: healthcare management, leadership, and training and development. Since the public management reforms of the 1980s and 1990s (see section 1.6.3) there has been academic interest in how health care is managed and the power relations between clinicians and general managers (Degeling *et al.*, 2006; Speed, 2011). Under these ‘managerialism’ reforms clinicians were drawn into the structure not as representatives of the wider collective community (as in the previous professional bureaucracy), but as clinical managers placed in positions of authority over that community (Walshe and Chambers, 2010). This together with a focus on performance management and market reforms created strong tensions between clinical and managerial paradigms and led to conflicting loyalties between the clinical profession and the organisation (*ibid*). Past research has suggested that these historic tensions have led to a lack of enthusiasm for dual-roles; with clinicians often regarding them as a necessary but unwelcome add on (Kirkpatrick *et al.*, 2009) and peers viewing them as disloyal practitioners who have gone over to the opposition (Llewellyn, 2001).

Yet, in recent years there has been a renewed focus on engaging clinicians in the management and leadership as a means of transforming health care systems and creating public value (Bennington, 2011; Dickinson and Ham, 2008). This is supported by a new discourse of ‘leaderism’ which has been promoted across the public sector (O’Reilly and Reed, 2010). Within a clinical setting this emphasises the application of ‘soft power’ through incorporating powerful clinical professional groups, especially doctors, into the decision-making process to help overcome clinical resistance (Sheaf *et al.*, 2003). The concept of ‘soft power’, which first emerged in politics literature (Nye, 1990; 2004), refers to the process of co-opting and influencing others to achieve the outcomes you desire rather than coercing them through threats or inducing them through payments. Thus, soft power in leadership rests on the ability of leaders to shape the preferences of others and emphasises the importance of the legitimacy and credibility of the leader in the eyes of others, in particular followers (*ibid*).

The concept ‘soft power’ is closely related to Courpasson’s (2000) notion of ‘soft-bureaucracy’ which refers to organisations in which ‘...processes of flexibility and decentralization co-exist with more rigid constraints and structures of domination’ (p.157). Under this paradigm, it is proposed that incorporating key professionals into decision-making, through for example hybrid professional-leadership roles, enhances the legitimacy and credibility of managerial initiatives and helps to engage and empower professional employees (Courpasson and Clegg, 2006). Nonetheless, despite political support for hybrid roles, there is no accepted definition of clinical leadership in either the policy or academic literature and questions remain as to what makes it different from other forms of management and leadership in healthcare (Howieson and Thiagarajah, 2011; Mackintosh *et al.*, 2011). To some extent this is due to the competing logics underpinning the concept in practice (Robertson, 2011). However, it is also partly due to the array conceptualisations and contested nature of leadership in general (Grint, 2005b; Thorpe, Gold and Lawler, 2011).

Leadership research and practice has its foundations in psychology and traditionally focused on traits, styles and behaviours of individual leaders (Yukl, 1999; Bass, 1997). However, recent social constructionist approaches have criticised these leader-centric theories and have positioned leadership as co-constructed between leaders and followers (e.g. Fairhurst, 2009; Grint, 2010; Kellerman, 2008; Shamir, 2007; Schyns and Shilling, 2011). In addition, there has been a growth in critical paradigms which advocate more collective, distributed, and ethical forms of leadership (e.g. Gardner *et al.*, 2011; Gronn, 2002; Grint, 2009; 2011). Distributed and hybrid forms of leadership which promote leadership at multiple levels of the organisation have been advocated as an alternative to previous ‘heroic’ theories focused the skills and abilities of the select few (Gronn, 2002; 2009). The clinical leadership literature has evolved in a similar pattern with recent approaches advocating the need for more inclusive and collective forms of leadership as means of engaging staff in change and achieving effective healthcare (Bolden and Gosling, 2006; Buchanan *et al.*, 2007).

For the most part, leadership development theory and practice has focused on individual leaders and the delineation of desirable traits, behaviours and qualities (Day, 2011; Edmonstone, 2005; Hartley and Hinksman, 2003). However, there has been a call in the

literature for more inclusive integrative perspectives and there is evidence to suggest that leadership practice is gradually moving beyond such leader-centred approaches to incorporate wider social constructionist and critical perspectives (Carroll and Levy, 2010; Day, 2011; Dvir *et al.*, 2002; DeRue and Wellman, 2009; Petriglieri, 2011). Though, questions remain as to how leadership development initiatives are informed by the plethora of leadership theories available. One perspective that has gained increasingly importance within the social constructionist leadership literature relates to the dynamic co-construction of leadership identity at an individual, relational and collective level (DeRue and Ashford, 2010).

There has been a growth of literature around the role that development efforts play in identity construction, maintenance and regulation (Carroll and Levy, 2010). For instance, Petriglieri (2011) conceptualises leadership development programmes as ‘identity workspaces’ where participants can step back from their daily routines and revise and consolidate their leadership identity. He suggests that programmes that provide opportunities for practice-based learning, reflection, and peer identification help to personalise and contextualise participants’ learning. However, there is debate over how training and development initiatives contribute to leaders’ identity construction, the relationship between leaders and leadership, and the individual and organisational effects of off-the-job development (Day, 2011; Dvir *et al.*, 2002; Grint, 2010; Lord and Shondrick, 2011). An individual’s identity is multifaceted and fluid; it is a product of their experiences and interactions therefore shifts in relation to the social and temporal context (Beech, 2008; Carroll and Levy, 2010; Cunliffe and Eriksen, 2011). Consequently, some authors have questioned the value of episodic development programmes that are removed from the relational processes in which their identities and acts as leaders are constructed (Day, Harrison and Halpin, 2009; Duguid, 2005; Grint, 2007; Hosking, 2002). Moreover, there is a lack of consensus as to how individual learning is transferred into organisational learning (Tourish, 2012; Watkins, Lsyø and deMarrais, 2011).

Nonetheless, others have proposed that leadership development initiatives can and should be designed to include activities that enhance not only participants’ human capital (i.e. their personal capabilities, knowledge, skills, and attitudes), but also their social capital (i.e. their positive relationships and networks with other individuals and organisations)

(Day, 2000; 2011; Shamir 2007). Thus, programmes have the potential to contribute to the co-construction of participants relational and collective leadership identities (DeRue and Ashford, 2010). However, as noted in section 1.2, both the leadership and intellectual capital literature acknowledge that knowledge transfer and the creation of value is dependent on a supportive organisational context and the development of strong organisational capital (i.e. institutionalised knowledge and codified experiences). Moreover, in knowledge-based organisations as well as public services like education, health and policing, it is important to take account of the complex processes of ‘co-creation’ between producers and users of the service within which value is created (Moore, 1995; Bennington, 2011; Prahalad and Ramaswamy, 2004).

### **1.5: Conceptual Framework**

A key outcome of the literature review was the development of a conceptual framework linking leadership development to personal and organisational value (see figure 1.2). This conceptual framework contextualises the research and provides an overview of the key factors relevant to the study and the presumed relationships among them (Miles and Huberman, 1994). The notes in blue highlight the main stakeholders involved within the research. The framework acts like a map that gives coherence to the empirical study (Stake, 1995). Figure 1.2 shows that leadership theory together with the organisational and industrial context will inform and influence the leadership development approach. It theorises that a well-designed, effective leadership development programme will build and enhance participants’ human capital (their personal capabilities, knowledge, skills, and attitudes) and social capital (positive relationships /tight and loose coupled networks with other individuals and organisations) (Day, 2011). However, learning application and transfer as well as the establishment of intellectual capital (organisational knowledge resources and capabilities) will be influenced by the organisational context (the culture, support systems, existing networks and forums available for applying and sharing knowledge) (Bontis and Fit-enz, 2002; Garnett, 2011; Petty and Guthrie, 2000). Thus, it is proposed that human capital, social capital and the organisational context complement and enable each other, interacting to create intellectual capital which in turn drives value creating processes such as dynamic capabilities, innovation, efficiency and collaborative working (Subramaniam and Youndt, 2005).

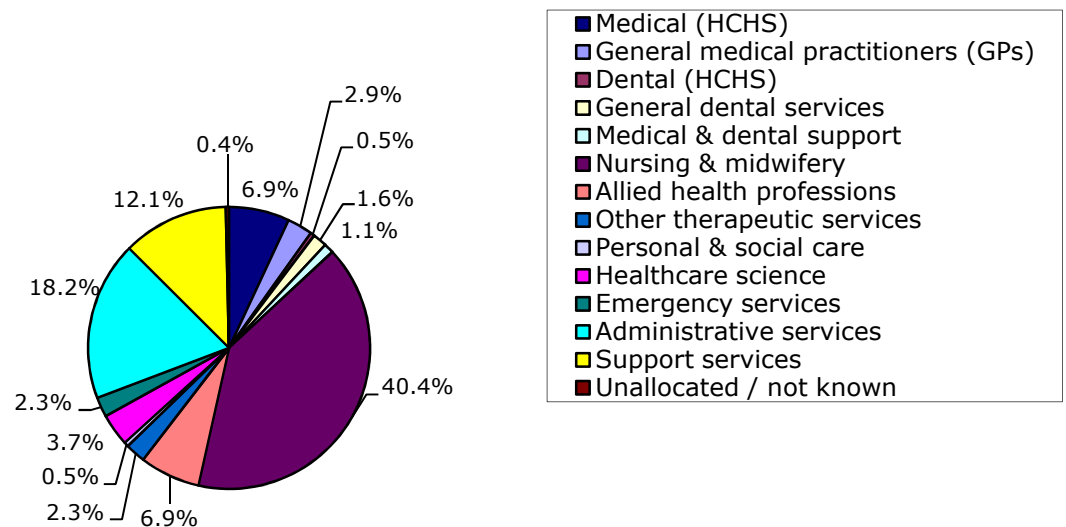
Wallace (1971) argues that research should be a cyclical process, that is, the logics of induction and deduction should be combined in an ongoing cycle. Thus, while the conceptual framework guided the research it was continually refined to provide an explicit link between theory and research (Blaikie, 2009). This study is primarily concerned with the participants' views of how the programme has impacted their own human and social capital, but also begins to explore accounts of learning transfer and application and subsequent value creating processes within the participants' teams and organisations. The conceptual framework allows us to consider this study in relation to existing theory. It highlights the key concepts to be studied, recognises the complexity of the process under examination, and informs the choices made within the empirical study (Bryman, 2008; Miles and Huberman, 1994). Nonetheless, as the model was grounded in prior, largely positivistic, research, I followed Mintzberg's (2005) advice on developing theory. He recommends that it is important for researchers to first get close to the phenomena by inductively unearthing data, stories, and accounts before stepping back and relating these findings to existing theory. Thus, semi-structured interviews were used to collect participants' accounts and the initial analysis allowed findings to emerge from the data before they were then linked back to the concepts and relationships proposed within the conceptual framework. A further important aspect of phenomenological research is taking account of the context in which the phenomena occurs and how this may impact people's socially constructed worlds and views (Bogdan and Taylor, 1975), which is the subject of the next section.

## 1.6: The Research Context

When conducting case study research it is important to understand the context in which the research is situated as it can impact the phenomenon under study (Yin, 2003). In the leadership literature social constructionist theorists emphasise that leadership identities are context specific and shift over time and across situations. Consequently, they recommend that researchers delve deep into the context and gain an understanding of the historic and social factors that explain how local knowledge is formed within the context (DeRue and Ashford, 2010; Fairhurst, 2009). In this case, the Scottish NHS and the DTF development programme form the settings where participants constructed and enacted their clinical leadership identity. An overview of health service reform and leadership development in Scotland and the UK is now provided. This is followed by a brief discussion on leadership in NHS Scotland and the role of DTF.

### 1.6.1: NHS Scotland - A Diverse Workforce

**Figure 1.4: NHSScotland Workforce by Staff Grouping as at 30<sup>th</sup> September 2009**



Source: ISD Scotland National Statistics Website, accessed 5<sup>th</sup> September 2010

The National Health Service (NHS) was set up in 1948 to provide healthcare for all citizens - based on need, not ability to pay. This rationale still exists today; however the rising cost of care and the expanding scope of treatments available have caused healthcare

expenditure to rise. To cope with this rise successive governments have looked towards new approaches to service provision, management, and methods of funding (Ham, 2003; Hebson *et al.*, 2003; Richardson and Cullen, 2000). Consequently, the NHS has undergone numerous reforms since its inception. In 1999 health care became a devolved issue which led to some important differences between NHS Scotland and NHS England with each adopting different systems of governance and methods of provision (Connolly, Bevan and Mays, 2010). NHS Scotland is a multidisciplinary organisation that operates in a multitude of contexts and locations across Scotland. It is a large and complex organisation; comprising of 14 regional Health Boards, 8 Special Boards, the Mental Welfare Commission and Mental Health Tribunal. In 2008/2009, the net operating expenditure for these bodies amounted to £9.96 billion (ISD Scotland, 2010). NHS Scotland has around 169,000 staff in post (headcount) with the largest proportion of those being nursing and midwifery staff (*ibid*). Figure 1.4 illustrates the diversity of occupations within the health service.

NHS Scotland was identified as a suitable case organisation for the current research as it employs a variety of human resources (including: doctors, nurses, allied health professionals, managers, administrators, and auxiliary staff, such as cleaners and porters) who must use their own knowledge and skills to meet specific objectives while working together to achieve overall success. There is a clear emphasis on delivering quality through partnership and leadership within the service (e.g. Scottish Executive, 2003; 2005; Scottish Government, 2007; 2009; 2010). The particular importance of leadership was demonstrated by the establishment of a national leadership strategic framework in 2005 and the launch of a flagship national clinical leadership programme in 2006 (see section 1.6.7). Positive outcomes depend on the communication and collaboration between those working in primary, community, and acute services as well as partnerships with external bodies such as local authorities and the voluntary sector (Scottish Government, 2007). Moreover, recent strategy documents have argued that developing leadership capability and capacity is central to engaging professions in the wider change agenda and improving the quality of care and services provided by NHS Scotland (Scottish Government, 2009; 2010). However, leadership in a healthcare context faces deep-seated challenges due to the both professional environment and bureaucratic structure (Donaldson, 2001; Kirkpatrick *et*

*al.*, 2009). To understand these contextual challenges this chapter now considers four eras of reform within the NHS more broadly, which also apply to Scotland.

### ***1.6.2: An Overview of Reform: Post-war to Present***

Despite a forty year history of attempting to reform the NHS some commentators query if there has been any significant change in the intervening years (Grint, 2008). Nonetheless, most researchers refer to at least four eras of policy reform, all of which have influenced the current leadership agenda (Walshe and Chambers, 2010). From its establishment until the mid-1970s, the NHS could accurately be described as a classical professional bureaucracy (Mintzberg, 1980), in which government provided funding for the NHS but the main operating core of the NHS, especially doctors, were granted substantial control over decision making and clinical priorities. The second phase, which began in the 1970s and lasted until the early 1980s, saw the introduction of hospital administrators to form a tripartite structure with doctors and nurses to run NHS organisations on a consensus and inclusivity basis. Although administrators in some situations were first among equals, they nevertheless recognised that leadership was based on winning consent of medical staff. The tripartite form of governance fell down, however, because it resulted in slow and bureaucratic decision-making. This led to two further phases of reform: phase three developed following the Griffiths Report (DHSS, 1983) and encompasses the post-Griffiths reforms in the 1980s-1990s, while phase four takes account of the diversity that resulted from devolution in 1999 as well as the more recent post-devolution quality reforms evidenced by Scotland's *Better Health, Better Care* (Scottish Government, 2007) and the Next Stage Review report in England (DoH, 2008). As both these periods of reform have been particularly important to the current agenda on clinical leadership they are now discussed in detail.

### ***1.6.3: The Management Reforms of the 1980s and 1990s***

The story of health care reform over the last three decades is well documented by healthcare management researchers (e.g. Speed, 2011). In a move away from traditional public administration the Conservative government of the 1980s and 1990s introduced the concept of 'New Public Management' (NPM); they believed that management principles



from the private sector could be used to improve the efficiency and quality of public services (Brookes and Grint, 2010; Cutler and Waine, 2000). This agenda followed a government inquiry in 1983 into NHS management led by Sir Roy Griffiths, Deputy Chairman and CEO of Sainsbury's. Griffiths and his team took the view that the previous consensus approach lacked coherent management and leadership as 'no-one was in charge', thus the report recommended the introduction of new NHS management structures and new management accounting practices at national, regional and local levels. Most significantly, it also recommended an introduction of general managers, who could focus on levels of service, quality of service, budgeting, cost improvements, productivity and motivating and rewarding staff (Speed, 2011).

A second Griffiths report (DHSS, 1988) led to a further piece of legislation, the NHS and Community Care Act 1990, which introduced the idea of 'quasi-markets' within the NHS. Health authorities became purchasers of health services and those providing services became sellers. It was thought that combining competition, devolved decision-making and performance measurement would create an efficient and quality service (Cutler and Waine, 2000; Fischbacher and Francis, 1998). NHS hospitals, traditionally owned and directly managed by government were granted corporate status in 1991 as NHS trusts. This process led to hospitals, like private businesses, having their own institutional identity and accounting systems (Pollock and Price, 2011); though in practice government regulation was still significant. Financial incentives were also introduced so that GPs could use any budgetary savings they made to invest in their own practices, thus creating the foundations for GPs to see themselves as businesses as well as primary care clinicians, so creating a division between themselves and their acute sector colleagues (Speed, 2011).

In 1997, the election of a 'New Labour' government brought further reforms. They supported the general objectives of public sector managerialism (Clarke and Lapsley, 2004), though they saw the internal market as 'fragmenting' the service and initiated a more collaborative and flexible approach (Bradshaw, 2003; Flynn, 2002; McMaster, 2002). The emphasis moved away from fiscal metrics to quality measures and various structural and management reforms ensued. The District Health Authorities in England were assigned a quality role and a number of new quality bodies were established, including the National Institute for Clinical Excellence (NICE) and the Commission for Health

Improvement (CHI). Speed (2011) contends that the focus of these reforms was to standardise clinical practice using guidelines rather than financial control; thus representing a further intervention into clinical practice and a reduction of clinical autonomy.

#### ***1.6.4: Diversity Following Political Devolution***

Perhaps the most notable policy change for this study came with Scottish devolution in 1999. This resulted in the National Health Services in Scotland becoming the responsibility of the Scottish Government. For the first eight years after devolution, the Labour party remained in government (either independently or in coalition) in Scotland, England, Ireland and Wales. However, as a consequence of geographical and demographical circumstances there has always been some variation in the organisation and administration of health policy in different parts of the UK and these differences were sharpened by devolution with different countries taking contrasting approaches to both the structure and governance of the NHS (Sullivan, 2002; Woods 2002; Winchester and Storey, 2007). This was evidenced in a recent report by the Nuffield Trust, 'Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution', which examined the impact of different approaches in England, Scotland, Wales and Northern Ireland (Connolly, Bevan and Mays, 2010).

The report highlighted that there are now four distinctive National Health Services. Over the last decade, England has placed further emphasis on provider competition through patient choice and the establishment of multiple providers (Trusts, Foundation Trusts, private providers, etc.). In contrast Scotland and Wales abandoned the purchaser / provider split that previously existed under the unified NHS and re-established organisations more focused on regional population and service needs. In effect, this re-organisation privileged the virtues of large-scale integration and coordination of care and patient pathways over patient choice and markets. For example, regional boards were established in Scotland, which have a 'dotted line' responsibility to a Scottish Government Health Department based in Edinburgh, while Wales established a system of regional boards supported by three national trusts. Northern Ireland Health and Social Care (HSC) is organised on the basis of five regional Trusts and a Health and Social Care Board (Connolly *et al.*, 2010).

Governance and policy differences were further accentuated when, in May 2007, the Scottish National Party (SNP) came into power in Scotland leading to a renewed focus on collaboration and collectivism (Kerr and Feeley, 2007). The action plan for health, 'Better Health, Better Care' (2007) set out a vision for the NHS in Scotland calling for an integrated health system that supports partnership across acute, primary and community services and promotes a high level of engagement from both the workforce and citizens in the development of services (Scottish Government, 2007). This is in contrast to the model pursued in England where health reforms focusing on patient choice have been designed to combine competition in some areas of care and collaboration in others (Blacker, 2006; Ham, 2007). Nonetheless, recent policy documents, such as the 2010 Healthcare Quality Strategy for NHS Scotland and Lord Darzi's (2008) Next Stage Review for NHS England, have illustrated the common aspiration to deliver high quality healthcare and to evaluate service quality in relation to indicators of patient safety, clinical effectiveness and patient experience. So while the broad aims (such as to streamline the acute sector, provide more care in community settings, and make more preventative interventions) for health services across the UK are similar, these aims are being pursued within different political contexts and policy communities (Smith and Babbington, 2006).

#### ***1.6.5: The Future of the NHS***

The current economic situation together with the changing political environment, namely the election of a new UK coalition government in 2010 and the re-election of a majority SNP government in Scotland in 2011, means that the NHS will continue to face a spectrum of change and reform in the future. Being open and adaptive to change is vital to organisational performance. However, if an organisation is in a state of perpetual change it can lead to a loss of direction and a sense of 'change fatigue' amongst its employees (Bamford and Daniel, 2005; Garside 2004). It has been suggested that successive organisational restructuring within the NHS has had a negative effect on the psychological contract of NHS staff (Cortvriend, 2004). Past disappointments alongside a lack of communication and managerial support have led to scepticism amongst employees, in particular, clinicians of the value of further reforms (Edwards, 2003; Ham, 2003; Worthington, 2004). Therefore, it is important that future change is communicated and

managed sensitively to overcome potential change fatigue (Bamford and Daniel, 2005; Edmonstone, 1995).

#### ***1.6.6: Leadership in the Scottish NHS***

Recent practitioner and policy documents have postulated that effective leadership can help overcome change fatigue and encourage collaborative working to provide efficient and effective healthcare (e.g. DoH, 2001; 2008; The Kings Fund, 2011; NLC, 2010). Consequently, the Scottish Government and Scottish NHS have launched a number of leadership development programmes that are designed to enhance the leadership capabilities of both managers and clinicians (Scottish Executive, 2005; Scottish Government, 2009). These represent a significant investment in the organisations human capital. Audit Scotland (2005) estimated that the country's public sector spends roughly £5m a year on identifying and training leaders and that the NHS spends £1.5m per year across the service on identifying and training leaders. Notwithstanding this investment Government ministers, health service managers and a substantial number of senior clinicians themselves still talk in terms of a leadership deficit in the NHS (Walshe and Chambers, 2010).

Within NHS Scotland leadership development has been initiated at an individual, local, regional and national level. As part of their self-development many clinicians have completed external courses (such as an MSc in Healthcare Management or Clinical Leadership) to enhance their own managerial and leadership skills. Local and regional training initiatives have also been developed which aim to promote team cohesiveness and provide targeted and work-based learning. At a national level, development programmes have been established to provide senior clinicians with a more holistic grounding in management and leadership. Such programmes aim to create networks of strategically-minded clinical leaders who work together to foster a leadership 'mind-set' throughout the organisation (Edmonstone and Western, 2002). Each of these approaches to development has their own merits; however it has been argued that it is important for this activity to be coordinated so that there is mutual reinforcement between levels and professions (*ibid*).

Despite the political support for clinical leadership roles, as mentioned above, leadership development within the Scottish NHS faces a number of inherent challenges not least due to the historic power relations between managers and clinicians and across different clinical professions (Kippist and Fitzgerald, 2009; MacIntosh *et al.*, 2011). There is debate over whether leadership development should be tribal with each profession addressing its own perceived needs or whether it is better to support joint education and multi-professional training (open to nurses, doctors, managers and allied healthcare professionals) to help professionals understand and accommodate the diverse interests and concerns of those involved in healthcare (Edmonstone and Western, 2002; Prosser, 2010). Existing programmes have also been criticised for being inadequately evaluated (Audit Scotland, 2005; Day, 2011; Tourish, 2012). However, others have highlighted that it is particularly difficult to ascribe cause-and-effect relationships between specific development experiences and organisational change (Grint, 2008; Lee, 1995). Although it may be easier to attribute individual benefits (for example, Edmonstone and Western found that the opportunity to stop, take stock, reflect and plan ahead was highly valued by programme participants), there is a view that attempting to quantify such personal development may be inappropriate in the short-term as benefits of a course, for example, can become visible later in a different context or situation, sometimes long after the course has been completed (Day, 2000; Hannum *et al.*, 2007; Lee, 1995).

#### ***1.6.7: Delivering the Future: The Case Programme***

In 2005, NHS Scotland published its first leadership development framework, *Delivery through Leadership* (Scottish Executive, 2005). This framework positioned leadership as central to improving performance, redesigning services and securing better delivery. It set out the national priorities for action in leadership development and the qualities required of NHS Scotland leaders (an updated version is summarised in figure 1.5).

Figure 1.5: Summary of Leadership Qualities



Source: Scottish Government, 2009, p.14

Figure 1.5 emphasises the value placed upon developing ‘positive’ leadership qualities and behaviours within the Scottish NHS. Personal qualities are at the heart of the framework and encompass personal governance, personal management and seeking understanding. These reflect theories of ethical and authentic leadership (e.g. Avolio and Gardner, 2005). Working in a political environment, NHS leaders need to manage upwards as well as across the organisation, manage uncertainty, and be prepared to take difficult decisions (Mintzberg, 2009). Alongside personal factors are three qualities aimed at delivering service excellence and four qualities aimed at ensuring future focus. Leaders in the NHS are deemed to be required to balance long-term focus on health improvement with the short-term imperative of meeting HEAT (Health improvement, Efficiency, Access to services and Treatment) targets and manage the tension between innovation and risk (Scottish Government, 2009). Paradoxically, however, the policy literature supporting the framework also stresses the importance of collaborative working and distributed forms of leadership, which do not sit easy with individualised leadership frameworks.

In tandem with the framework, NHS Scotland launched *Delivering the Future* a flagship national programme focused on the development of senior clinical leaders across the Scottish Health Service (NES, 2006; Scottish Government, 2008). Built on the principles

set out in *Delivery through Leadership* and in the subsequent strategy *Delivering Quality through Leadership* (Scottish Government, 2009) it has adopted a multi-disciplinary approach to learning. The programme runs over a period of eighteen months and takes a blended approach to learning that encompasses multiple elements including: master classes, action learning, coaching, 360° appraisal feedback, and a final individual project. DTF is now in its sixth year, recruiting 24 senior clinical leaders annually from across the NHS boards in Scotland. The programme attracts leaders from different levels and professional backgrounds including nurses, doctors, and allied health professionals.

This section has outlined the specific context in which the central research question, relating to how development programmes can impact on participants' leadership identities and the organisational factors that influence outcomes and the degree of learning transfer, is explored. The chapter now concludes by providing an overview of the thesis and how it addresses this question.

### **1.7: Structure of Thesis**

This thesis is divided into eleven chapters. This chapter has introduced the main issues that the research addressed, provided some background to the case organisation and has outlined the methodology employed to review and synthesise relevant literature. The next three chapters then consider the various literature bases that inform the research. These chapters situate the research within the existing theory and provide clarification of the different elements that constitute the conceptual framework. Chapter two begins by critically reviewing the leadership literature. Chapter three then considers theories and debates that surround leadership development and intellectual capital. It observes that although there are encouraging signs that the field is moving beyond a 'best practice' approach there is scope for further development by considering more fully the dynamic interplay between leaders and followers as well as taking more fully into account the context in which these interactions occur. Moreover, it explores the personal and social aspects of leadership identity construction at an individual, relational and collective level. Finally, chapter four considers literature relating to the special case of clinical leadership.

Chapter five then outlines the methodology of the empirical study. A phenomenological case study design with multiple levels of analysis allowed the collection of in-depth data from a range of stakeholders within the case and helped the researcher explore how organisational context influences participants' accounts of individual and organisational impact. This chapter covers the philosophical stance underpinning the study and addresses the methods employed to collect data. It explains the analytical strategy and finishes by exploring the ethical issues surrounding the research. The subsequent four chapters then present the most significant findings of the study in relation to the research question and objectives.

Examining the key themes that emerged during semi-structured interviews with twelve HR Directors, chapter six explores the policy and organisational context within the Scottish National Health Service. Chapter seven, eight, and nine then present the findings from the in-depth case analysis of the DTF programme. Chapter seven explores participants' experiences of the programme as an identity workspace. Chapter eight then builds on this to consider participants' accounts of the individual impact of DTF in relation to their human, psychological, and social capital. Next, chapter nine explores the role of organisational context on these accounts. Moreover, it examines how individual, relational and organisational factors influence learning transfer and leadership effectiveness.

Chapter ten subsequently provides a discussion of how these findings relate to the existing literature. Drawing upon the data presented in the results chapters and critically reflecting on the interpretation process it examines the implications of the research on current theoretical thinking on clinical leadership and leadership development. Moreover, it considers the contributions of the study to the policy context of the Scottish Government and National Health Service. The thesis ends, in chapter eleven, by briefly summing up and drawing together conclusions that reinforce the understanding of clinical leadership development. It reflects on my professional learning and the experience of conducting the study and points towards future possibilities for research, practice and policy making.



## Chapter 2: Leadership in Theory and Practice

Chapter one set out the policy background, research questions and objectives, and conceptual framework underpinning this study. It stressed that developing clinical leadership is a key area of investment within the Scottish health service and proposed that there is a need for greater understanding of the role of context on perceived leadership development effectiveness and learning transfer. The purpose of this chapter together with chapter three and four is to situate this research within existing theory. Reviewing relevant literature this chapter explores the traditions, theories and debates that surround the concept of 'leadership'. Chapter three then considers how this examination of leadership relates to the practice and theory concerning 'leadership development'. Chapter four then focuses on the literature on the specific case of 'clinical leadership'.

### 2. 1: Reviewing the Literature

Figure 1.1 in the previous chapter mapped the areas the literature which informed the study. Following initial scoping searches a review protocol was developed, this outlined the search strategy and inclusion and exclusion criteria for the focused literature review (Petticrew and Roberts, 2006; Tranfield *et al.* 2003). The search and selection criteria which guided the review are now discussed.

#### 2.1.1: Search Criteria

The first stage of the review was to identify relevant literature. Principally, keyword searches of six relevant academic databases were used to identify articles (see box 2.1). Searches were limited to articles published in English and in the last fifteen years. This was not an arbitrary boundary as it allowed the focus to be on contemporary research, yet key papers outside this timescale were included by examining the top cited references of the papers selected for review. Supplementary searches were also performed pertaining to management, policy and human resource theories supporting the research (see chapter 3 and 4).

To ensure thorough coverage, manual reviews of four additional sources were conducted. Firstly, the 1995-2011 volumes of the *Academy of Management Review*, *Academy of Management Journal*, *International Journal of Management Reviews*, *Strategic Management Journal* and the *Journal of Management Studies* were reviewed as these journals are often cited as high quality within management literature (see, e.g. Serenko and Bontis, 2004). Secondly, specialised journals such as the: '*International Journal of Clinical Leadership*', '*Social Science & Medicine*', '*The Leadership Quarterly*', '*Human Relations*', and '*Leadership*' were reviewed. Thirdly, key texts, including, for example, *The SAGE Handbook of Leadership*, were located and examined. Finally, principal policy documents and government reports were gathered from local and national policy organisations. Following these initial searches, the references of key papers were examined to identify major authors and theories within the

field. To decrease the risk of publication bias, the personal websites of key authors of the research were examined for additional material. Searches were repeated periodically (every six months) over the course of the PhD to ensure that the review reflected current thinking.

### 2.1.2: Selection Criteria

The product of these searches was a large volume of articles which were subsequently categorised and condensed according to relevance and quality (Saunders *et al.*, 2003). This review focused on literature relating to leadership development within organisations rather than the wider concept of leadership. Drawing on intellectual capital theory, it considered the role of context on leader identity construction and learning transfer. Thus,

#### **Box 2.1– Summary of Search Terms**

**Databases:** EBSCO; Emerald Fulltext; ISI Web of Science; SAGE Journals; Wiley-Blackwell; and Science Direct.

**Where:** Title, Keywords, & Abstract

**Keywords/ phrases:**

- 1 Leader\*
  - 2 #1 AND #2or #3 or #4 or #5 or #6 or #7or #8
  - 3 Develop\*
  - 4 Learn\*
  - 5 Train\*
  - 6 Intellectual capital
  - 7 Intangible\*
  - 8 Human capital
  - 9 Social capital
  - 10 Identity\*
  - 11 #1 or #3 or #4 or #5 or #6 or #7or #8 or # 9 or #10 AND #12 or #13 or #14 or #15 or #16 or #17or #18 or #19
  - 12 Intellectual capital
  - 13 Context\*
  - 14 Situation\*
  - 15 Network\*
  - 16 Relationship\*
  - 17 Skill\*
  - 18 Knowledge\*
  - 19 Ability\*
  - 20 #1 or #3 or #4 or #5 or #18 AND #21 or #22
  - 21 Evaluation
  - 22 Transfer
  - 23 Healthcare\*
  - 24 Clinician\*
  - 25 Medic\*
  - 26 Doctor\*
  - 27 Nurse\*
  - 28 #1 or #3 or #4 or #5 or #10 AND#21 or #22 or #23 or #24 or #25 or #26 or #27
- \* denotes that that wildcard and truncation symbols were used to allow for multiple spellings and various endings

at a general level, studies eligible for review were those explicitly integrating theory and concepts from both *leadership development* and *intellectual capital*. At a more specific level, some studies were explicitly positioned to the provision and evaluation of leadership development programmes, while others focused on the social construction of leader identity. Further articles discussed the broader notion of intellectual capital and its impact on innovation and organisational performance.

In accord with the focus on organisational context, articles excluded from the review included those pertaining to the effects of political leadership on a country's culture, economy, and political situation as well as those that considered the impact of a country's education system on its national human capital. Similarly, leadership has been studied within a number of disciplines and is influenced by a number of theoretical paradigms. However, in keeping with the studies phenomenological approach this review is particularly interested on how leadership is socially constructed and distributed throughout the organisation. To compensate for the mechanistic approach of the review several additional articles were manually included based on recommendations from colleagues.

As this research adopts a 'realist synthesis' approach, which acknowledges the complexity of social research and the many forms in which research can be conducted and reported, it was not possible to review articles based on definitive quality criteria before the synthesis started. Instead, in line with Pawson *et al.* (2004), quality (rigour) was considered in relation to synthesised elements of the reviewed articles. Articles selected for full review were examined in relation to their contribution to the field, strength of argument, theoretical basis and methodological rigor. Thus, a paper with a highly original conceptual contribution may be included in the review even if the empirical work suffered from quality problems. One particular issue evident in past reviews of management literature (Marr and Moustaghfir, 2005; Petty and Guthrie, 2000) is deciding what literature constitutes academic research. This review has used three factors in discriminating against what literature to use revolving around the journal in which the work was published, the nature of the empirical research, if any, and the perceived quality of the Journal. Another guide used was the Journal Quality List (Harzing, 2011). Selection was made by looking at the journal remit and intended audience. Journals and books intended for practitioner-based audiences as opposed to an academic focus were examined and referenced as

appropriate, although they were not subject to in-depth critical assessment and therefore do not form part of the main discussion.

### ***2.1.3: Strengths and Weaknesses of Review***

Leadership development is multidimensional field of research, attracting authors from different disciplines that introduce different theoretical frameworks, different levels of analysis and different methodological traditions (Denis *et al.*, 2011; Grint, 2011; Jing and Avery, 2008; Morrell, 2010). By using a number of databases, key journals and established references the review considers those authors that have published across disciplines in recognised 'leading' journals as well as those who have been cited by these authors. However, the comprehensive nature of the review - despite the relatively large numbers included - can be questioned. In contrast with a Cochrane or Campbell review that follows very specific (often positivistic) procedures to select and analyse relevant studies, the quality assurance in a realist synthesis review is dependent on the reflexivity and explicitness of the researcher. By reviewing disparate bodies of literature I attempted to synthesise a range of insights into leadership development and intellectual capital creation. However, the considerable size of the literature meant that parameters became more focused as the research progressed and consequently there is scope for human error or oversight. To minimise the risk of omitting relevant papers prevalent references within existing papers were also examined.

## **2.2: Introducing Leadership**

Although the focus of the current research is on leadership development and not on leadership per se, it is evident from the literature that the approach to development is influenced by the model (explicit or implicit) of leadership which underpins it (Hartley and Hinksman, 2003). Therefore, the review begins with an introduction to key perspectives within the leadership literature.

### 2.2.1: So what is *Leadership*?

Leadership itself is an age-old concept which is present in all cultures regardless of their economic or social makeup (Bass, 1990; 1997). It is often cited as both the problem and solution to a wide range of contemporary issues such as: ending world poverty, addressing global warming; creating scientific breakthroughs, producing efficient hospitals, and engaging local communities in service delivery (Collinson and Grint, 2005; Jackson and Parry, 2008). There is a plethora of academic and practitioner literature which proposes a link between strategic leadership, employee performance and organisational effectiveness (Avolio, 1999; Bass, 1998; Carmeli *et al.*, 2010; Finkelstein *et al.*, 2009; Judge and Piccolo, 2004; McGrath and MacMillan, 2000; Purcell *et al.*, 2003; Rowe *et al.*, 2005; Yukl, 2008). Yet, the academic literature often appears vague and contradictory; there is confusion as to what the field of leadership actually encompasses, how it should be studied and what can be done to improve it in practice (Grint, 2005b; 2010; Jing and Avery, 2008; Morrell, 2010; PIU, 2001; Western, 2008).

Throughout the literature, leadership has been conceptualised in a multitude of ways and there is no single, universally accepted definition. As Bass (1990) pithily states: *‘there are almost as many definitions of leadership as there are persons who have attempted to define the concept’* (p. 11). Some researchers have gone so far as to say that it is impossible to define leadership in words, but people know it when they see it (Pye, 2005; Western, 2008). Leadership is inherently complex and can mean different things to different people depending on their experience, background, and developmental level (Day *et al.* 2004; Grint, 2005b). This elusiveness can presents some issues for leadership development as if there is no clear and agreed approach to the concept of leadership then development practices may be inappropriate for the type of leaders which the organisation is aiming for or old and out-dated practices may be relabelled as ‘leadership’ to suit the current organisational rhetoric (Alimo-Metcalfe and Lawler, 2001).

### 2.2.2: *Making Sense of Leadership*

Despite myriad interpretations, there are shared meanings of leadership within the literature. For example, Grint (2005a) suggests that leadership has traditionally been understood in four different ways:

- Leadership as person: it is who ‘leaders’ are that makes them leaders.
- Leadership as position: it is where leaders operate that makes them leaders.
- Leadership as process: it is how leaders get tasks done that make them leaders.
- Leadership as results: it is what ‘leaders’ achieve that makes them leaders.

The term leadership is commonly taken to describe an individual’s traits and behaviours as in ‘he or she demonstrated leadership through engaging and motivating staff’ (Bass, 1990; Western, 2008; Yukl, 1989). A second view is that those in a formal position may be described as leaders by virtue of their recognised managerial role, for example, in the NHS this might be chief executives, medical directors, nurse managers etc. The implications for leadership development are important. If leadership is defined solely by role, then the focus is on leadership development for those roles (Hartley and Hinksman, 2003). Alimo-Metcalf and Lawler (2001) note that there are dangers in seeing leadership development as related solely to particular roles as opposed to leadership ‘cascaded’ through the organisation (distributed leadership) or building critical mass across the organisation through leadership development. This relates to the critical theory assertion that leadership should be distributed across multiple organisational levels (Gronn, 2002; 2009; Grint, 2011). Moreover, some commentators (e.g. Rost, 1995) suggest that formal positions provide authority but not necessarily leadership. Leadership requires more than simply holding a particular office or role (Jing and Avery, 2008). Heifetz (1994) distinguishes between formal and informal leadership and argues that each may tackle leadership issues through different processes, for instance informal leaders may work through influence rather than through authority or direct control.

A third approach considers leadership as a set of interpersonal processes or dynamics occurring between leaders and followers within a group setting (Barker, 2001; Bass, 1990; Shamir *et al.*, 2007). In this approach, leadership involves an array of activities concerned

with motivating and influencing people to shape and achieve outcomes. The distinction between leaders and followers is somewhat arbitrary as in a given situation, an individual may adopt both a leader and a follower role depending on whether he or she is influencing others or being influenced, setting direction or following direction, or providing support or receiving support at a particular moment (Day, 2004; Kellerman, 2008). Leadership development programmes influenced by this approach are concerned with building social capital as well as human capital (Day, 2000)

The fourth view explores the leadership-performance relationship, debating the effectiveness of different leadership styles and behaviours on organisation performance and value creation (Analoui, 1999; Avery, 2004; Hawkins and Dulewicz, 2009; Hiller *et al.*, 2011; Shamir and Howell, 1999; Yukl, 1999). Yet, several authors acknowledge that there is no panacea and different styles of leadership reflect social and historical roots (Bryman, 1992; Finkelstein *et al.*, 2009; Hiller *et al.*, 2011; Jing and Avery, 2008; Shamir and Howell, 1999; Yukl, 1999). This implies that different leadership approaches could affect performance differently, depending on the context. Thus, when researching leadership development both the underpinning paradigm and context needs to be taken into account.

### **2.3: Leadership: Organising the Literature**

To appropriately situate this study it is important to compare and contrast previous leadership theories and paradigms (Grint, 2005a; Hartley and Hinksman, 2003; Martin *et al.*, 2011; Munshi *et al.*, 2005; Storey, 2005; Yukl, 2010). Figure 2.1 attempts to divide a vast interdisciplinary body of literature into six main ‘paradigms’: leader centred, follower centred, critical, higher purpose, cultural and contextual. This is not a definitive typology and the boundaries between categories are fuzzy and overlapping (see appendix B for a mind-map illustrating the full spread of the literature). However, the figure and subsequent discussion shows how each of the different paradigms impact leadership development theory and practice.

**Figure 2.1: Perspectives on Leadership**



Source: Adapted from Grint, 2000; 2005; Jackson and Parry, 2008; Yukl, 2010

### ***2.3.1: The Leader-Centred Paradigm***

Since the early 1900's leadership research has been dominated by an interest in leaders, initially focusing on leader 'traits', and, then after the Second World War, on leadership 'styles' (Yukl, 1989; 1999). This literature tends to focus on the skills and abilities, the personality, the styles of engagement (e.g. Fiedler, 1967, Avolio *et al.*, 1999; Judge *et al.*, 2002; Lewin *et al.* 1939), gender differences (Alimo-Metcalfe, 1999; Gardiner and Tiggemann, 1999), and the behaviours (e.g. Burns, 1978: cited in Bass, 1990) of individual leaders. The style of leadership adopted is considered by some researchers (e.g. Awamleh, 1999; Conger, 1999; Yammarino *et al.*, 1993) to be particularly important in achieving organisational goals, and in stimulating subordinate performance (Barling *et al.*, 1996; Berson *et al.*, 2001; Zacharatos, Barling and Kelloway, 2000). One particularly influential model of leadership comes from the work of Bass (1985, 1990) who, building on Burns (1978) conceptualisation, compared 'transactional' leaders, exercising contingent reward and management by exception, with 'transformational' leaders, exercising idealised influence and inspirational motivation in a 'charismatic–inspirational' style. Transformational leadership theory is one among a number of conceptualisations referred



to as ‘new leadership’ (Bass, 1997; Bryman 1992), which advocate the need for visionary or charismatic leaders, but also account for the role of followers and leaders’ ethical obligations (Alimo-Metcalfe and Alban-Metcalfe, 2005; Brown and Trevino, 2006; Dent *et al.* 2005).

Kotter (1999) and others have argued that transformational leadership should be distinguished from management as it is aimed at radical rather than incremental change or stability. It does so by (a) developing continuous novel, credible and compelling visions, ideas and approaches (Parry and Hansen, 2007), and, in the process, engages staff by generating pride, respect and trust in their organisations, (b) motivating and inspiring people through raising expectations, modelling expected behaviours and using symbolic rather than material resources and rewards to help staff focus on what is important, and (c) giving staff personal attention, respect and challenge (Martin *et al.*, 2010). Transformational leadership is generally measured using the 360 degree Multifactor Leadership Questionnaire (MLQ) instrument (Avolio, Bass and Jung, 1999; Kirkbride, 2006).

The MLQ instrument has been used to study leaders in a variety of organisational settings such as manufacturing, the military, financial services and educational institutions and at various levels in the organisation including first line supervisors, middle manager and senior managers (Antonakis, Avolio and Sivasubramaniam, 2003; Lowe *et al.*, 1996). Empirical studies have found transformational leadership to be more highly correlated with the exertion of extra effort, satisfaction with the leader, and perceptions of leader effectiveness (Avolio *et al.*, 1999; Densten *et al.*, 2010; Lowe *et al.*, 1996). However, the generalisability and validity of the instrument has been questioned, in particular it is suggested that the concepts identified as transformational behaviours are overlapping and vague and that the theoretical rationale for differentiating among the behaviours is not delineated by theory (Tejeda *et al.*, 2001; Van der Weide and Wilderom, 2004; Yukl, 1999). Moreover, some of the measures have been criticised for being subjective, for example, what may be inspirational for one need not be inspirational for someone else (*ibid*).

A further perspective relates to what has been termed the ‘narcissistic leader’ (Maccoby, 2000). Narcissistic leaders are often represented by the larger-than-life personalities who we observe running organisations and figuring prominently in society. They have an exaggerated sense of self-importance and engage in ego-defensive behaviours to protect their self-esteem; however narcissism has both constructive (healthy) and destructive (reactive) forms (Brown, 1997; Kets de Vries, 2006; Kets de Vries and Balazs, 2011). Maccoby (2000) discussed the ‘incredible pros’ and the ‘inevitable cons’ of narcissistic leaders. A key strength of narcissistic leaders is that they can engage followers with impressive and compelling vision. However, they are sensitive to criticism, poor listeners, lack empathy and have distaste for mentoring although they have intense desire to compete (*ibid*). This together with their expectation of blind obedience distinguishes them from transformational leaders who promote attainable shared goals based on moral foundations (Bass and Steidlmeier, 1999). Support for an alternative, anti-narcissistic form of leadership has emerged in the literature. Collins (2005) refers to the ‘level 5 leader’ as ‘an individual who blends extreme personal humility with intense professional will’ (p136). In his large scale, five-year study he (and colleagues) found that in the leaders who possess this paradoxical combination of traits are catalysts for transforming a good company into a great one (*ibid*).

Past work has also stressed the importance of ‘emotional intelligence’ to leadership, especially transformational leadership (Rossete and Carrochi, 2005). Salovey and Mayer (1990) have argued that people vary in their capacity to process emotional information/relate to wider cognition, and Goleman (1996) and others (e.g. Hawkins and Dulewicz, 2007) have taken this further by associating ability in this area, called ‘emotional intelligence’ (EI), with leadership effectiveness and business successes. In a recent critical review of the EI leadership literature Walter *et al.* (2011) conclude that there is encouraging evidence that EI is a useful construct for understanding leadership, but warn that: ‘the pattern of findings reported in the published literature suggests that EI does not unequivocally benefit leadership across all work situations. Hence, incorporating EI in leadership education, training, and development should proceed on strictly evidence-based grounds, and it should not come at the expense of other equally or even more important leadership antecedents’ (p.55).

Walter *et al.*'s (2011) review demonstrates that emotional intelligence is one of many factors that influence leadership outcomes. This highlights the disadvantage of most leader-centred approaches, namely that they can lead to the idolisation of particular individuals (assuming that they have superior capacity and power) while ignoring 'followers' and organisational and community constraints (Kellerman, 2008). Subsequently, too much emphasis is placed on personal development at the expense of leadership development as collective capacity (Hartley and Hinksman, 2003). Alimo-Metcalf and Lawler (2001) note that a number of organisations are still taking a 'strong leader' approach to their leadership development, placing the focus on the individual and his/her personality. Grint (2010) suggests that one reason for this is that society often socially constructs events as crises and is addicted to strong, commanding leaders. Thus, collective forms of leadership are often regarded as difficult and dangerous.

### ***2.3.2: Follower-centric Perspectives.***

Although transformational leadership theory attempts to specify a relationship between leaders and followers, it is still regarded as leader-centric, at least in its policy and practical applications (Martin *et al.*, 2010). Both trait and transformational theories have received criticism as they assume that followers are passive recipients of leadership influence and that leadership occurs in a vacuum away from situational influences (Barker, 2001; Currie and Lockett, 2007). Thus, several alternative perspectives have emerged to re-balance the debate by emphasising *the role of followers* in the leadership process (Meindl *et al.*, 1985; 1995). At modest level theorists have tried to develop more contingent theories of leadership which acknowledge that the leaders influence on followers' attitudes and performance is moderated by the individual follower's characteristics such as their maturity, emotional intelligence and values (Fiedler, 1967; Hersey and Blanchard, 1977; Vroom and Yetton, 1973; Wong and Law, 2002). However, in practice followers are made up of multiple voices (Schyns and Schilling, 2011; Tourish and Pinnington, 2002), thus it is proposed that the effectiveness of leadership will depend on the quality of relationships between leaders and followers (Kellerman, 2008). With successful leaders building rapport and helping individuals and teams to coordinate and integrate their differing approaches to drive change through a process of applied creativity and innovation (Basadur, 2004).

Kellerman (2007; 2008) developed a typology of followership based on their level of engagement. These included:

- Isolates (totally detached and uninterested)
- Bystanders (observe but do not participate)
- Participants (care about the organisation and try to make an impact)
- Activists (feel strongly about the organisation and leaders and act accordingly)
- Diehards (passionate about an idea, a person, or both and will give all for them).

Kellerman proposes that good followers will invest time and energy in making informed judgments about their leaders and causes, actively supporting effective and ethical leaders and responding appropriately to bad leaders, whereas bad followers are seen as making no contribution and supporting the wrong types of leader.

Followers have also been conceptualised in more active influencing roles. Some theorists go as far as suggesting that followers can be substitutes for leaders (Dionne *et al.*, 2005, Buchanan *et al.*, 2007). This is thought to be particularly applicable in professional organisations like the National Health Service where change requires the consent of powerful occupational groups (Ferlie *et al.*, 2005; Powell *et al.*, 1999). Consequently, there has been a drive to engage influential clinicians in managerial and leadership roles in a healthcare context (Buchanan *et al.*, 2007; Edmonstone, 2008; Kippist and Fitzgerald, 2009). Similarly, some authors argue that the political and bureaucratic nature of public organisations means that it is politicians rather than public managers that lead change (Blackler, 2006). Alternatively others, referring to the recent focus on networked governance, have proposed that a combination of managerial and political leadership is required to overcome public sector challenges and engage support in organisational change (Hartley, 2010). This view relates to notions of shared and distributed leadership discussed in the following section.

Researchers have also become interested in followers' perceptions of leadership (Chong and Wolf, 2010; Jackson and Parry, 2008). For example, Meindl *et al.* (1985) refer to the Romance of Leadership. In this approach, leadership is understood from a social constructivist perspective and is defined as 'an experience undergone by followers'

(Meindl, 1993, p.97). Therefore, individuals are actively involved in constructing leadership rather than leadership being simply what a leader does (Schyns *et al.*, 2007; Schyns and Schilling, 2011). It is proposed that followers socially construct the leadership process by engaging in a 'romance with leaders', a strong (and often mistaken) belief by followers in leaders' abilities to influence or control organisational outcomes (Meindl *et al.*, 1985; Meindl, 1995; Pye, 2005). As a follower-centred approach, the *Romance of Leadership* has been criticised for neglecting the role of the leader in the process and for not recognising the effect of leadership on performance (Day and Lord, 1988). Others have argued that the conceptualisation is too narrow as it does not take into account the different styles of leadership or the situation in which followers' act which can bring about different social constructions (e.g. Giessner *et al.*, 2009; Schyns, 2007; Tourish and Barge, 2010). In a response to this critique, Meindl (1998b) stresses that this approach focuses on processes not directly connected to actual leader behaviour and characteristics. He underlines that *Romance of Leadership* is simply an alternative way of looking at leadership (cited in Schyns *et al.*, 2007).

To address these criticisms, contemporary research has moved towards notions of co-constructed leadership where both leaders and followers contribute to its formation, nature and consequences (DeRue and Ashford, 2010; Grint, 2000; Shamir 2007). Researchers have begun to explore the interrelationships and dynamics of individual and social processes (Lord and Brown, 2001, Giessner *et al.* 2009; Haslam and Platow, 2001; Hogg, 2001). Leadership takes place within the context of a shared group membership, where leaders, as group members, ask followers, as group members, to apply themselves on behalf of the collective (van Knippenberg and Hogg, 2003). Thus, follower evaluations and endorsement of a leader also depend on characteristics of the leader as a group member (Chong and Wolfe, 2010; Haslam and Platow, 2001, Hogg, 2001, Reicher, Haslam and Hopkins, 2005). Similarly, followers' attitudes and characteristics will shape the group's identity and will moderate the leaders influence (Kellerman, 2008; Schyns and Shilling, 2011; Shamir 2007).

This links to leader-member exchange (LMX) theory which focuses on the quality of the dyadic exchange that develops between leaders and followers (Graen and Uhl-Bien, 1995). Research has shown that strong inter-personal relationships between leaders and followers

are associated with positive work-related outcomes, such as follower satisfaction, commitment, performance and retention (Gerstner and Day, 1997; Loi *et al.*, 2009) as well as citizenship behaviour (Ilies, Nahrgang and Morgeson, 2007). Although one focus is on the reciprocal exchange between a leader and a follower, the theory also acknowledges that both parties contribute to the development and maintenance of the ongoing relationship quality (Schyns and Day, 2010). Much of the research focus has concentrated on antecedents and outcomes of LMX at the individual or dyadic level, but recently has advanced to the team level (Graen, Hui and Taylor, 2006; Naidoo, Scherbaum, and Goldstein, 2008). However, the socially constructed nature of the world means that there are possible differences between leader and member perspectives on the same relationship as well as lack of consensus among followers of the same leader regarding their LMX with this leader (Schyns and Day, 2010).

One further influential approach to understanding the influence of shared group membership on perceptions, evaluations, and behaviour is the social identity approach (Tajfel and Turner, 1986; Turner *et al.*, 1987). The key assumption of this approach is that individuals define themselves not only on the basis of their individual characteristics and their interpersonal relations (i.e., personal identity or personal self), but also in terms of characteristics of an 'in-group' to which they belong (i.e., social identity or collective self) in comparison to an 'out-group'. Hence, group membership can shape people's cognitions, feelings, and behaviour. Recently, the social identity approach has been used to explain leadership processes (DeRue and Ashford, 2010; Haslam *et al.*, 2001; Hogg, 2001; Hogg and van Knippenberg, 2003; Lord and Brown, 2001; Platow *et al.*, 2003; Reicher, Haslam and Hopkins, 2005). It is proposed that followers construct leaders based on their ability to represent or 'prototypicalise' the groups' similarities and differences with others in respect of beliefs, values, attitudes and behaviours (Giessner *et al.* 2009; Hogg, 2001; van Knippenberg and Hogg, 2003).

Leaders that are perceived to be more group prototypical are perceived to be more effective and receive stronger leadership endorsement (Giessner *et al.*, 2009; Hogg and van Knippenberg, 2003). Furthermore, Haslam *et al.* (2001) have revealed that social identity theory has relevance for the 'romance of leadership'. In their experimental study they found that leaders who demonstrate behaviours that were in line with the norms and values

of the group received less negative attributions after an organisational crisis than leaders whose behaviour differed from the group's values and norms. Thus, followers' negative attribution of organisational failure was moderated by the degree to which leaders showed identity-affirming behaviour.

A key theme within this literature relates to the dynamic co-construction of leadership identity at three levels: individual, relational and organisational (Brewer and Gardiner, 1996; Lord and Brown, 2001; Carroll and Levy, 2010). At an individual level, individuals come to incorporate the identity of a leader or follower as part of their self-concept (DeRue and Ashford, 2010). In other words, they must believe that they are leaders (or followers) and demonstrate the appropriate skills and attributes (e.g. 'I am a leader because I engage followers in the organisation's vision'). Relational or interpersonal identities are based on relationships between the individual and important others (Brewer and Gardiner, 1996; Lord and Brown, 2001). Leadership identity is thought to be stronger when it is relationally recognised by important others through the adoption of reciprocal role identities as leader and follower (DeRue and Ashford, 2010). Leadership occurs through the positive relationships forged with followers in the organisation (e.g. followers believe in an individual's identity as leader and work to support them) (Cunliffe and Eriksen, 2011).

Finally, collective identity refers to an individual's membership of an organisations or important group. At this level, an individual's focus is on working for the collective good and they will be collectively endorsed as part of a social group – for example leaders or followers (Brewer and Gardiner, 1996; Lord and Brown, 2001). It is argued that the more an individual is collectively endorsed as part of the group 'leaders' or the group 'followers', the more those related identities will be reinforced and the stronger and more stable that particular identity construction will be (DeRue and Ashford, 2010). Collective endorsement might come from other individuals (e.g., an upper-level manager addressing one member of the group as the leader) or the social context more broadly (such as credibility through hierarchical authority or autonomy).

Lord and Hall (2005) have suggested that as leaders develop their identities widen in focus from individual to include relational and then collective levels. Thus, leader identity is

thought to change in terms of its underlying level of inclusiveness, ranging from least inclusive (individual) to most inclusive (collective) as a function of the developmental process. They suggest that shifts in level of identities occur in parallel with the development of leadership knowledge structures and social processes. Yet, Carroll and Levy (2010) caution that developing leadership means engaging with the complex and shifting processes of identity construction and reconstruction, identity changes over time in relation to contextual factors.

### ***2.3.3: Critical Theory***

Strongly linked to followership theory, a third paradigm of *critical leadership theory* has emerged. This has sought to reveal and evaluate the micro-political agendas and hegemonic influence of leaders and conventional organisational studies (Alvesson and Sveningsson, 2008). Conventional theory is predicated on the arguably questionable assumptions that top-level leaders are, and should be, in control, and have significant claims to expertise or rights to lead, while followers are there to be influenced, motivated or engaged and essentially obligated to follow if the conditions are right (see Khurana, 2007). These critical views have important roots in follower-centric theories and have advanced the case of (i) co-leadership or shared leadership (Heenan and Bennis, 1999), which emphasises sharing of the leadership function, or collaborating among the leader, and, more recently, (ii) distributed leadership which promotes leadership as occurring different levels within the organisational through the establishment of team structures and employee empowerment (Gronn, 2000; 2002; Spillane *et al.* 2001). These perspectives argue that instead of focusing on the personal qualities of leaders, researchers need to focus on the leadership challenges faced by communities, societies and organisations in a more collective way (Boydell *et al.* 2004; Grint, 2005b; Yukl 1999). Thus, the development focus within this perspective is on establishing shared theories of leadership and on developing leadership rather than leaders (Day, 2000; Iles and Preece, 2006).

Shared leadership has been studied in various guises, for example researchers have studied the role of individual and team self-leadership in improving work attitudes and performance (Stewart, Courtright and, Manz, 2011). Others have compared the effectiveness of leaderless workgroups or self-managed teams with that of vertically led



teams (Banker *et al* 1996; Cohen and Ledford, 1994; Pearce and Sims 2002). Doos and Wilhemson (2003) studied shared leadership in four Swedish organisations: the national football team, a product development company, a management consulting firm and a communications company. In their analysis, leadership was seen in terms of ‘co-leadership’, as a specific form of shared leadership where the two leaders worked side by side, not in tandem with each other, with each exercising equal responsibility and influence. This process was seen as contributing to sustainability and enhanced competence, and the authors highlight that ‘learning, grounded in interaction and communication’ (p. 1) is key to its success, with the actors as active constructors of knowledge. We can therefore conceptualise leaders as members of a community of practice (Drath and Palus, 1994; Gronn, 2009; Iles and Preece, 2006; Wenger, 1998). Both shared and distributed leadership is characterised by interdependence and the complementary overlapping of responsibilities and coordination, and the management of interdependencies (Gronn, 2008; Iles and Preece, 2006).

A key driver of distributed leadership is the nature of problems faced by post-Fordist organisations. These are claimed to be ‘wicked’ rather than ‘tame’ in nature (Grint, 2008; Heifetz, 1994; van Bueren *et al.*, 2003). Wicked problems have a number of characteristics, but, unlike tame ones, have no single or obvious solutions. On the contrary, they are typically complicated and complex and cannot be solved through the application of technical knowledge rather they must be resolved through discussion and reflecting on the pros and cons of alternative solutions (Beinecke, 2009; Grint 2008). Such resolution is typically accomplished by distributing ownership for such problems to those people in an organisation who are more knowledgeable about the issues involved rather than assuming senior figureheads at the apex of organisations have the necessary expertise (Currie *et al.*, 2009). Although wicked problems are a feature of most modern organisations, they are particularly evident among professional bureaucracies in the public sector operating in complicated stakeholder environments (Grint, 2008; Martin *et al.*, 2010). They are also typically found in organisations in the creative and knowledge-intensive industries, which operate in dynamic market environments (Teece, 2007).

The need to deal with wicked problems has also led to some authors proposing a network approach to leadership that compels leaders to actively manage network relations that

connect people within and between organisations (Balkundi and Kilduff, 2005; Carson *et al.* 2007; van Bueren *et al.*, 2003). Some authors relate this to ‘the heroic individual who instigates change and generate followers’ commitment to change initiatives by fostering social capital through relationships, networks, trust and co-operation (Carmeli *et al.*, 2009; Ferlie and Pettigrew, 1996; Sheaff *et al.*, 2004). However, others propose that leveraging social capital through internal networks can promote collective ‘innovative’ leadership across the team (Basadur, 2004; Day, 2000; Brookes and Grint, 2010). External relationships are also important to leadership, it is important to note that stakeholders not only interact with the organisation, but also with each other (Rowley, 1997). Hence, network theory stresses the need for managers to understand the relationships between individual stakeholders and to recognise that the organisation has direct and indirect stakeholders (Lawton, 1999; McVea and Freeman, 2005).

Enthusiasm for distributed leadership as a kind of post-heroic alternative has translated into an accumulating body of literature which encompasses conceptual discussions, empirical investigations and a handful of studies that measure the impact of distributed leadership (Gronn, 2002; 2009). It has been studied in a variety of contexts for example: school education (Currie *et al.*, 2009; Spillane, 2006), further education (Collinson and Collinson, 2009), higher education (Bolden *et al.*, 2008), police service (Gordon, 2010), health care (Buchanan *et al.*, 2007) and business (Heenan and Bennis, 1999). Several authors advocate the use of distributed or collective leadership within the public sector as a means of building organisational capability, encouraging learning and developing better ways of working (Buchanan *et al.*, 2007; Grint, 2005b; Lawler, 2008). However, others caution that distributed leadership cannot be divorced from its institutional context; its effectiveness can be hindered by pre-existing power relations and expectations of individual accountability (Currie *et al.*, 2009; Gordon, 2010; Grint 2009). Moreover, based on a discursive study looking at distributed leadership within an NHS context, Martin and Learmonth (2012) argue that the discourse of leadership masks a process of subjectivisation that persuades individuals to think of themselves as leaders but in reality aligns their sense-of-self with the objectives of the organisation (i.e. regulating their identity). Thus, given the realities of organisational life for those within ‘distributed’ roles the authors suggest that over time leadership may lose its positive associations.

In his more recent work Gronn (2008; 2009) has moved away from the aggregated sharing of influence in organisations to a mixed or hybrid approach whereby a hypothetical pattern of leadership in an organisation may comprise some teams, networks and a series of individuals whose influence stems from their presumed charismatic inspiration – that is, leadership is required at different levels within the organisation. This is supported by Stewart *et al.* (2011) who conclude that self-leadership should not be considered as a complete substitute for external leadership as teams ultimately require guidance and support from individual leaders. Equally, Shamir (2007) argues that leadership is not a function that can be wholly shared or substituted for but rather a social relationship which is characterised by disproportionate influence. In other words, leadership can only occur when there are both leaders and followers.

Social network theory also highlights that wider networks can also impact leadership effectiveness and organisational performance (Balkundi and Kilduff, 2005). Rowley (1997) contends that managers should pay attention to the density of their network and centrality of their organisation within their network. Network density is a term used to denote the environment's interconnectedness - a higher network density results in more-efficient communication across the network and the production of shared behavioural expectations. Network centrality refers to an individual actor's power in a network deriving from their position relative to others. The greater the centrality of an organisation, the more the organisation will be able to resist stakeholder pressures. It is proposed that a leader must strategically identify and engage with stakeholders in such a way to promote a high centrality of the organisation within an optimally dense network (Balkundi and Kilduff, 2005). Networks provide the means by which leaders can discover new opportunities and access skills, knowledge, and resources (Batrol and Zhang, 2007; Inkpen and Tseng, 2005). Thus, investing in social capital networking activities is particularly important for public sector organisations, which have limited resources and place importance on co-operation and collaboration with other organisations to create 'public value' (Goss and Tarplett, 2010; Moore, 1995).

#### **2.3.4: Higher Purpose / Post-transformational Paradigm**

Responding to the high-profile corporate governance scandals at the beginning of the 21<sup>st</sup> century and the more recent global financial service crisis, a fourth, *post-charismatic* and *post-transformational paradigm* is emerging (Parry and Bryman, 2006; Grint. 2009, 2011). It is argued that traditional theories of leadership promote unhealthy power relationships and lead to corruption (Hardy and Clegg, 1996). Consequently, leadership critics have returned their attention to re-constructing leaders and leadership with a moral purpose and a (re)turn to higher values (Khurana, 2007; Grint 2011), originally promised by transformational leadership theory in its early days but rarely delivered by the policy and practice it spawned (Currie and Lockett, 2007). These new attempts have sometimes invoked spirituality (Dent *et al.*, 2005; Tourish and Pinnington, 2002) and ethics (Brown and Trevino, 2006; Ciulla and Forsyth, 2011) to deal with the dark side of leaders and charisma (Kets de Vries, 2006; Judge *et al.*, 2009), and to advocate a post-transformational leadership.

The dangers of narcissism and the associated misuse, and even abuse, of power were recognised even at the height of the period when charismatic and transformational leadership were being celebrated (e.g. Conger and Kanungo, 1998; Howel and Avolio, 1992; Maccoby, 2000; Sankowsky, 1995). However, it has only been in the last ten years that a more developed argument has been established. For example, following a study of CEO successions in the US, Khurana (2002) found that the widespread faith in power of charismatic leaders had resulted in a number of problems. There was an exaggerated belief in the impact of CEOs on companies because recruiters were pursuing the chimera of a special type of individual. There was also a further tendency for companies to neglect suitable candidates while entertaining unsuitable ones. In addition, appointed charismatic leaders were found to be problematic as they ‘can destabilise organisations in dangerous ways’ (*ibid*: 4) by deliberately fracturing their organisations to effect change. Similar themes have emerged in investigations of the causes of the global financial crisis (e.g. Stiglitz, 2010). Consequently, commentators have presented alternative leadership theories that stress the need for leaders to balance influence with humility and create a learning culture throughout the organisation (Collins, 2005; Fullan, 2001; Western, 2008).

Key characteristics of these developments to rejuvenate leaders and leadership are: (a) a need for senior figures in organisations to embrace humility, (b) to learn from experience, and (c) to acknowledge their mistakes and limitations in dealing with complicated and complex wicked problems (Grint, 2005a,b; Heifetz, 1994). They typically also involve the need for leaders to be authentic (Yammarino *et al.*, 2008), requiring them to focus on universal values and developing trust, integrity and transparency in organisations, leader self-awareness, self-regulation and readiness to publically admit to mistakes, transforming followers into leaders, and generally bringing out the best (rather than the worst) in people (Avolio and Gardner, 2005; Tourish and Pinnington, 2002). Various metaphors have emerged within the literature to assist in the sense-making of this new ‘moral’ leadership (Parry, 2008). For example, Hatch *et al.* (2006) have proposed that there are three faces of leadership – manager, artist, and priest. Leadership is simultaneously rational, disciplined, organising and strategic; curious, imagining, emotive and artistic; and empathetic, inspiring, comforting and transcendent.

Several theories within the higher purpose paradigm, like those discussed above, place emphasis on the leader. However, others acknowledge the importance of the social context, observing that followers and other stakeholders should not be passive observers, but have a positive and active role to play in identifying and ending unethical practices (By *et al.*, 2012; Tourish and Pinnington, 2002). A key argument within this school is that leadership should be considered an art rather than a science as it provides an alternative way to both understand and respond to complex situations (Grint 2001; 2005a; Ladkin and Taylor, 2010). By taking a step back to reflect on the environment, think outside the box and accept contradictions it is proposed that leaders can engage followers and overcome ambiguity (*ibid*). Interestingly, in his critique of leadership, Western (2008) discusses the emerging paradigm of eco-leadership based on ecological theory, this perspective views the organisation as a social system comprised of various inter-dependent parts which make up the whole. Leadership is not the territory of a particular position rather it emerges within the system and for sustainability to be achieved leaders must understand how the solutions in one area of business may create problems in another (*ibid*). Eco-leadership is underpinned by an ethical and socially responsible stance that asks leaders to consider the wider environment in decision making and acknowledges the influential role of elements beyond the organisation’s control (Wielkiewicz and Stelzner, 2005). Thus, although the

arts and ecological perspectives stem from disparate domains they both emphasise the need to consider the inconsistencies and complexities inherent within the wider environment.

### ***2.3.5: Cultural Theories***

As highlighted in the previous section, leadership does not occur in a vacuum rather it emerges in the context of social structures and processes (Porter and McLaughlin, 2006). Consequently, there are extensive literatures exploring the importance of international cultural differences, industrial sector differences, organisational structural differences and other contextual variables (Storey, 2004). The role of organisational context on leadership behaviours and outcomes is often taken to be one aspect of cultural influence (e.g. Jackson and Parry, 2008); however both are discussed separately within this review as a key objective of the current research is to understand the contextual influences at the level of the organisation.

Developments in globalisation and the rise of international management have led several authors to explore the influence of national culture on leadership styles and outcomes (Martin and Hetrick, 2009; Storey, 2004). The authority in national culture and leadership is Hofstede (1998; 2001) whose work on the collective programming of the mind by different dimensions of national culture has spawned an industry of replicators and critics. His cultural characteristics of individualism vs. collectivism, power distance, uncertainty avoidance, masculinity vs. femininity and time orientation (short vs. long-term) have been used to describe prototypical organisational structures in nation states and the type of leadership expected within them. However, this work has been criticised for its poor methodology and its focus on nation states as cultural constructs (Ailon, 2008). For example Osland and Bird (2000) have argued that Hofstede's framework can be described as sophisticated stereotyping as it is based on theoretical concepts and encourages us, among other things, to commit the 'fundamental attributional error' of attributing our behaviour to situational variables but others' behaviour to their (national) character (Kanter and Corn, 1994; Martinko *et al.*, 2007).

Building on these shortcomings, the GLOBE (Global Leadership and Organisational behaviour Effectiveness) project has attempted to identify prototypical attitudes, values,

personality characteristics and behaviours of outstanding leaders by followers specific to national cultures (Brodbeck *et al.*, 2000; Chhokar *et al.*, 2007). In essence these are implicit theories of leadership (Schyns and Meindl, 2005) held by followers in different countries. Uncovering these implicit theories across national cultures has formed the basis of a large multi-phase, multi-method research programme to test the universality of transformational leadership models among middle managers in sixty-two cultures (House *et al.*, 2004). Although they found some variations in implicit theories of effective and ineffective leader behaviours across cultures - middle managers in cultures differed in their implicit theories of leadership were in expectations of autonomy (independence from superiors) and self-protection (status consciousness, self-centredness and narcissism) - there were commonly held perceptions in nearly all studies that team working, communication of a vision and values, and confidence and respect for staff were the hallmarks of effective leaders. Like Hofstede's (2001) work which preceded it, the GLOBE studies have engendered criticism and replication (Peterson and Castro, 2006), but represent an important step forward in highlighting universalist values in leadership theory and in proving partial support for transformational theory. However, other research still signals that national culture shapes the emergence of transformational leadership (Walter and Bruch, 2009), thus indicating that there remains debate on this important line of research.

In addition to national context differences, other studies have emphasised the importance of industry sector as a factor influencing receptivity to types of leadership. For example the leading authors in transformational and charismatic leadership (Antonakis *et al.*, 2003; Bass, 1990; 1999) have noted that the sector contributes to the way these roles are performed, how effective they are and how they are perceived. There are numerous other studies which explore the idiosyncrasies of leadership in different sectors such as education (e.g. Blandford and Squire, 2000) and health care (e.g. Edmonstone and Western, 2002). A key argument within this literature is that the sector context becomes of critical importance when implementing leadership development.

### 2.3.6: Organisational Context Theories.

#### 2.3.6a: The importance of organisational context

Research into the potential effects of both national culture and industry setting provide useful insights into the implicit theories and norms of leadership and how the environment can influence leadership practice and development. One further area of theorising relates to the role of the local *organisational context* in shaping leadership behaviour and outcomes (Antonakis *et al.*, 2003, Cardinal and Hatfield, 2001; Pawar and Eastman, 1997; Zaccaro *et al.*, 2004). The organisational milieu is considered to be particularly influential as it forms the immediate situation in which leaders and followers interact, thus has the potential to affect organisational outcomes such as innovation and effectiveness (Mumford *et al.*, 2002; Porter and McLaughlin, 2006). Moreover, social constructionist theory emphasises that leadership is not the property of an individual but rather is embedded in its context, thus a change in the context will change leaders, leadership, and leadership effectiveness (Osborn *et al.*, 2002; Tourish and Barge, 2010).

Contextual approaches have been important in leadership theory and practice for many years. Even the early leader-centric theories, for example Lewin's (1939) style theory, Fiedler's (1967) contingency theory and House and Mitchell's (1974) situational work took context into account when discussing the person-environment relationship. However, it was almost considered as an afterthought and it has only been in the last decade or so that researchers have adopted more sophisticated approaches to explore the role of context on individual and group behaviour (Liden and Antonkasis, 2009; Osborn *et al.*, 2002; Pawar and Eastman, 1997). Such context-based conceptualisations complement rather than substitute alternative leadership theories (Porter and McLaughlin, 2006). As such, Fry and Kriger (2009) propose a theory of leadership which emphasises *having* and *doing* – either having appropriate traits and competencies or doing appropriate actions depending on the situation. The organisational context encompasses both the physical and social environment within the organisation. In their review of leadership and organisational context literature Porter and McLaughlin (2006) identify seven important components of organisational context: (1) culture/climate; (2) goals/purposes; (3) people/composition; (4) processes; (5) state/condition; (6) structure [and design]; and (7) time. Each of these



components has have been studied in relation to leadership to varying degrees and the associated literature is now briefly discussed.

### *2.3.6b: Organisational culture*

Organisational culture is generally seen as a set of key values, assumptions, understandings, and norms that are shared by members of an organisation and taught to new members as correct (Daft, 2005). It has been suggested that the type of culture or climate prevalent within an organisation (e.g. bureaucratic, adaptive) and the behavioural norms and values of a given culture or climate (e.g. an emphasis on ethical behaviour) can affect both leadership style and leader-follower relationships (Bess and Goldman, 2001; Davis and Gardner, 2004; Ehrhart, 2004; Liden and Atonakis, 2009; Yiing *et al.*, 2009). Several authors have examined the receptivity of different cultures to transformational or charismatic leadership (e.g. Pawar and Eastman, 1997; Waldman and Yammarino, 1999). Shamir and Howell (1999) proposed that an adaptive or clan culture can lead to charismatic leadership. Likewise, Yagil (1998), in his empirical study of soldiers in the Israeli military, found that the effects of charismatic leadership, particularly at the dyadic level, were enhanced by an organisational culture that endorsed close social relationships. However, culture can also have a negative influence on leadership, for example it has been suggested that cultures characterised by high levels of stress affect the strategic decisions made by executives (Hambrick *et al.*, 2005)

Much of the work around organisational culture has focused on the notion of person-organisation fit, that is when leaders and followers engage in behaviours that correspond with the values espoused by their workgroups and organisations, they are viewed as more effective (O'Reilly *et al.*, 1991; Liden and Atonkin, 2009). Nonetheless, an alternative body of work contemplates the influence of leaders on organisational culture. Trice and Beyer (1991) described two types of leaders, those focused on changing an organisation's culture and those focused on maintaining it. They stressed that there is a need for both and that while their focus is different the underlying 'charismatic' behaviours remain the same. However, it is the former that appears to have received most of the attention with several articles examining the relationships between leadership, organisational culture and innovation or change (e.g. Howell and Avolio, 1993; Jung *et al.*, 2003; Morrison and

Phelps, 1999; Mumford *et al.*, 2002; Sarros *et al.*, 2008, Yiing *et al.*, 2009). In a study of 275 employees in different organisations, Morrison and Phelps (1999) found that an employee's willingness to lead, to 'take charge', was directly related to top management's openness to change and to an overall climate supportive of innovation and change.

### *2.3.6c: Goals and purposes*

As an organisational context component, goals and purposes have received only limited attention, with most of what there is appearing in the empirical rather than the conceptual literature (Porter and McLaughlin, 2006). Nonetheless, a small number of theorists have considered the effect of individual, group and organisational goals and strategies on leadership behaviour and outcomes (e.g. Currie and Locket, 2007; de Hoogh *et al.*, 2005; Pastor, Meindl and Mayo, 2002). In their discussion of different organisational context components which could affect the emergence and effectiveness of charismatic leadership, Shamir and Howell (1999) stressed the importance of performance goals, specifically whether they were clear or ambiguous. The authors suggested that ambiguous performance goals, particularly when combined with challenging tasks, contribute to both the emergence and the effectiveness of charismatic leadership. At an individual level, Colbert *et al.* (2008) asserted that it is important for members of the senior leadership team to hold congruent notions of goal importance. Maner and Mead (2010) reiterated this point when they highlighted the issues that arise when leaders act for their own interest rather than work the goals of the group. Conversely, others have explored how different leadership behaviours can facilitate the achievement of organisational goals (e.g. Colbert and Witt, 2009; Waldman and Yammarino, 1999). Yet, Hiller and colleagues (2011) caution that there are multiple goals and sub-goals within organisations and as such there is often some degree of goal conflict. Consequently, the relationship between leadership, goals and outcomes is complex. In addition, the effects of leaders and leadership are not always absolute; some effects of a given leadership style or leadership behaviours in a given situation may be positive and others may be negative - even at the same time. Moreover some tangible outcomes related to leadership may accrue quickly, while others may be more beneficially understood over months or years.

### 2.3.6d: *People and composition*

The people (composition) element relates to distributed leadership theory (discussed in section 2.2.4) and encompasses the demographic variability within the organisation and the capabilities of individuals and groups. Studies within this area often consider the role of gender dynamics (e.g. Cliff *et al.*, 2005; Reuvers *et al.*, 2008; Rowley *et al.*, 2010) or team heterogeneity in perceived leadership effectiveness (e.g. Hooijberg and DiTomaso, 1996; Scandura and Lankau, 1996). Some advocate diversity as a means of developing positive leader-follower relationships and encouraging innovation (Mumford *et al.*, 2002). Alternatively others suggest that too much diversity can lower leaders' perceptions of effectiveness (e.g. Mayo *et al.*, 1996).

### 2.3.6e: *Processes*

Organisational processes incorporate a wide range of contextual aspects such as the mode of governance, strategic policies (e.g. HRM strategies) and task factors (e.g. differentiation, complexity, ambiguity). Thus studies that concentrate on the link between leadership and organisational processes either focus on the connection between a specific process, such as governance on leadership approach (e.g. Avolio *et al.*, 2000; Whittington *et al.*, 2004), or explore the interrelationships between different processes, leadership and organisational outcomes (e.g. McClusky, 2002; Wallis and Gregory, 2009). For example, Pawar and Eastman (1997) argue that organisations with a clan mode of governance will be most receptive to transformational leadership. In the public and non-profit sectors theorists have noted that leaders' attempts at innovation and collaboration are often constrained by pre-existing governance structures (Currie *et al.*, 2009; 2010; McClusky, 2002; Wallis and Gregory, 2009)

### 2.3.6f: *State / Condition*

Porter and McLaughlin (2006) suggest that the state of the organisation will be determined by elements such as the availability of resources, the organisation's financial and reputational health and whether it is in a state of stability or crisis. The effects of state or condition as a contextual variable have so far been discussed and tested almost exclusively

at the top levels of organisations and have focused on large scale changes and crises involving top management teams, CEOs and Boards of Directors (*ibid*). A key theme of this literature is the relationship between leadership and organisational change and/or crisis. Some articles propose that more responsive and supportive leadership styles are appropriate to periods of change (Choi and Mai-Dalton, 1998; Hunt *et al.*, 1999). Denis *et al.* (2001) studied five health care organisations and determined that collective leadership is most likely to be exhibited and be effective in periods of substantive organisational change. Similarly, Alexander, Fennell and Halpern (1993) examined archival data on health care organisations and found, not surprisingly, that unstable and/or declining organisations were most likely to experience top management instability.

### 2.3.6g: Structure

An organisations structure encompasses various aspects including its size, shape, or type; its degree of formalisation and/or centralisation; hierarchical levels of positions; and spatial distances between leaders and followers. Thus, studies within this domain are wide-ranging; some consider the relationship between leadership style and type of organisations (Shamir and Howell, 1999), while others examine the effects of hierarchical level on implicit theories of leadership, followers' perceptions and leader behaviour (e.g. Hunt and Ropo, 1995; Mumford *et al.*, 2000; Walter and Bruch, 2009). For example Brown and Gioia's (2002) qualitative study of Fortune 500 Company launching a web-based business found that adopting distributive leadership principles help organisations to respond to the complexity, ambiguity, and need for rapid responses in dynamic business environments. A further theme within the literature considers the effects of physical distance between leaders and followers and of a leader's position within a network (Balkundi and Kilduff, 2005; Howell *et al.* 2005). For example, in a year-long study involving 317 participants, Howell and Hall-Merenda (1999) tested whether spatial distance moderates the relationship between the type of leadership and subordinate performance. They found that transformational leadership significantly improved subordinate performance when the leaders and followers were in close physical proximity.

### 2.3.6h: Design

Closely related to structure is organisational design. Mintzberg (1980) developed a typology of five basic organisational configurations including: Simple Structure, Machine Bureaucracy, Professional Bureaucracy, Divisionalised Form, and Adhocracy. The *Simple Structure* refers to organisations with a relatively flat structures consisting of one large unit with one or a few top managers. The organisation is relatively unstructured and informal compared with other types of organisation, and the lack of standardised systems allows the organisation to be flexible. The *Machine Bureaucracy* is defined its standardisation. Work is formalised, there are many routines and procedures, decision-making and power is centralised, and tasks are grouped by functional departments. Jobs will be clearly defined; there will be a formal planning process with budgets and audits; and procedures will regularly be analysed for efficiency. The *Professional Bureaucracy* is also very bureaucratic. The key difference between these and a machine bureaucracy is that they rely on highly trained professionals who demand control of their own work. So, while there's a high degree of specialisation, decision making is decentralised (*ibid*).

In the *Divisionalised Form*, a central headquarters supports a number of autonomous divisions that make their own decisions, and have their own unique structures key benefit of a divisional structure is that it allows line managers to maintain more control and accountability than in a machine structure. Also, with day-to-day decision-making decentralized, the central team can focus on overarching strategic plans. Finally, *Adhocracy* coordinates primarily by mutual adjustment among all of its parts, calling especially for the collaboration of its support staff; jobs are specialised, involving extensive training but little formalisation, units are small and combine functional and market bases in matrix structures, liaison devices are used extensively, and the structure is decentralised selectively in both the vertical and horizontal dimensions. These organisations are less impacted by bureaucracy and can succeed in complex, dynamic environments. However, there can be lots of conflict when authority and power are ambiguous (*ibid*).

These categories are not discrete forms as some organisations will inevitably be driven to hybrid structures as they react to contradictory pressures or while they effect a transition

from one configuration to another. Nonetheless, it is suggested that the design of the organisation will impact its receptiveness to different forms of leadership and the subsequent impacts of leadership (Currie *et al.*, 2009; Gordon, 2010; Sheaff *et al.*, 2003)

#### 2.3.6i: Time

The 'time' organisational context component refers to the durational aspects of leadership effects or effects that vary according to organisational life cycle stage, team developmental stage, or any other time dependent phenomenon. Thus literature in this area is concerned with whether or not leadership is constant over time and how leadership adapts to different life cycle stages. In their examination of collective leadership in organisations, Denis *et al.* (2001) found that change in organisations is cyclical and sequential and that leadership is not constant across time. Rather it is a dynamic phenomenon in which participants (i.e. those involved), their roles (i.e. individuals dynamically switch between follower and leader roles), and influences (i.e. the perceived team, organisational and societal impacts will vary) evolve over time. In other words, leadership group members may promote change through their actions, but where these actions simultaneously alter the future form and viability of the leadership group because their legitimacy is constantly being re-evaluated by powerful stakeholders (*ibid*). Similarly, others note that a leader's current behaviour and the associated outcomes will impact the leader's future choice and behaviour (Hunt and Ropo, 1995; Finkelstein *et al.*, 2009). In terms of life-cycle effects, it has been suggested that charismatic or transformational leadership is most likely to be present early in an organisation's life cycle (Pawar and Eastman, 1997; Shamir and Howell, 1999). Moreover, examining executive turnover and succession, Finkelstein *et al.* (2009) note that new leaders cannot directly create organizational performance, but must influence performance through the changes they initiate and the actions they take.

#### 2.3.6j: Leaders as organisational architects

Early work on context tended to adopt a somewhat mechanistic approach, characterised by the simplistic assumption that different types of contexts could be matched with appropriate types of leadership (Osborn *et al.*, 2002; Storey, 2004). However, contemporary approaches are more open to the notion that context is socially constructed;

and is to some extent multi-layered, co-created, contestable, and locally achieved (Fairhurst, 2009; Grint, 2000, 2005). Thus, while the focus of the current research is to examine contextual influences on leadership it should be noted that leaders (and followers) can play a key role in determining the organisational environment (Munshi *et al.*, 2005; Tsui *et al.*, 2006). Several authors have sought to explore the ability of senior leaders to influence different aspects of organisational context such as governance, strategy, culture and structure (Munshi, *et al.*, 2005; Tsui *et al.*, 2006; Yukl, 2008). Similarly, others have drawn on ‘upper echelon’ theory to revisit the role played by top executives and senior leaders, in relation to context, on organisational effectiveness (Hambrick, 2007; Patzelt, *et al.*, 2008).

It is proposed that senior leaders’ experiences, values and personalities influence their interpretations of the situations they face and, in turn, affect their choices (Hambrick, 2007). This relates to the social network approach to leadership (see section 3.1.4) which draws attention to the fundamental importance of cognitive structures, such as schemas, in shaping a leader’s network relationships and explores how network relationships, through social capital, affect leadership effectiveness both within and across organisations (Balkundi and Kilduff, 2005). The extent to which leader characteristics are reflected in organisational outcomes and performance is moderated by the degree of managerial discretion and job demands placed on executives (Hambrick, 2007). Moreover, in a recent study of 50 leader-follower groups, Cole *et al.* (2009) considered how hierarchical leader-distance moderates the effects of transformational leadership and individual-leader outcomes. They found that high social distance reduced or neutralised transformational leadership association with followers’ emulation of leader behaviour. However, in contrast, high levels of social distance between leaders and followers enhanced the effects of transformational leadership on individuals’ perceptions of their units’ positive emotional climate and individuals’ sense of collective efficacy (*ibid*).

Taken together this literature highlights the importance for leaders to understand and manage stakeholder perceptions as the organisational environment is co-created and influences leadership effectiveness (Hambrick, 2007; Storey, 2004; Yukl, 2008). In his review of strategic leadership, Storey (2005) argues that, at the senior executive level, leadership research needs to address three interrelated issues. The first is concerned with

the link with corporate governance and is termed *structural/relational*. Leadership teams can influence governance, but are also constituted by these governance arrangements, which, from time to time, are also shaped by governments and institutional investors' interventions. The second set of issues concern the functional priorities and challenges which face leaders of whole organisations. Generally, strategic leaders are expected to pursue wealth creation through innovation and creativity, and wealth protection through appropriate risk management (Martin and McGoldrick, 2009). Such a function requires senior leadership teams to be active in identifying a central purpose and clarity on values for their organisations, which relate to the third set of issues surrounding the legitimacy function of top teams. Legitimacy here refers to how senior (public) leaders build authority for themselves and their organisations; it also refers to how they use this legitimacy to build *reputational capital* - especially among clients, funders, analysts, and the media - to influence perceptions of public value (Moore, 1995; Storey, 2005).

### ***2.3.7: Taking Stock: Socially Constructed Leadership***

The purpose of bringing these six overlapping but still separate bodies of knowledge together was to clarify the frameworks underpinning contemporary leadership development and situate this study within existing leadership theory. This study is interested in how participants of a leadership development programme account for the impact on their human capital (their personal leadership knowledge and skills) and social capital (relationships, networks, and knowledge exchange opportunities) and the role of organisational context on these accounts. It links to the growing body of social constructionist literature, alluded to throughout the review, which positions leadership as a co-constructed reality. This perspective draws on social constructionist theory which argues that people construct their social and cultural worlds and at the same time these worlds construct them (Berger and Luckmann, 1966; Burr, 2003; Crotty, 1998 Gioia, 2003; Hacking, 1999). Realities are subjective and evolve over time through interactions between and among social agents (Gioia, 2003; Hacking, 1999).

Social constructionist approaches to leadership commonly exhibit two interrelated characteristics. First, they criticise leader-centric approaches in which the leader's personality, style, and/or behaviour are the primary factors shaping follower's thoughts and



actions (Fairhurst and Grant 2010; Tourish and Barge, 2010). Most constructionist leadership approaches highlight the ability of followers to ‘make sense of and evaluate their organisational experiences’ (Meindl, 1995, p. 332). Second, emphasis is given to leadership as a co-constructed reality, in particular, the processes and outcomes of interaction between and among social actors (Fairhurst, 2009; Grint, 2010; Shamir, 2007). It emphasises that leadership is a complex process that cannot be explained by a single account thus researchers should explore what key events means to the people involved and acknowledge contested social constructions (Tourish and Barge, 2010). A key theme within the literature relates to the dynamic co-construction of leadership identity at an individual, relational and collective level (see section 2.2.2). Moreover, it highlights that the situation or context in which leadership occurs is also subjective and co-constructed by leaders and followers (see section 2.2.6j).

Grint and Jackson (2010) and others argue that there is a need for leadership theory to become more integrated with practice. Others within the constructionist paradigm have taken a more critical stance contending that basic premise of leadership is flawed and require radical transformation (Martin and Learmonth, 2012). For example, some, like Hardy and Clegg (1996), cast leadership as a mechanism of domination that can legitimise corruption. This has led theorists to explore alternative ‘collective’ and ‘ethical’ approaches to leadership (see section 2.1.5 and 2.1.6). Both the general and critical styles of constructionist theory are worthy of note as they have the potential to influence approaches to and perceptions of development. Thus, building on this review of the leadership literature, chapter 3 now considers the theory and practice of leadership development.

## Chapter 3: Leadership Development

### 3.1: An Overview

The previous chapter noted that new themes have emerged in the leadership literature. There are now a variety of approaches that go beyond the traditional leader-centred perspectives to emphasise the importance of the social context and followers in the co-construction of leadership. There have been shifts in understanding of what constitutes appropriate modes of leadership with authors advocating alternative schemas such as shared or distributed leadership. Moreover, doubts about the transformational and charismatic models of leadership have led to a call for leader integrity and more ‘ethical’ forms of leadership. These changes in focus raise questions for the set of competencies associated with leadership and how they should be developed. The following sections review the leadership development literature and examine the influence of different perspectives on theory and practice.

#### 3.1.1: A Global Industry – Why?

In the introduction it was observed that leadership development is a substantial global industry; with an estimated £34 billion spent<sup>1</sup> annually in the field throughout the world (Reade and Thomas, 2004). Yet, surprisingly little of the money invested has been spent on evaluating the impact that this investment has had on organisational performance (Audit Scotland, 2005; Burgoyne *et al.*, 2004; Dvir *et al.*, 2002). Much of the investment appears to be based on a leap of faith that leadership development improves organisational effectiveness. Storey (2004) has suggested four interrelated explanations for this faith. The conventional explanation associates the increased complexity and dynamic pace of contemporary society with a need for higher and more creative levels of leadership. The institutional explanation refers to the pressure that is placed on individuals and

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<sup>1</sup> Within the literature global estimates are often given in US dollars and range between US\$15 and US\$50 billion (Grint, 2007)

organisations to emulate others to maintain credibility or as pithily stated by Jackson and Parry (2008), ‘if everyone is doing leadership development, we better do it too’ (p.9). The sociological explanation emphasises the role that leadership can play in legitimising the authority, power and privileges of elites. It provides a socially acceptable means of justifying the status quo. Finally, the strategic advantage explanation argues that leadership is an intangible asset that must be cultivated in order to gain a rare and invaluable source of competitive advantage (Storey, 2004).

### ***3.1.2: The State of the Field***

Over a decade ago, in his seminal review of the leadership development literature, Day (2000) concluded that interest in the field ‘appears to be at its zenith’ (p.581) especially among those with more applied interests (e.g. HR practitioners, consultants); however he found less scholarly interest in the topic, citing a lack of published research in the field. This and other critiques led to a call for more a systematic and evidenced-based approach to research in the field (Day and Zaccaro, 2004; Rousseau *et al.*, 2008). In the last ten years the argument that: ‘leaders who keep learning may be the ultimate source of sustainable competitive advantage’ (Fulmer *et al.*, 2000:49) has filtered through into the academic domain resulting in a substantial body of theoretical, conceptual and, to a lesser extent, empirical literature focusing on the methods used for developing leaders and leadership (Alimo -Metcalf and Lawler, 2001; Day *et al.*, 2004; Dvir *et al.*, 2002; Iles and Preece, 2006; Lord and Hall, 2006; McAlearney *et al.*, 2006; Wright *et al.*, 2001a). Leadership development is also a strong part of government agenda for the delivery of public services. Consequently, several specialised leadership research centres have been established and various White Papers, reviews and discussion papers have been published on the importance of leadership to public services (e.g. PIU, 2001; OPM, 2003; Hartley and Hinksman, 2003).

Even with the recent growth in academic attention and the sustained investment in leadership development in both the private and public sector there remains debate in the field as to how leaders are developed, the relationship between leaders and leadership and the effects of development (Day, 2011; Grint, 2010; Lord and Shondrick, 2011). Moreover, recent global survey data for the 2008/9 DDI Global Leadership Forecast

(Howard and Wellins, 2008), suggested that leaders are increasingly dissatisfied with their organisation's development offerings and that perceptions of programme quality have declined. This together with the revelation that confidence in leaders has steadily declined in the last eight years led the authors to pessimistically state that despite its perceived criticality to long-term organisation sustainability, 'leadership development is going nowhere fast' (*ibid*, p.4). The survey respondents' critical assessment may be in part due to, as Day (2011) suggests, a rise in expectations as development initiatives have become more widely used. However, it may also be that leadership development is a complex social process rather than an individual event and that 'learning' leadership requires more than studying a body of theoretical knowledge or captured by replicable skills (Doh, 2003; Grint, 2007; Lave and Wenger, 1991). This perspective highlights the importance of the practical wisdom that leaders gain through on-the-job learning (Day, 2011; Grint, 2007; Kodish, 2006; McCauley, 2006).

Section 2.2 highlighted that leadership theory is continually evolving and there are now many different leadership paradigms and frameworks to choose from. The transformational leadership model (e.g. Avolio, 1999; Kelloway and Barling, 2000; Alimo-Metcalfe and Alban-Metcalfe, 2005) and the charismatic model (e.g. Conger and Kanungo, 1988) remain popular within leadership development. Nevertheless, development studies are gradually considering alternative perspectives such as co-constructed realities and the influence of development on followers (e.g. Dvir *et al.*, 2002); shared (team) leadership (e.g. Carson *et al.*, 2007), and multiple levels of leadership identity (e.g. Day *et al.*, 2009; DeRue and Wellman, 2009; Lord and Hall, 2005). It is anticipated that the (implicit) leadership perspective adopted within an organisation will impact its approach to leadership development (Hartley and Hinksman, 2003). However, questions remain with regard to how contemporary leadership development is informed by the plethora of leadership theories available. The current review explores the key theoretical debates in the field before considering the practice of leadership development and evaluation.

## 3.2: Key Theoretical Perspectives

### 3.2.1: *Leader vs. Leadership Development*

The leader-centric/follower centric debate, discussed in section 2.3.1 and 2.3.2, has led to a fundamental distinction being made in the literature between leader development and leadership development, the former focuses on the development of individuals (leaders) while the latter aims to build supporting social structures and processes (Day, 2000, 2011; Hartley and Allison, 2000; Iles and Preece, 2006). Despite this distinction leader development and leadership development are often treated as synonymous (Alimo-Metcalfe and Lawler, 2001; Day 2000; 2011; Iles and Preece, 2006; Shamir 2007). Day (2011) explains that often what researchers, theorists, and practitioners call leadership development focuses on developing individual leaders, thus he suggests might more accurately be called leader development. Most development programs and practices ignore the social context (including the roles that followers play in the leadership process) in which leadership occurs. Instead, the focus of most programs is typically on helping individual leaders acquire or enhance knowledge, skills, and abilities in ways that are expected to improve their overall ability to lead (*ibid*). In other words, the aim is to develop individuals' human capital. However, as was mentioned earlier, leadership emerges through social interaction and is dependent on the pattern and quality of networked relationships (social capital) in an organisation (Balkundi and Kilduff, 2005; Day, 2000; McCallum and O'Connell, 2009).

Although the conceptual distinction between leader development and leadership development is useful, effective leadership requires attention to both human capital (HC) and social capital (SC) (Day 2000; 2011). As an organisational concept, HC refers to the individual capabilities, knowledge, skills, attitudes and experience of an organisation's employees and managers, relevant to the task at hand (Carmeli, 2004; Dess and Picken, 1999; Subramaniam and Youndt, 2005). It incorporates elements such as creativity and entrepreneurial spirit as well as expertise and tacit knowledge (Bontis and Fit-enz, 2002; Roos *et al.*, 1997; Stewart, 1998). Alternatively, SC has been defined as the goodwill displayed by stakeholders towards an organisation and the trust they place in it through internal, *bonding* ties to produce a strong sense of corporate or group identity and external

*bridging social capital*, in which individuals and organisations benefit from wide and dense networks of relations with other individuals and external organisations (Adler and Kwon 2002; Burt, 2001; Payne *et al.*, 2011). SC is thought to promote organisational learning, innovation and improved performance behaviours (Kulvisaechna, 2006; Perry-Smith and Shalley, 2003; Wu, 2008). Moreover, it has been found to enhance both the personal and organisational impacts of human capital (Nahapiet and Ghoshal, 1998; Lay, 2006; Subramaniam and Youndt, 2005).

Developing HC without attention to SC ignores the fact that leadership is based on interactions among leaders, followers, and the social environment (Shamir 2007). Likewise, attempting to develop the relational aspects of leadership without preparing individuals with the necessary skills to communicate, influence, inspire, and otherwise effectively participate in leadership is impracticable (Grint, 2007; Popper and Mayseless, 2007). Consequently, it is recommended that organisations coordinate their leader development and leadership development initiatives, invest in follower development, and coordinate development with the wider organisational strategy and context (Shamir 2007). Leadership has been traditionally conceptualised as an individual-level skill and, as a result, much more is known about leader development than leadership development (Day, 2011).

Successful leader development is thought to develop individual self-management capabilities (such as: self-awareness and leadership values), social capabilities (e.g. the ability to build and maintain relationships and enhanced communication skills), and work facilitation capabilities, such as: management skills and the ability to initiate and implement change (Van Velsor and McCauley 2004: cited in Day, 2011). Such personal leader development is characterised by several features, including that it unfolds over time, is maximised by a variety of experiences that provide feedback, challenge and support; and it is also based on an individual's ability and willingness to learn from experience (*ibid*). The relationship between leader development and leadership development is less clear cut; however it is generally assumed that developing leaders at all levels within the organisation (distributed) is an effective means of transforming organisations (Day *et al.*, 2004; Hernez-Broome and Hughes, 2004). Several authors have explored the role of networks and social capital in facilitating such transformations, often advocating

development initiatives that leverage relationship building and knowledge exchange (McCallum and O'Connell, 2009). The social and relational aspects of leadership are also emphasised within theories that promote distributed and collective forms of leadership.

### ***3.2.2: Fostering Shared and Distributed Leadership***

Section 2.2.3 acknowledged the increasing recognition of the importance of distributed leadership (e.g. Bolden, 2011; Buchanan *et al.*, 2007; Currie *et al.*, 2009; Gronn, 2000; 2002; Thorpe *et al.*, 2011). At its most basic this approach attempts to create the conditions that enable shared and dispersed leadership which allow new innovations to emerge from all parts of the organisation. Leadership is not a position in the hierarchy but a process that occurs throughout the organisation and beyond (Gronn, 2002). Advocators of the concept argue that leadership development should be embedded in organisational culture and suggest that it may be in part most appropriately achieved through team-wide or organisation-wide initiatives, rather than individualistic programmes (Edwards, 2011; Hartley and Hinksman, 2003; Western, 2008). Nonetheless, Bolden (2011) suggests that distributed leadership poses some important challenges to traditional development processes and requires greater investment in the development of interpersonal networks and shared understandings both within and beyond organisations. It is proposed that more systemic approaches to leadership development that situate development activities within a wider change process are required (e.g. James *et al.*, 2007; Ross *et al.*, 2005a,b). Thus, authors have attempted to conceptualise how distributed leadership is developed, for example, Day *et al.*, (2004) present a model of developing team-based leadership capacity, understood as the amount of shared, distributed, and connected ways of working together to collectively address leadership challenges. They propose that team leadership is shaped by individual members' skills, the extent of team or collaborative working, and formal developmental interventions. This can be linked to the idea that human, social and organisational capital interact to produce intellectual capital (see section 3.4.4).

Carson *et al.* (2007) examined both internal and external antecedents to the emergence of leadership influence across team members (i.e. shared leadership). Interestingly, rather than asking team members or their manager about the level of shared leadership in the team (e.g. Hiller *et al.*, 2006; Pearce and Sims, 2002) they adopted a social network

approach involving a measure of density or the perceived amount of leadership as perceived by all other members. The study found that both the internal team environment, consisting of shared purpose, social support, and voice, and external coaching were important predictors of shared leadership emergence. In turn, shared leadership was found to predict team performance as rated by clients. Yet, Pearce and Sims (2002) found both vertical and shared leadership to be significantly related to team effectiveness. This links to Gronn's (2008; 2009) notion of 'hybrid configurations' which asserts that leadership is required at different levels (individual, team and network) within the organisation.

The notion of shared or distributed leadership is particularly important to this study as it sits comfortably with the recent campaign to engage clinicians within healthcare leadership (Currie and Lockett, 2011; Dickinson and Ham, 2008; Edmonstone and Western, 2002; The Kings Fund, 2011; Sheaf *et al.*, 2003). Moreover, it corresponds with the Berwick, Ham and Smith's (2003) recommendation that collaborative leadership is key within complex organisations like the NHS which are subject to a complex web of regulation, legislation, and codes of conduct: 'The complexity of the NHS will make it true that 'leadership' will have to be a system, involving the coordinated energies of a number of top level people who should act as a team – if not in unison, at least in coordination – to get aims accomplished' (p1422). This also relates to Gittel's (2009) theory of relational coordination which focuses is the 'coordination of work through relationships of shared goals, shared knowledge and mutual respect' (p13). This theory is built upon the proposition that when doctors, nurses, therapists, case managers, social workers, other clinical staff, and administrative staff are connected by shared goals, shared knowledge and mutual respect, their communication tends to be more frequent, timely, accurate, and focused on problem solving, enabling them to provide cost-effective, high quality patient care. However, it notes that it can take time to embed shared goals, shared knowledge and mutual respect across different professions.

More recently there has also been support for leadership across all levels of the organisation with the introduction of self-managed teams and policy advocating leadership as everyone's responsibility (Hewison and Griffiths, 2004). Despite this rhetoric, when the content of many clinical leadership and other leadership programmes are examined, the continued emphasis on individual competencies and abilities is regarded by some as being



in conflict or at least at odds with this ‘new’ leadership (Brookes and Grint, 2010; Thorpe *et al.*, 2011). A number of tensions underpin the development of distributed leadership in healthcare. For example, individuals and groups socially constructed their interests in accordance to their own professional logics which may be contradictory to those of senior leadership. In addition many professionals remain ambivalent about being incorporated into leadership (*ibid*). Thus, Hewison and Griffiths (2004) argue that NHS organisations must create conditions, which support and enhance new models of leadership to avoid staff frustration with the lack of progress and change. Others have emphasised the importance of collective sense-making (Weick, 1995) and the establishment of trust in developing effective distributed leadership (Louis *et al.*, 2009; Simkins, 2005). One further way that development has been considered is through the lens of social identity theory (Busher, 2005; Loder and Spillane 2005).

### ***3.2.3: Identity and Psychological Capital***

Theorists have recently begun to explore the role of self-perception and social identity construction in leadership development (Carroll and Levy, 2010; Day and Harrison, 2007; Petriglieri, 2011; Shamir and Eilam, 2005). One area of potential relevance to this discussion is psychological capital, encompassing: an individual’s self-efficacy (confidence), optimism, hope (goal-orientated nature) and resiliency (Luthans *et al.*, 2007.). Each of these four components has considerable theory and research. Snyder *et al.* (1991) defined hope as a ‘positive motivational state that is based on an interactively derived sense of successful (a) agency (goal directed energy) and (b) pathways (planning to meet goals)’ (quoted in Luthans *et al.*, 2007, p.545). In this way, as a psychological construct, hope consists of three major conceptual foundations: agency, pathways, and goals. The agency component of hope can be thought of as having the will to accomplish the intended or desired effect (Snyder, 2000). Those high in hope utilise contingency planning as they forecast obstacles to achieving goals or sub-goals and proactively identify multiple pathways to attain the targeted goal (*ibid*).

In positive psychology, resilience is characterised by positive coping and adaptation in the face of significant risk or adversity (Masten and Reed, 2002). Applied to the workplace, resilience refers to the positive psychological capacity to rebound and recover from

adversity, uncertainty, conflict, failure, or even positive change, progress and increased responsibility' (Luthans *et al.*, 2007). Like hope, optimism is commonly used in everyday language, but also like hope, in positive psychology it has a very specific meaning with theory and research addressing this positive construct. Drawing on attribution theory, Seligman (1998) defines optimists as those who make internal, stable, and global attributions regarding positive events (e.g., task accomplishment) and those who attribute external, unstable, and specific reasons for negative events (e.g., a missed deadline). Finally, discussing the importance of self-efficacy, Bandura (1998) notes that: 'evidence shows that human accomplishments and positive well-being require an optimistic sense of personal efficacy to override the numerous impediments to success' (quoted in Luthans *et al.*, 2007, p.546).

Organisational learning theory proposes that psychological capital is a key determinant of an individual's motivation to learn and this, in turn, is an important factor in training success (Combs *et al.*, 2009). The importance of self-efficacy has also been reiterated in the leadership literature with prior research suggesting that seeing oneself as a leader and having confidence in one's abilities not only enhances one's motivation to lead (Chan and Drasgow, 2001) and one's engagement in the leadership process (Kempster, 2006), but also promotes the seeking out of leadership responsibilities and opportunities to develop leadership skills (Day and Harrison, 2007; Day *et al.*, 2009). Moreover a recent study by Day and Sin (2011) found that leadership effectiveness (independently rated by team coach) was positively related to the self-rated strength of a leader's identity.

#### ***3.2.4: Leadership Development and Identity***

Within the organisational domain identity has been studied at various levels (e.g. organisational, professional, social and individual) and from three main theoretical approaches: social identity, identity work, and identity control (Alvesson, Ashcraft and Thomas, 2008). Social identity theory examines how people understand and position themselves and others in terms of social group categories, i.e. in-group vs. out-group (Tajfel and Turner, 1986). Group memberships can influence how we see ourselves and others, thus it is proposed that leaders are more effective in mobilising and influencing followers when they are seen as group prototypical (Hogg, 2001; van Knippenberg and

Hogg, 2003; van Knippenberg, 2011). The second approach, identity work refers to the processes of identity construction, revision and maintenance. It emphasises social and discursive contexts in which identities are formed and the dynamic nature and on-going struggles around creating a sense of self (Beech, 2008; Sveningsson and Alvesson, 2003). Finally, a key topic within the identity control literature is managerial interest in regulating employees through appeals to develop self-images and work orientations that are congruent with the organisation's strategy and values (Alvesson and Willmott, 2002).

Lord and Hall's (2005) model of leadership skill development (section 2.2.2) proposes that as a leader proactively acquires additional domain specific expertise their leadership identities shift from individual to relational and to collective levels. At each skill level, the emphasis is on qualitatively different knowledge and information processing capabilities. It is thought that expert leaders (with a collective leader identity) can develop unique skills by grounding their identities and leadership activities in coherent, self-relevant, authentic values. Building on this model, Day and Harrison (2007) postulate that as leaders move up an organisation's hierarchy, there is a need to move from an individual to relational and then collective identity. They advocate incorporating processes that involve participants in engaging across boundaries (functional, hierarchical, and geographical) as a way to develop collective leader identities and engage in leadership development. An implication of these approaches is that leader development is thought to occur over an extended period of time and the needs of leader development change in relation to the leaders experience and responsibilities.

The notion that leadership develops over time and possibly across an individual's lifespan has led several authors to suggest that leadership development should be understood within an adult development framework (Day *et al.*, 2009; Komives *et al.*, 2005; Mumford and Manley, 2003). Adult development theories assume that development is a qualitative, transformative, progressive and internally directed change that transforms an individual's structural characteristics and his or her patterns of interaction with the external environment, producing a shift in the meaning the individual given to events (Bartunek *et al.*, 1983; Moshman, 2003; Stevens-Long and Michaud, 2003). A central assumption of some adult development theories is that individuals are capable of understanding concepts and thoughts that are at their own level of development or below, but cannot comprehend

aspects that are considered at higher levels (Day and O'Connor, 2003). Thus, leader development becomes orientated at identifying which stage of an individual functions from, to provide a personalised pathway to the next level or stage (Carroll and Levy, 2010).

Social constructionist approaches to leadership identity move beyond conceptualisation of identity as either a tool or a personalised journey; instead they perceive identity formation to be 'an exercise of social power' (Thomas and Linstead, 2002, p75). An individual's identity is multifaceted and fluid and there are relational and social processes involved in coming to see one's self and being seen by others as a leader or a follower (Beech, 2008; Cunliffe and Eriksen, 2011; DeRue and Ashford, 2010). Consequently, Carroll and Levy (2010) propose that identity should be recognised as a project as well as a product in the context of leadership development. Leadership identity is co-constructed in organisations when individuals claim and grant leader and follower identities through their social interactions. Through this claiming-granting process, individuals internalise an identity as a leader or follower, and those identities become relationally recognised through reciprocal role adoption and collectively endorsed within the organisational context. Identities are context specific and shift over time and across situations (*ibid*). This relates to Wenger's (1998, p.5) social theory of learning which proposes that learning occurs through four interconnected components:

1. community (learning as belonging);
2. practice (learning as doing);
3. identity (learning as becoming); and
4. meaning (learning as experience)

This suggests that as practitioners come together and are involved with one another in action (in the workplace and beyond) they become a 'community of practice' wherein they learn to construct a shared identity underpinned by mutual understanding amidst confusing and conflicting data (Cunliffe, 2008; Lave and Wenger, 1991; Raelin, 2000). In keeping with the notion that identity is a project and product of development, Petriglieri (2011) has conceptualised leadership development programmes as 'identity workspaces' which can promote not only the attainment of knowledge and skills but also facilitate the revision and

consolidation of individual and collective identities. It is proposed that off-the-job development programmes can provide participants with the opportunity to step back from the rush and familiarity of their daily contexts to reflect on their experiences and explore how their inner and social worlds affect the ways they make sense of and act on those experiences (Day, 2010; Ibarra, 2003; Petriglieri, Wood and Petriglieri, 2011). Moreover, participants are thought to form a new ‘community of practice’ within the programme that encourages knowledge sharing and collective identity construction (Carroll and Levy, 2010; Siebert *et al.*, 2009). Thus, participants are thought to engage in activities that promote both individual and social ‘sensemaking’ (Weick, 1995). However, there is still a lack of clarity over how training and development initiatives contribute to participants identity construction and how such practices interact with experiences gained within the ‘real world’ to foster relational and collective identities and more inclusive world views (DeRue, Sitkin and Podolny, 2011; Watkins *et al.*, 2011). The following section considers some of the methods currently being used in leadership development practice.

### **3.3: Leadership Development in Practice**

#### ***3.3.1: An Applied Subject***

Due to the applied nature of the field, a fundamental theme within the leadership development literature relates to the practical implementation of different types of training and development methods. There are various practices that are used to promote leader and leadership development including both formal programmes (e.g. training courses, development programmes, and educational programmes) and informal supportive activities (e.g. on-the-job experiences chosen to create ‘stretch’ for the job incumbent, mentoring etc). Interventions vary with regard to their focus (individual, group, or organisation) and level of intensity (from postgraduate education lasting several years to focused courses of a few days). Although the most common development approach is still the formal classroom programme, there is a growing trend to embed development in the context of ongoing work (Day, 2000; 2011; DeRue and Wellman, 2009; McCauley, 2006; McRoy and Gibbs, 2009; Raelin, 2000; 2006). Appendix C provides an overview of popular methods. Each of these methods may be used as a stand-alone activity or as part of a multifaceted programme that combines embedded elements such as action learning, 360 degree feedback, and coaching

alongside more traditional forms of learning including lectures and assignments (Day, 2000; Hartley and Hinksman, 2003). This review focuses on the first six practices as these are popular throughout the field and are integral to the case programme discussed within the empirical chapters. Each practice is considered in turn in sections 3.3.2 to 3.3.7. Section 3.3.9 then discusses some of the problems with leadership development.

### ***3.3.2: 360 degree feedback***

Constructive feedback is regarded as essential to learning as it provides direction and helps to boost confidence, increase motivation and self-esteem (Atkins and Williams, 1995; Begley and White, 2003; Day, 2011; DeRue and Wellman, 2009). 360 degree feedback is where the multiple ratings of subordinates as well as colleagues, superiors and in some cases clients are fed back to the candidate. Some studies suggest that such feedback, where well handled, can improve participants' self-awareness, provide the required feedback to embed learning and inspire behaviour change (DeRue and Wellman, 2009; Drew, 2009). However, others have cautioned that if organisations try to do too much with the same instrument (e.g., learning feedback as well as performance appraisal) or overemphasise its quantitative aspects and neglect the qualitative ones, the tools worth is diminished (Conger and Toegel, 2003). A basic principle in both goal setting and learning theories is that actions devoid of feedback are not as potent as actions with feedback in terms of learning (Day, 2011). It is proposed that 360 degree feedback is especially useful if combined with other efforts (such as coaching or mentoring) that are directed at helping an individual change in ways suggested by the feedback (Day, 2000; Hurd, 2009). Moreover, reporting findings from a recent qualitative study, Drew (2009) emphasises that the feedback process should be supported by sound facilitation and, if possible, active organisational endorsement.

### ***3.3.3: Mentoring***

Mentoring refers to both formal and informal support relationships in organisations. Formal mentoring programmes are run by the organisation, whereas informal mentoring, while typically encouraged by the organisation, is not initiated or administered through official channels (Ragins *et al.*, 2000). Mentoring is believed to assist leadership

development as it gives individuals the opportunity to learn about leadership challenges in strategic contexts (especially where mentoring occurs with senior managers as mentors), and in building cognitive complexity and mental representations of leadership challenges and opportunities (Baranik *et al.*, 2010; Scandura and Williams, 2004). However, the impact of mentoring appears to be differential. Researchers have found gender differences (Ragins and Cotton, 1999) and in general it is reported to be more effective when it occurs informally than formally (Ragins *et al.*, 2000). Day (2000) also raises the potential issue of over-dependence on the mentor.

Scandura and Schriesheim (1994) and Hartley and Hinksman (2003) link mentoring to the wider concept of leader-member exchange (LMX) (e.g. Dansereau *et al.*, 1975; Graen *et al.*, 1982: both cited in Graen and Uhl-Bien, 1995) which draws attention to the increased performance of the leader and his/her subordinates through building strong inter-personal relationships between leader and ‘followers’, resulting in mutual benefit (Graen *et al.*, 2006; Scandura and Schriesheim, 1994). Studies have shown that newcomers who form high LMX with their new superior develop higher job satisfaction, commitment and retention (Loi *et al.*, 2009). Seers (2004) points out that such support relationships between co-workers become increasingly important in flat organisational structures where leadership is shared or distributed. Leadership development initiatives based on LMX focus on building team leadership by encouraging leaders and followers to develop high-quality trust, respect, and commitment relationships with each other, but not get too friendly (Graen *et al.*, 2006).

#### **3.3.4: Leadership coaching**

Coaching is a form of goal-focused, personal, one-on-one learning. It involves a professional coach supporting an individual, referred to as a coachee, through the development process by helping them identify and reach their leadership development goals (Douglas and Morley, 2000; Dunn, 2009; Ely *et al.*, 2010; Kilburg, 1996). Coaching is now a key part of many leadership development initiatives and the number of coaches, coaching programs, and coaching publications have increased dramatically in the last twenty years (Bolch, 2001; Ely *et al.*, 2010; Kampa-Kokesch and Anderson, 2001; Quick and Macik-Frey, 2004). Coaching tends to be a relatively short-term intervention aimed at

improving specific leadership competencies or addressing specific challenges (e.g. Smither *et al.*, 2003; Olivero *et al.*, 1997). It is proposed that coaching can raise an individual's self-awareness, help them build strong and weak ties (networks) in and outside the organisation and encourage reflection and 'out-of-the-box' thinking (Day, 2000; Dunn, 2009; Hurd, 2009; Olivero *et al.*, 1997). A number of evaluation studies have been carried out in the area; however they have been criticised for relying on post-coaching surveys and presenting descriptive statistics of findings (Ely *et al.*, 2010; Kampa-Kokesch and Anderson, 2001). Commentators have suggested that the discipline would benefit from further empirical research which examines some of the wider factors that influence coaching relationships including: who makes a good coach (and why), what sort of leader most benefits from coaching, what happens during coaching that supports leadership development, when it is successful and why it is successful in some settings (and possibly not in others) (Ely *et al.*, 2010; Hartley and Hinksman, 2003). One difficulty is that organisations sometimes adopt coaching for particular executives where there is a clear problem (e.g. interpersonal insensitivity, remedial action) and this can attract a sense of stigma (Day, 2000).

### **3.3.5: Action learning**

Action Learning is increasingly being used in leadership development (Conger and Xin, 2000; Dotlich and Noel, 1998; Leonard and Lang, 2010; Raelin, 2006). In its current form *action learning* dates back to the work of Revans (1982; 1998) who promoted the method as a means of generating learning from peer-interaction. It is a process that encourages a group of learners to work together to address real workplace issues or problems, in complex situations and conditions (Raelin, 2000; 2006). Learning occurs through group discussion, trial and error, reflection, and fellow learners' questions (Zuber-Skerritt, 2002; Yorks, O'Neil, and Marsick, 1999). The rationale for this type of learning relates to situated learning theory which proposes that knowledge is in part a product of the activity, context and culture in which it is developed and used (Brown, Collins, and Duguid, 1989). It implies that the learning of knowledge in a classroom or training situation is sometimes of limited value, as the transfer of training to the work situation can be limited due to the limits of memory and difficulties involved in changing attitudes and behaviour (Ardichvili, 2003; Raelin, 2000). Action learning can also promote collaborative discussion prior to



action; this has potential benefits for networking and joint-working within and across organisations (Hartley and Hinksman, 2003; Leonard and Lang, 2010). With regard to leadership, several authors have examined optimum conditions for development to occur including the importance of selecting the most appropriate peers for the action learning set, and also ensuring that the action learning group addresses the most appropriate organisational issues (e.g. Newman and Fitzgerald, 2001; Smith, 2001; Zuber-Skerritt, 2002; Leonard and Lang, 2010). Others have explored how action learning can help generate more collaborative forms of leadership (e.g. Raelin, 2006). Despite vast support for the method, Conger and Toegel (2003) contend that limited opportunity to reflect on learning, poor facilitation and a failure to follow-up on project outcomes impede the intervention's potential to develop leadership capabilities.

### ***3.3.6: Job-related assignments***

As mentioned above, supporters of situated learning have long argued that a great deal of learning and development takes place away from the classroom through on the job experiences (Ardichvili, 2003; Brown *et al.*, 1989; Keys and Wolfe, 1988; McCall, 2004; Mumford, 1995). Job assignments usually take the form of organisational projects that aim to challenge leaders and help them link learning back to their work (McCall, 2004; McCauley *et al.* 1995; Yukl, 2010). It is believed that working through these challenging experiences can help leaders to build individual skills and capabilities as well as assist team-building skills and influencing skills (*ibid*). Moreover, they are thought to assist knowledge transfer and produce organisational benefits from the value of work-based project itself, the creation of collective knowledge resources, and subsequent organisational changes (Costley, 2011; Garnett, 2001). Although there is widespread support for the use of job assignments within leadership development some authors raise concerns over the strength of the approach. It is argued that for job assignments to provide optimum results three elements must be present assessment, challenge and support (DeRue and Wellman, 2009; McCauley *et al.* 1994; McCauley, 2006).

Assessment can include self-reflection and feedback from others, for example colleagues or a coach. Challenge comes from being stretched by the assignment due to encountering new tasks, new responsibilities, increased demands, or more complex situations.

Experience can impede learning if activities become repetitive, rather than adaptive (Rashman *et al.* 2009). However, Day (2011) cautions against over challenging people such that the ability to learn from the experience is compromised. Organisational support will help people deal with the struggles of a challenging assignment and the underpinning culture must sponsor not only performance but also learning from mistakes (DeRue and Wellman, 2009). As people learn differently it is also important to match the job challenge to the individual and ensure they have the autonomy to try-out different leadership approaches during the assignment (Day, 2000; Hartley and Hinksman, 2003; McCall, 2004; Rousseau and Tijoriwala, 1999). The literature is still evolving and there remain questions with regard to the developmental components of jobs, how learning is related to job experience and how leaders can make the most of the experiences they have (McCall, 2004; McCauley, 2006; DeRue and Wellman, 2009).

### **3.3.7: *Networking***

In section 2.3.3 it was noted that actively managing network relationships (as a source of social capital) is considered fundamental to effective leadership (Balkundi and Kilduff, 2005; van Bueren *et al.*, 2003). Networks between individuals and groups, built upon reciprocity, trust and face-to-face interaction have also been found to support organisational learning (Addicott *et al.*, 2006; Inkpen and Tsang, 2005; Rashman *et al.*, 2009). Consequently, a number of commentators have suggested that networking can play an important role in leadership development (e.g. Bartol and Zhang, 2007; Day, 2000; Iles and Preece, 2006; McCallum and O'Connell, 2009). It is proposed that while mentoring is beneficial to individuals early in their careers, networking provides support to leaders as they progress through their careers (Tracey and Nicholl, 2006). Networks provide a wider range of contacts, both inside and outside the organisation, enabling the leader access to a greater range of knowledge, information, perspectives and views (Day, 2000; Inkpen and Tsang, 2005). They can facilitate the sharing of tacit as well as explicit knowledge. However, the extent to which knowledge is shared and developed is influenced by the quality of relationships and organisational context - e.g. structure, values and culture (Hartley and Benington, 2006; Rashman *et al.*, 2009; Tsai and Ghoshal, 1998).

The level of a person's 'emotional intelligence' or interpersonal skills has been found to influence their ability to take advantage of the opportunities of networks (Riggo and Lee, 2007). Hartley and Hinksman (2003) caution that this can present a potential issue as those who are most proactive in using networks are likely to take advantage of a range of development opportunities, while those most in need of leadership development may be less confident or strategic in their use of networks. Research has suggested that optimum results occur when there is diversity within networks (Inkpen and Tsang, 2005; Burt, 2001). It is argued that network ties that span 'structural holes' and bridge disparate groups provide a source of feedback, comparison and support for leaders and can challenge existing assumptions and views (Adler and Kwon 2002; Bartol and Zhang, 2007; Burt, 1992; 2001; Iles and Preece, 2006). However, too much diversity can lead to a lack of understanding and confusion across parties (Burt, 2001; Mayo *et al.* 1996). Moreover, closed networks can also be useful as they promote trust and strong bonding network ties which encourage knowledge sharing and collaboration (Abrams *et al.*, 2003). Evaluating the impact of networks is particularly challenging as the impacts tend to be both diffuse, indirect, and take place over an extended period of time (Inkpen and Tsang, 2005; Hartley and Benington, 2006; Tsai and Ghoshal, 1998).

### ***3.3.8: The Problems with Leadership Development***

The above discussion of the six practices of development illustrates that attempts are being made to embed learning within ongoing work. Yet, within the training literature more generally there is a tendency to take an episodic view of development whereby it is (implicitly) assumed that development occurs only as part of a discrete programme or a challenging job experience. However, Day (2011) notes that this view fails to capture the more important aspect of what was learned from the programme or experience and how it influences future behaviour or decision-making in leadership situations: 'It is not the experience but the learning from experience that is most important for development' (p.44). A key finding from the previously mentioned DDI report (Howard and Wellins, 2008) is that participants reported that there are not enough opportunities to learn on the job. This is problematic as learning and development should be an ongoing process occurring every day (Vicere and Flumer, 1998). From the supporting comments provided in the DDI report, it appears that respondents saw learning as closely tied to having a

mentor or having access to interesting and challenging job assignments. Day (2011) notes that while this perception is not wrong it is limited. Referring to the expert performance literature, he suggests that developing the expert leader will require a minimum of 10,000 hours of intensive, dedicated practice supported by ongoing positive and negative feedback. This perspective sees leadership as embryonic, developing within a dynamic social context.

When considering leadership from a social constructionist perspective a further drawback is that the development methods of the sort outlined may remove participants too far from the relational processes in which their identities and acts, as leaders, are constructed (Hosking, 2007). Social constructionists acknowledge that multiple realities coexist therefore argue that workplace training and development should grow directly out of the needs of the workplace situation and should be embedded in workplace interactions (Ardichvilli, 2003; Raz and Fadlon, 2006). The focus moves from individual to the organisation. There is a lack of consensus as to exactly how individual learning is transformed into organisation-level learning; however it is thought to be embedded within the organisational culture and occur among and through other people in the organisation (*ibid*). Almost all leadership development activities are aimed at those who occupy formal leadership roles. However, if leadership and learning are co-produced then it is argued that leadership development should include followers as well as leaders (Jackson and Parry, 2008)

In contrast to the traditional orientation towards leader-follower relations from the standpoint of individuals, the 'relational' view of leadership starts with processes, and views persons and leadership as things that are made through these processes (Hosking, 2007; Cunliffe and Eriksen, 2011). Under this perspective 'leadership development and training should not only include both leaders and followers, but should actively blur the divide, generate collective understanding, and resist the temptation to impose top-down predefined models of leadership in favour of bottom up locally generated content' (Jackson and Parry, 2008, p122). This again connects to the relational and collective levels of leadership identity co-construction.

Drawing on the work of Aristotle, Grint (2007) suggests that knowledge can be taught in lectures, but skills must be honed through practice while wisdom can only be secured through experiencing leadership itself. He recommends that the first step for those involved in the education of leaders is to: ‘acquire more humility concerning the limits of their experience’ (p.18), encouraging participants to engage in reflective learning. This relates to the need to make leadership development sustainable and not to rely exclusively on an episodic or programme-focused approach to development (Day, 2011). However, as mentioned earlier, others emphasise that leadership development programmes provide opportunities for participants to work on their self-identify and can affect others perceptions of them as a leader (Carroll and Levy, 2010; Petriglieri, 2011). Nonetheless, organisations must have mechanisms in place to support participants once the programme is complete. On-going leader development has been found to be particularly important when succession planning for senior leadership positions (Berke, 2005). It is argued that the most effective leader development initiatives are those that integrate various experiences and embed them in their organisation’s context, in other words organisations must allow and indeed enable leaders to lead (Hewison and Griffiths, 2004; McCall, 2004; McCauley, 2006).

### **3.4: Learning Transfer and Evaluation**

An area that is often neglected within leadership development practice is evaluating the results of such initiatives. Despite a range of taxonomies and frameworks designed for evaluating training at different levels (e.g. Kirkpatrick, 1959; Phillips, 2003) most evaluation efforts are focused on participants’ reactions to the development programme (i.e. smile sheets) with little attention to understanding whether the leader’s developmental experience has an impact on his behaviour or the organisation (Day, 2011; Jackson and Parry, 2008; Tourish, 2012). This may be in part due to the time-scale and complexity involved in distinguishing causal connections. It is widely recognised that leadership development is a relatively long-term investment in the human and social capital of an organisation (Day, 2000; Hannum *et al.*, 2007). Additional factors may mediate the development-performance relationship and effectiveness may be assessed from a variety of perspectives including peers, self, subordinates, superiors, or subject matter experts, each with their own idiosyncrasies and preconceptions (Hiller *et al.*, 2011; Raz and Fadlon,

2006). The following sections 3.4.1 to 3.4.4 outline four interrelated themes relating to learning transfer and evaluation.

### ***3.4.1: Evaluating Learning and Development***

The organisational learning and training evaluation literature is well established (see Blume *et al.*, 2010 or Collins and Holton, 2004 for useful reviews). It is argued that the effectiveness of training depends ultimately on whether the learned outcomes are used in the workplace (Benson and Dresdow, 1998; Olsen, 1998; Salas and Cannon-Bowers, 2001). Thus, a key theme within the literature relates to how individual learning from training and development is transferred into participants' organisations. Several authors have sought to conceptualise this transfer process and there are now a range of approaches for evaluating training at different levels. Popular measures of effectiveness include: successful learning, improved on-the-job performance, changes in key business measures and return on investment (Phillips and Phillips, 2005). The Kirkpatrick evaluation framework is the most commonly used framework in training evaluation (Tamkin *et al.*, 2002). The taxonomy describes four stages of evaluation: participant reactions, learning, behaviour, and organisational outcomes. Reaction considers participants' reaction to the programme and stakeholder satisfaction with the programme and planned implementation. Learning includes skills, knowledge, or attitude changes related to the programme and implementation. Behaviour refers to changes in behaviour on the job and specific application and implementation of programme. Lastly, organisational outcomes consist of changes to business outcomes and processes related to the programme (Kirkpatrick, 1994).

Although the Kirkpatrick model is widely used as a basis for evaluating management and leadership development programmes (e.g. Hechanova-Alampay and Morgan, 2000; Broaden, 2005; Edmonstone, 2009), the model has been criticised for implying a hierarchy of power related to the different levels, with organisational performance measures being seen as more important than reactions. More fundamentally, there have been criticisms of the assumption that levels are each associated with previous and subsequent levels as this implies linear level progression and a causal relationship that has not always been established by research (Tamkin *et al.*, 2002). Others have argued that the model is too simplistic, failing to take account of the various intervening variables affecting learning

and performance (Collins and Holton, 2004). Consequently, theorists have developed alternative methods that purport to resolve some of these difficulties.

Several of these may be thought of as Kirkpatrick's offspring, in that they take much that was inherent in the original model and extended it either at the front end, with the inclusion of training design or needs analysis, or back end, with an evaluation of societal outcomes - and sometimes both (Tamkin *et al.*, 2002). For example Phillips (1994) (see also: Phillips and Phillips, 2005) proposes a five level framework encompassing: reaction and planned action, learning, job application, business results, and return on investment (ROI). The first four are similar to Kirkpatrick's, however the fifth level, ROI, goes beyond to measure the monetary value of the business impact in relation to the investment (cost of the programme). Alternatively, Kaufman *et al.*'s (1996) Organisational Elements Model extends the original model at both ends incorporating six elements: input, process, micro (acquisition), micro (performance), macro and mega. This implies that evaluating should begin prior to the training intervention at the planning stage and include outcome measures at the level of the individual, organisation and community.

All of these models tacitly base themselves on the assumption that there is a chain of impact from a developmental process to individual learning, change behaviour and resulting organisational and social impact. However they rarely make such a model explicit, and therefore they are open to criticism that they ignore some of the key variables that impact on this chain of events (Tamkin *et al.*, 2002). For example, research has shown that there is relatively little correlation between participant reactions and measures of learning or subsequent measures of changed behaviour (e.g. Holton, 1996; Warr *et al.*, 1999). Likewise there are issues with linking learning to application (Benson and Dresdow, 1998). There are wealth of studies that comment on the failure of training to transfer into the workplace and which have identified a range of organisational factors including organisational culture, job autonomy, and peer and superior support (Cole, 2009; Holton, 1996; Warr *et al.*, 1999; Schilling and Kluge, 2006). Similarly, there are a number of individual factors that influence transfer and application of learning; self-efficacy, motivation to learn, and general intelligence of all the associated (Combs *et al.*, 2009; Chan and Drasgow, 2001; Kemster, 2006; Salas and Cannon-Bowers, 2001). Whilst organisational results are probably the most difficult to evaluate, many commentators take

the view that training must be evaluated using hard outcome data (e.g. Cascio and Boudreau, 2008; Leven, 1983; Phillips and Phillips, 2005). The difficulties of doing so tend to be dismissed by these researchers. Others, however, express caution, pointing out the many assumptions that are made (Bee and Bee, 1994) or the inherent difficulties in linking soft skills training to hard results (Abernathy, 1999; Laker and Powell, 2011) the time delays that are rarely taken into account (Barnett and Ceci, 2002), and that hard measures miss much that is of value (Kaplan and Norton, 1996).

### ***3.4.2: On-the-job vs. Off-the-job learning***

Many of the above criticisms can be linked to different approaches to organisational learning such as incidental or informal (i.e. unplanned) learning (Marsick and Watkins 1990), the acquisition of work process knowledge (Boreham *et al.*, 2002) and situated learning theory (Brown *et al.*, 1989; Brown and Duguid, 1991). The situated learning approach, in particular, stresses the importance of learning as identity formation through participation in ‘communities of practice’ and the importance of knowledge that is tacit and collectively held (Brown *et al.* 1989; Duguid, 2005; Lave and Wenger, 1991; Sandberg, 2000). It places emphasis on learning through practice in context. This raises questions in terms of the worth of off-the-job training and suggests that conventional training transfer research may be inadequate to understand the dynamics of performance improvement through training (Cheng and Hampson, 2008; Tennant, 1999).

According to Becker (1993), there are three types of training or knowledge investment, which are directly related to human capital accumulation. These three types of training or knowledge are:

- 1) On-the-Job Training: ‘learning new skills and perfecting old ones while on the job’ (p. 31). This concept can be broken down into two types of training; general training (those skills which are useful in many firms); and specific training (training that relates only to the current organisation and would not be useful in other firms);



- 2) Schooling (off-the-job): ‘an institution specializing in the production of training, as distinct from a firm that offers training in conjunction with the production of goods’ (p. 51); and
- 3) Other Knowledge: any other information that a person obtains to increase their command of their economic situation.

Accordingly, a central theme within human capital research is the assessment of returns from investment in different types of development (Nafukho, Hairston and Brooks, 2004; Zula and Chermack 2007). Resource-based theorists suggest that, as individual expertise may or may not stay within an organisation, only training that develops organisation-specific knowledge is likely to generate organisational value, since it is those assets that are likely to be inimitable and rare (Coff, 1997; Lepak and Snell, 1999). However, investing more generally in employees’ transferable human capital (for example, through external courses that develop individuals’ professional or managerial skills) has been found to improve employee morale and commitment (Galunic and Anderson, 2000), and promote the transfer of knowledge (Martin, Pate and Beaumont, 2001). Moreover, as mentioned in section 3.3, development programmes that incorporate practice-based elements linked to participants’ organisations such as action learning and job-related projects are thought to help participants embed off-the-job learning within their organisation (DeRue and Wellman, 2009; Petriglieri, 2011). Therefore, it is argued that off-the-job and on the job-learning combine to provide overall learning (Cheng and Hampson, 2008).

#### ***3.4.3: Evaluating Leadership Outcomes***

If off-the-job and on-the-job learning both combine to provide the overall learning, it can be assumed that leadership abilities can be enhanced through leadership training and development and that it is important to understand how off-the-job learning is transferred to the organisation and how different forms of learning relate to each other. Despite the above critique Kirkpatrick’s model provides a useful starting point for the evaluating the outcomes of leadership development, however greater understanding of the individual and contextual influences would enhance this approach (Bligh *et al.*, 2007; Blume *et al.*, 2010; Schilling and Kluge, 2009; Tourish, 2012). Past management and leadership training evaluation efforts have tended to involve only the first three levels of

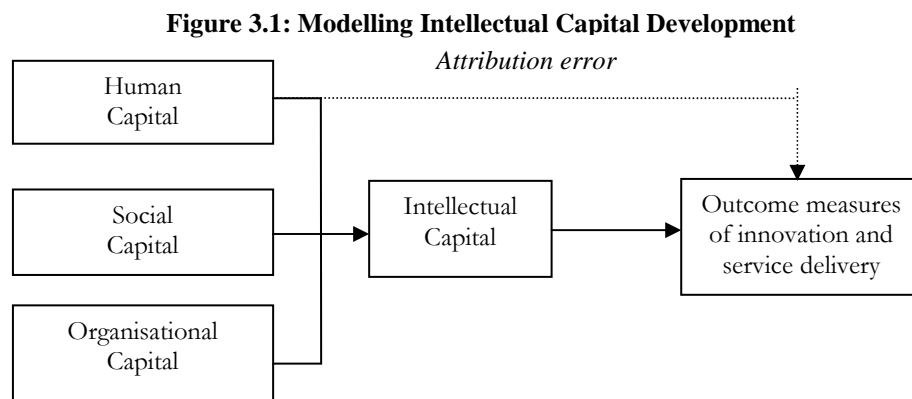
reaction, learning and individual behaviour (Collins and Holton, 2004). Moreover, evaluation is generally conducted from a leader-centred view that romanticises the leader by focusing on the leader's characteristics and behaviours. However, as followers play an active role in the leadership process they are also responsible for the consequences of leadership (Shamir, 2007).

One study that did consider the role of leadership on followers is Dvir *et al.*'s (2002) longitudinal, randomised field experiment of Israeli military cadets which examined whether enhancing transformational leadership through training would impact follower development and performance. Indirect follower performance was operationalised in terms of variables such as light weapons, physical fitness, and marksmanship (direct follower performance was not measured). Direct and indirect follower development was operationalised in terms of variables such as self-efficacy, collectivistic orientation, extra effort, active engagement and internalisation of moral values. In general, results indicated that those leaders receiving transformational leadership training had a more positive impact on direct followers' development and indirect followers' performance than those in the control group.

In their recent systematic review of the literature Hiller *et al.* (2011) make four suggestions for future research. Firstly, they recommend incorporating a greater variety of perspectives into examinations of leadership and outcomes. Past research has focused predominantly on subordinate perspectives of leadership and, while this is useful, the authors' propose that the understanding would be enhanced by additional peer and superior evaluations. Secondly, they suggest that a more complete investigation of the multifaceted effects of leadership is required. Greater attention is needed to the impact of leaders and leadership on emotional constructs (Bono and Ilies, 2006; Sosik and Godshalk, 2000), on motivational states and social identification (Dvir *et al.*, 2002; Shamir, Zakay, Breinin, and Popper, 1998), and on cognitive constructions of meaning (Marks, Zaccaro, and Mathieu, 2000). Thirdly, they advocate greater temporal mapping of relationships. Certain tangible outcomes related to leadership may accrue quickly, while others may be more beneficially understood over months or years. Finally, they recommend integrating micro (traditional) and macro (strategic) investigations of leadership.

### 3.4.4: Knowledge Transfer and Intellectual Capital

Hiller's call to integrate micro and macro approaches brings us back to the concept of intellectual capital (IC). Intellectual capital is a multi-dimensional concept which refers to the collective knowledge resources within an organisation (Andereou *et al.*, 2007; Mayo, 2000, Nazari and Herremans, 2007; OECD, 1999; Petty and Guthrie, 2000; Stewart, 1998). There is debate over the exact composition of IC (see appendix D for a comparison of definitions). However, past research has identified three prominent aspects including: human capital (the knowledge skills and abilities of people), social (relational) capital (the valuable relationships among people), and organisational (structural) capital (the processes and routines within the organisation). Figure 3.1 shows that it is proposed that it is the interaction and complementarities among these three antecedents that generates IC, which, in turn, drives innovation and organisational value (Bontis and Fit-enz, 2002; Kinnie and Swart, 2006; Lin and Haung, 2005; Litschka *et al.*, 2006; Subramaniam and Youndt, 2005).



Source: Adapted from Bontis, 1998; Bontis and Fit-enz, 2002; Subramaniam and Youndt, 2005

As a field of research, IC has gained momentum over the last fifteen years with two different but overlapping themes emerging from the literature. The first relates to measurement and is concerned with constructing new reporting mechanisms for quantifying the non-financial, qualitative items of intellectual capital (e.g. Lev *et al.*, 2005; Litschka *et al.*, 2006; O'Regan *et al.*, 2001; Pulic, 2004; 2004; Roos, 1997; Sveiby, 2001). The second is concerned with the development and management of knowledge and focuses on the way knowledge is created, applied, shared and leveraged into value (e.g. Bontis, 1998, 2001; Bontis and Fit-enz, 2002; Marr and Roos, 2005, Stewart, 1998;

Subramaniam and Youndt, 2005). This second theme is particularly relevant to the current study as it stresses the importance of knowledge application and the sharing and transfer of learning.

Section 3.2.1 highlighted that leadership development programmes aim to enhance participants' human capital and social capital. However, IC theory suggests that knowledge transfer and application will be influenced by the organisational context, in particular the availability and strength of organisational capital (OC). OC encompasses the institutionalized knowledge and codified experiences residing within organisations in the form of databases, filing cabinets, patents, manuals, organisational structures, routines, processes and culture (Bontis, 1998; Bontis and Fitz-enz, 2002; Subramaniam and Youndt, 2005). As Kong (2008) has pithily stated, it is what is left behind in the organisation at night when people leave the building. The principal role of organisational capital is to link the resources of the organisation together into processes that create value for customers and sustainable competitive advantage for the organisation (Dess and Picken, 1999; Huiyan and Run-Tian, 2006). The interactions between its dimensions are important in providing employees with the motivation to develop and use their skills and knowledge for the collective good (Kulvisaechana, 2006).

Some dimensions of OC are particularly important to the creation of intellectual capital. For instance, culture plays a significant role, as only certain types of cultural capital will be conducive to innovation and learning (Battu *et al.*, 2004; Kulvisaechana, 2006; Martin *et al.*, 2001). An entrenched and outdated culture, fear of change, internal competition, and measurements that lead nowhere can also create barriers to learning application. Thus, before new knowledge and ideas can be implemented, an organisation's culture and philosophy may have to be radically changed. Even if the new knowledge is acquired by new and open leadership, it will not be implemented until employees (followers) are acquainted with the organisational cultural reforms (Pfeffer and Sutton, 2000). Therefore Wright *et al.* (2001b) propose that organisations should 'define knowledge, identify existing knowledge bases, and provide mechanisms to promote the creation, protection and transfer of knowledge' (p. 713). This should be a recurring process with organisations developing dynamic capabilities to help them coordinate their knowledge resources and adapt quickly to external changes (Teece, 1998; Wang and Ahmed 2007).

Similarly, an organisation's performance management and incentive structure will influence human capital development. It is argued that intellectual capital is increased when skilled and motivated employees are directly involved in determining what work is performed and how this work is accomplished (Delaney and Huselid 1996). Furthermore, according to Rumelt (1984), the routines and processes that act as the glue for organisations can either enhance or disable co-operative working and the development of knowledge (cited in Stiles and Kulvisaechna, 2003). Hence, poor organisational capital can have a negative impact on the value an organisation can gain from its human and social capital (Kor and Leblebici, 2005). This was illustrated by a recent longitudinal study of financial services analysts which found that 'star' employees relied on a supportive (non-transferable) context for them to perform effectively in their original employment and parachuting in stars into unreceptive contexts often resulted in disruption and low morale across the organisation (Groysberg *et al.*, 2004).

### **3.5: Conclusion**

This review opens a multitude of questions about leadership, leadership development, and learning transfer. It highlights that leadership theory has evolved over the last decade and multiple perspectives now influence the development of leaders and leadership. The literature comprises of more conceptual than empirical publications, but considers a variety of interesting themes including: the role of followers in developing expertise, developing leadership capacity in teams; the importance of context and work-place learning, and the co-construction of leader and follower identities. Specifically, it noted the importance of the different levels of analysis in which social identity can be investigated (individual, relational and collective) and the role that they might have on leader and leadership development separately and the linkage that they might provide for these two aspects of development. This was linked to the intellectual capital framework.

The review observed that there are encouraging signs that the field of leadership development is moving beyond a 'best practice' approach to adopt a scientific stance in developing theory and theoretically grounded research. However, there is scope for further development by considering more fully the dynamic interplay between leaders and

followers, as well as taking more fully into account the context in which these interactions occur. Moreover, there is a need for greater understanding of how development programmes can contribute to the construction of a leader's identity and how these practices interact with experiences in the wider context to create individual and organisation leadership outcomes. The connection between leadership effectiveness and leadership development appears weak; yet, it is only by exploring this link can we begin to understand the role and value of leadership development initiatives in general, and of each perspective in particular, for organisations. It would also be useful to explore how leadership development programmes can change participants' views about the organisation's identity and how these perceptions alter their own views of themselves (leader identity). The next chapter concludes the literature review by focusing on the research context and examining the policy, practice and academic literature surrounding clinical leadership.

## Chapter 4: Clinical Leadership in NHS Scotland

The previous chapters have discussed the various literature bases that inform this research. This chapter reviews the literature surrounding clinical leadership and discusses how such dual-roles relate to current public policy. Chapter 5 then provides a detailed discussion of the underpinning philosophy, methodological approach, and data collection methods employed within the current research.

### 4.1: Leadership in a Healthcare Context

#### *4.1.1: The Importance of Leadership in the NHS*

Over the last forty or so years the development of management and leadership capabilities has been a key strategy for the NHS in England, Scotland, Wales and Northern Ireland (Degeling *et al.*, 2006; Martin and Bushfield, 2011; Walshe and Chambers, 2010). This view is supported by a plethora of policy documents (see, e.g. NHS Scotland's leadership strategy: *Delivering Quality through Leadership*) that contend that leadership is central to delivering efficient and effective healthcare (Scottish Government, 2009). Consequently, health services across the world, including NHS Scotland, have invested heavily in developing the leadership skills of both their managers and clinicians (Cook, 2001; Kirkpatrick *et al.*, 2009). Notwithstanding this investment Government ministers, health service managers and a substantial number of senior clinicians themselves still talk in terms of a *leadership deficit* in the NHS (Walshe and Chambers, 2010). Thus, this chapter now considers the inherent challenges facing management and leadership in a healthcare context.

#### *4.1.2: Clinical Autonomy and Management*

When studying leadership in the NHS it is important to appreciate the historical relationship between managers and clinicians. There are a number of perceived cultural differences between managers and clinicians (Sutherland and Dawson, 1998). Stereotypically managers are seen as identifying themselves through the organisation in which they work and being accountable through the board of directors, are assumed to

have overriding concerns with costs and efficiencies, and aim for the ‘greatest good for the greatest number’ (Edwards, 2003; Sutherland and Dawson, 1998). Yet, Merali (2006) challenges this, arguing strongly for the altruistic core values and patient-centred goals of NHS managers. Clinicians identify mainly with their peer group, are accountable through clinical and professional standards and aim for the best for each individual patient. They have a strong sense of professional ethics but their commitment is often to the profession or speciality, rather than the organisation, and this may result in resistance to change (Dickinson and Ham, 2008; Kippist and Fitzgerald, 2009).

The relationship between clinicians and managers is inextricably linked to power and control (Sutherland and Dawson, 1998). As discussed in chapter 1, the NHS was historically classified as a professional bureaucracy valuing clinical autonomy over hierarchical management (see, section 2.3.6h). This independence was based on the negotiations that took place at the formation of the NHS, which agreed that while central government controlled the budget, doctors controlled what happened with that budget (Klein, 2006). However, since the early 1980s, the NHS has become more centralised and clinicians have become more accountable for the way that resources are allocated (Dickinson and Ham, 2008). Government-introduced performance targets (such as waiting times) have also reduced professional autonomy as they have influenced clinicians’ priorities by encouraging them to consider patients collectively (Black and Craft, 2004). These changes have resulted in a number of tensions between clinicians, managers and politicians. Clinicians prize their autonomy above all and resent managers attempts to ‘manage’ them. Moreover, they resist the repositioning of healthcare as customer service as opposed to a civic right (Worthington, 2004). Thus, despite the rebalancing of power between clinicians and managers, a sense often remains among both groups that the important power lies elsewhere (Davies and Harrison, 2003; Edmonstone, 2008; MacIntosh, Beech, and Martin, 2011). Professional credibility means that influential clinicians are still able to block or subdue the efforts of managers or politicians to impose change via top-down mechanisms (Dickinson and Ham, 2008; MacIntosh *et al.*, 2011).



## 4.2: The Clinical Leader

### 4.2.1: *A Hybrid Role and Dual-Identity*

One way that healthcare organisations have sought to engage clinicians in management processes is through the development of hybrid clinician managers (and more recently clinical leaders) whereby clinicians take on managerial and leadership roles (Edmonstone, 2008; Kippist and Fitzgerald, 2009). The assumption is that clinicians will be more likely to respond positively to management agendas set by medical (rather than non-medical) managers (Chauhan and Mason, 2008; Degeling *et al.*, 2006; Edmonstone, 2008). Llewellyn (2001) describes this role as a ‘two-way window’ which allows clinicians and managers to ‘constructively join two sets of traditionally opposed ideas’. This relates to the focus on creating public value and the related discourse of ‘leaderism’ (a development of ‘managerialism’), which has permeated policy and public services in the UK in recent years (Benington, 2011; O’Reilly and Reed, 2010; 2011). Under this discourse clinical leadership is regarded as a principal means of ‘regaining control by sharing control’ through incorporating powerful professional groups such as doctors, who have often used their powers in the past to impede reforms, into the decision-making process (Edmonstone, 2009; The Kings Fund, 2011). There is an expectation that competent clinical leadership will provide the means by which to manage the dynamic nature of healthcare and pressures from the ever-increasing expectations of the public by placing change in the forefront and engaging staff in the change process (Bogust *et al.* 2002; DoH, 2000; Gollop *et al.*, 2004; Howieson and Thiagarajah, 2011; Millward, and Bryan, 2005; Scottish Government, 2005; 2009; Sheaff *et al.*, 2003).

### 4.2.2: *Defining Clinical Leadership*

Despite a considerable amount of literature associated with ‘clinical leadership’ there are few definitions of the subject (Howieson and Thiagarajah, 2011). In some regards theory in the field echoes that of leadership (see chapter two) with early approaches focusing on the competences of individual clinical leaders while more recent approaches have advocated more inclusive and collective forms of leadership (Bolden and Gosling, 2006; Buchanan *et al.*, 2007). It has been suggested that contemporary healthcare structures are

becoming more inclusive and interdisciplinary and less dependent upon hierarchical, medical leadership (Aiken *et al.*, 2000). Thus, there is increasing opportunities for clinicians from different professions and at different levels to lead and direct health care service and clinical practice development (Buchanan *et al.*, 2007; Scottish Government, 2009). The focus on sharing and distributing leadership throughout the organisation is evident from the Scottish Executive's (2005) working definition:

‘Clinical leadership is about driving service improvement and the effective management of teams to provide excellence in patient/client care. This requires a distributed approach to leadership development.’ (p.5)

Although the above definition gives some clarity as to the tasks and anticipated outcomes of clinical leadership it remains fairly generalised. In addition much of the existing literature on clinical leadership focuses on the role from a medical (e.g. Baker and Denis, 2011; Dickinson and Ham, 2008; Ham *et al.*, 2011) or nursing perspective (e.g. Alleyne and Jumaa, 2007; Carryer *et al.*, 2007; Cook, 2001; Cook and Leathard, 2004). In an attempt to gain a more detailed understanding of clinical leadership Howieson and Thiagarajah (2011) undertook a systematic review of all academic, policy and practitioner articles, mentioning doctors and leadership in the abstract, published between 2000 and 2009 in the British Medical Journal. From this work, the researchers identified five levels of analysis at which clinical leadership could be seen to be important. Table 4.1 provides a summary of these and the corresponding issues that clinical leaders face at each level.

**Table 4.1: Levels of Analysis and Key Themes in the BMJ**

<b>Level of Analysis</b>	<b>Issues and Problems</b>
Grand strategic level (global)	The role played by doctors in global health issues. Important to seek long-term political solutions that reduce human suffering rather than short-term gains
Organisational level (strategic)	Building and aligning teams, culture and establishing/ re-establishing trust, identity issues among doctors and the problems of doctor manager relations.
Group or Team Level (operational)	The problems of integrating doctors into clinical teams, alignment, empowerment and diversity issues.
Dyadic level (relations between two people)	The importance of soft skills, delegation /empowerment /teamwork, standards/integrity/quality and styles/behaviours depending on the situation
Individual/ intra-individual levels	The need to develop non-clinical/technical skills, self-awareness and emotional intelligence.

**Source: Adapted from Howieson and Thiagarajah, 2011, p. 10-11**

A key point made by this work is that the issues faced by clinical leaders differ according to their seniority in the hierarchy, their experience and spans of control. Thus, clinical leaders at different stages in their career will have different focuses and require specific skills. At a broader level the findings emphasise that context and situation matter and universal models of clinical leadership competences that ignore different contexts are of limited value (*ibid*).

One of the few examples of research into clinical leadership in the UK that acknowledged the importance of context in clinical leadership was commissioned by the NHS North West Leadership Academy in 2008. The report concluded that there was confusion over the meaning of clinical leadership and what it was aimed at. For example, different theories of leadership evident in the *Next Stage Review* (DoH, 2008) and *Delivering Quality through Leadership* (Scottish Government, 2009) have different implications for clinical leadership as they advocate both a hierarchical model and a distributed one. Clinical leadership is also influenced by the context in which it is exercised; for example, whether it is a formal or informal role, whether it is seen as full-time rather than part-time, and the extent to which clinical leaders are accepted by different clinicians.

The report also distinguished clinical leadership from the kind of leadership exercised by career managers in healthcare in three ways. First, it required leadership of staff, especially doctors, who perceived themselves as historically more autonomous and better qualified than many other professionals inside and outside of healthcare. Second, since clinicians were schooled in a scientific, evidence-based approach, clinical leadership has to be based in this paradigm. Third, clinical leadership also had to embrace a 'reflective practice/professional artistry approach to healthcare rather than a technical one' (Mintzberg, 2004). These distinctions mean that additional analytical frameworks have informed clinical leadership theory.

### 4.3: Power Relations

#### 4.3.1: *The Division and Sharing of Power*

As mentioned above, there has been a global trend for clinicians (in particular doctors) to increase their participation in management and leadership. Referring to the work of Friedson (1985; 1994), Kirkpatrick *et al.* (2009) suggest that this has led to the process of re-stratification with new divisions emerging between medical elites and the ‘rank and file’. Friedson (1994) identified three strata: ‘rank and file’ representing those doctors who continue to provide direct patient care; ‘knowledge elites’ referring to doctors in research and medical education; and ‘administrative elites’ comprising of doctors in management roles assuming coordination and oversight functions. It is suggested that such stratification has had mixed implications for the medical profession. On the one hand, such change has resulted in the loss of autonomy for individual practitioners as their work becomes more circumscribed by clinical audit, protocols and guidelines (Dent, 2003). At the same time; however elite groups may be able to maintain or even extend their dominance through the capture of management roles (Jacobs, 2005). For example, drawing on Courpasson’s (2000) notion of soft bureaucracy and Nye’s (1990; 2004) concept of soft power, Sheaff *et al.* (2003) found that the strategy of co-opting strong professional groups into the management of healthcare in return for non-government interference into their internal affairs has resulted in GP’s in primary care remaining largely self-regulating and relatively autonomous.

#### 4.3.2: *The NHS as a Soft Bureaucracy*

The concept of soft bureaucracy stems from Weberian theories of organisation and leadership. It describes an ambivalent structure of governance whereby internal control is exercised through loosely coupled sophisticated operations management and human resource strategies using soft power with key groups such as doctors, but exercising hard power over non-professional groups (Courpasson, 2000; Sheaff *et al.*, 2003). Thus, the soft power exercised over medical staff and certain other clinical groups through sophisticated human resource management needs to be contrasted with the hard power exercised over non-professional groups to obtain their compliance, often by outsourcing,

redundancies, discipline, payment by results and other techniques associated with hard human resource management. Likewise, at the same time as exercising soft power internally, soft bureaucracies manage an outward impression of the exercise of hard power to key external stakeholders such as politicians, the press and general public to demonstrate value for taxpayers' money through ostensibly hard but essentially inconsistent performance management techniques and settlements (Courpasson, 2000).

A key strategy in the exercise of soft power is to give the best or most willing professionals managerial powers, though usually weak ones, over colleagues and service delivery because in soft bureaucracies professionals look to fellow professionals for leadership rather than to managers (Sheaff *et al.*, 2003). Thus, a form of soft governance emerges. This results in groups like clinical leaders acting as an intermediary between their clinical colleagues and general managers, influencing colleagues through a combination of knowledge management, collective self-organisation and the innuendo of political threats rather than overt financial administrative or regulatory controls (Berg *et al.*, 2000). In turn, general managers attempt to exercise their influence over these clinical leaders by seeking to engage them in managerial techniques such as performance management, work allocation etc (Sheaff *et al.*, 2003). Such a strategy in healthcare, however, relies on (a) managers being able to convince organisational members that managerial logics and decisions are in the best interests of the organisation, e.g. in meeting targets and accepting reforms, (b) that clinical groups renounce their power to oppose change and cede control to managers, and (c) that they accept that survival and progress is dependent on accepting managerial controls, however disagreeable (e.g. for example, given current public sector funding conditions, efficiencies have to be accepted).

Sheaff *et al.* (2003) concluded from their research that clinical governance in Primary Care Trusts resembled a form of soft bureaucracy. However, to make the concept more applicable to the primary care sector, it needed to recognise the power of local professional leaders in this soft bureaucracy, who were able to obtain legitimacy by harnessing their colleagues' perceptions of the relevance of managerial logics to the long-term value of the NHS as a whole rather than strategies (b) and (c) above.

### ***4.3.3: Moving Towards an Accessorized Bureaucracy***

Related to the above notion of soft bureaucracy is the suggestion that the effectiveness of leaders is determined as much by their ability to create and manage impressions of reforming the system as by their ability to achieve concrete reforms (Finklestein, Hambrick and Cannella, 2009). In their analysis of reform within NHS England Buchanan and Fitzgerald (2011) have argued that competing discourses mean that stakeholders in the NHS have a choice of three endings to the story of reform. The first is one of a radical transformation of healthcare into a quasi market, commercially-run system. This is a story that politicians in power have sought to tell and is one also told by many clinicians who use this discourse of transformation as a resource to oppose such change or to secure benefits in return (MacIntosh *et al.*, 2011).

The second story is that despite the numerous reforms, the NHS has remained unchanged as a professionally-dominated bureaucracy, with doctors continuing to exercise negative power to block change and to remain largely reluctant to engage in leadership of the service. This ‘more things change, the more they remain the same’ discourse has led to the leadership deficit argument offered by governments and general managers in the NHS (Grint, 2008). A third ending to the reform story is to see the NHS as a kind of hybrid, where both types of organisations co-exist in practice and in the narratives surrounding it. So, depending on whose interests are being served, politicians, managers and clinicians can point to some level of support for their frequently conflicting positions. According to Buchanan and Fitzgerald (2011), such a hybrid organisation can be thought of as an ‘accessorized bureaucracy’, which allows stakeholders to claim the perception of transformation because the organisation has all of the ‘trappings’ of reform (structures of control, performance management systems, lean management processes and a widespread leadership discourse) but without necessarily having to demonstrate substantive transformation.

Thus, while accepting evidence of transformation, Buchanan and Fitzgerald (2011) also believe that the NHS is increasingly rule bound and that professional power has been strengthened by doctors embedding themselves in the new structures to claim a significant degree of re-capture of their traditional powers. They point to substantial evidence that the

power of the Royal Colleges and other clinical professional bodies has remained strong, and that they have shown a willingness to become involved in clinical and medical leadership.

#### **4.4: Engaging Clinicians in Leadership**

##### ***4.4.1: Multi-Professional Leadership***

As noted in chapter one, NHS Scotland is a complex organisation encompassing acute, primary and community health services. It employs a range of professionals including doctors, nurses and allied health professionals – all of whom are in positions of influence because of their professional credibility. Thus, there is a drive to engage a variety of clinicians from across the organisation in management and leadership (Scottish Government, 2003; 2007; 2010). Consequently, doctors, nurses and allied health professionals can be observed in leadership positions at the top in the form of the Medical Director influencing the direction of the organisation, at the unit level with Clinical Directors leading the team and at the frontline with clinicians who focus on patient care but solve day-to-day problems and improve quality from the bottom up (Kirkpatrick *et al.*, 2009). The focus on multi-professional leadership can also be related to Gittell's (2009) theory on relational coordination (a form of social capital) which refers to how individuals communicate and relate for the purpose of task integration. It is proposed relational coordination is stronger when multi-professional relationships are underpinning by shared goals, shared knowledge and mutual respect. Gittell first applied the concept to the airline sector; however her latest work has been in health care where she has shown that organisations with high levels of relational coordination have better care outcomes and lower overall costs. Central to the theory is that it is not about blaming individuals for poor performance, but rather encouraging us to recognise the immense complexity of creating coordinated experiences for patients. However, it is acknowledged that various personal and social factors can hinder the creation of relational coordination in complex organisations (*ibid*).

#### ***4.4.2: Personal Challenges to Engagement***

Despite the introduction of hybrid roles and the political support for clinical leadership, leadership in the NHS faces a number of challenges, for example: financial pressures and targets can lead to short-term thinking, decisions take a long time to implement because the NHS tends to work on a consensus basis, and the size of the workload and unrelenting pressure can prevent managers from dedicating their time to priority tasks (NHS Confederation, 2007). Kippist and Fitzgerald (2009) identify several specific barriers to the effectiveness of the role of hybrid clinician manager such as time, lack of management education, lack of interest and the unpredictability of the clinical role.

Clinical leaders must balance their time between two professional roles and deal with both vertical and horizontal organisational demands and pressures (Allen, 1995). This can be challenging as professionals often have strong occupational identities and logics and these may be in conflict with the organisation's managerial objectives (Currie, Finn and Martin, 2009; Greenwood *et al.*, 2011). The dynamic nature of healthcare means that clinical leaders often find it difficult to allocate time away from their clinical role to focus on management duties (Kippist and Fitzgerald, 2009). Equally, while some clinicians see leadership as part of their career development and relish the challenge of taking on new managerial responsibilities, others see it as a distraction to their 'main' clinical job (Davies and Harrison, 2003; Kirkpatrick, *et al.*, 2009; Sheaff *et al.*, 2003). Those clinicians who do become involved in management positions are often regarded by their peers as second-rate or disloyal practitioners who have crossed an important 'line in the sand' by going over to the opposition (Llewellyn, 2001). Research also suggests that they are among the least satisfied with managers and with the ability of clinicians to influence reform (Davies and Harrison, 2003). Managers sometimes respond in kind, claiming that many clinicians are naïve and form a frequently 'disloyal opposition' because they fail to understand or do not wish to understand the complex realities and financial stringencies involved in running the NHS including the pressures managers face from politicians, other service providers and patient interest group. As a result, all too often the relationship between managers and clinicians becomes characterised by fixed and opposing positions, and 'disconnected dialogues' (MacIntosh *et al.*, 2011).



#### ***4.4.3: Ambiguity Surrounding the Role***

Currie and Lockett (2011) summarise the ambiguity involved in calls for clinicians to become involved in clinical leadership by pointing to three issues. First, powerful professionals such as doctors are often able to exercise control over clinical practice by appointing their own 'leaders' from within their own ranks, who are required to exercise a collegiate form of control without the need for formal clinical leadership appointments. Second, within clinical professions there is a well-recognised horizontal and vertical distribution of power and influence that privileges specialist doctors and marginalises others (Fitzgerald and Ferlie, 2006), thus creating a potential for political opposition to any form of distributed clinical leadership. Thirdly, the performance logics inherent in government control and target setting encourage individual rather than collective responsibility and accountability, sometimes leading to individuals being dismissed or disciplined for major health incidents or poor quality service. In such situations, leadership is more likely to be concentrated at the top because of the perceived risks involved in distributed decision-making and a general unwillingness of professionals to seek to make themselves accountable. They argue that these factors combined are likely to limit the potential for any form of distributed leadership to clinicians. This relates to the wider call within the literature for more contextual configurations of distributed leadership that take account of pre-existing power relations and expectations of individual accountability (Currie *et al.*, 2009; Edwards, 2011; Gordon, 2010; Gosling *et al.*, 2009; Gronn, 2009).

#### ***4.4.4: Limited Leadership Expertise***

Potential issues also arise due to a lack of management education and training. Clinical leaders are often experts within their professions; however they may have only limited organisational expertise which can result in them having a 'clinical' view of management (Iedema *et al.*, 2004; Fitzgerald and Dufour, 1998), a lack of awareness of others roles in the organisation (Ormrod, 1993), poor communication with fellow team members (Lopopolo *et al.*, 2004), and practicing individualistic decision making (Ahmos *et al.*, 2002). Moreover, it has been suggested that having a poor understanding of organisational management and leadership theory can impede strategic planning (Iedema *et al.*, 2004; King *et al.* 2004: cited in Kippist and Fitzgerald, 2009). Thus, there has been a growing

focus on developing the management and leadership skills of clinicians. This was highlighted in a recent report by the Kings Fund in the UK that summed up the desire to engage clinicians in leadership through development initiatives when it stated:

‘Leadership development needs to extend ‘from the board to the ward’. One of the biggest weaknesses of the NHS has been its failure to engage clinicians - particularly, but not only doctors - in a sustained way in management and leadership’. (The Kings Fund, 2011: 3)

Accordingly, as noted in the introduction, several training schemes and development programmes have been launched in the UK, which attempt to equip health care professionals with the leadership and management skills required to manage change and enhance the quality of care delivered to patients (Donaldson, 2001; Large *et al.*, 2005; Scottish Government 2005; 2009). However, there is uncertainty as to how clinical leadership identities are developed and maintained and the role of social context on this process (Fitzgerald *et al.*, 2006; Ham *et al.*, 2011; Millward and Bryan, 2005; Witman *et al.*, 2011). This uncertainty together with the limitations of such distributed forms of leadership are particularly apposite in the face of reforms proposed in the light of current UK government proposals on reform of health and social care, which proposes to distribute leadership to general practitioners. As Giordano (2011) argued, GPs will become the principal actor in the relationships between patients and healthcare, which has already attracted a degree of scepticism among certain healthcare professional groups. This will place GPs at the centre of a complex web of relationships spanning primary and secondary health and social care, some of which will be susceptible to dialogue while others may remain dialectical.

#### ***4.4.5: Critical Perspectives on the Leadership Deficit Argument.***

Like many clinicians, some academics disagree with the fundamental premises of the dominant leadership deficit argument in the NHS. Recent input from critical healthcare scholars into this debate sheds some light on developments thus far and raises some fundamental questions for the future of clinical leadership. One such example is the work of Martin and Learmonth (2012), who argue that leadership in the NHS is part of a wider call for leadership pervading the public sector, the assumption being that it is good for everyone and is effective in producing reform. Nowhere is this assumption more evident

than in the establishment of the National Leadership Council in the NHS in 2009. Critical leadership researchers, however, suggest that leadership is not in everyone's interests and is used as a discourse to mask political control exercised by powerful groups to frame and shape others' sense of identity. They propose that health service staff are being framed and shaped by the discourse of shared leadership to take part in 'governance at a distance', reminiscent of soft bureaucracy, as a complement to more coercive modes of control and the application of hard power.

Martin and Learmonth drew on interviews with 16 NHS CEOs conducted 1998-99 and analysis of policy documents published since 1997. Their discussion of the talk of CEOs during interviews led them to conclude that the discourse of leadership helped these CEOs construct a self-identity that reflected supremacy, prestige and authority, in contrast to the former usage of management. Injecting management into the jobs of healthcare professions has been one of the major achievements of managerialism, they argue, but it was not enough because of its low level status. Consequently, the discourse of leadership has been used because it does not carry, especially with doctors, the same negative connotations – leaders point the way, managers merely direct and administrate (Stewart, 1996).

However, they go further than claiming that leadership is merely a form of 'semantic inflation' or self-aggrandisement, seeing it as a seductive means of constructing the identities of many senior clinicians, especially doctors, who previously would have rejected a managerial identity, thus freeing them from what they perceived to be a low level administrative burden. Furthermore, by pluralising the notion of leadership to allow for front line, shared or distributed leadership as well as leadership concentrated at the top, policy (National Leadership Council, 2010) has created the possibility that everyone is a leader. Provocatively, Martin and Learmonth (2012) raise two key points if this is extension of leadership comes to pass:

- 1) Who will do the following and will they accept their increasingly deprived and peripheral status?
- 2) If the term leadership becomes so widespread and acceptable that management goes out of fashion, it may well become debased and lose its appeal as an acceptable new identity for clinicians.

These ‘limits to re-branding’ have occurred in other professions and are likely to present the NHS, with a new set of problems if leadership as a strategy of reform fails to deliver on its promises that is in terms of what do organisations next (*ibid*).

#### **4.5: Conclusions**

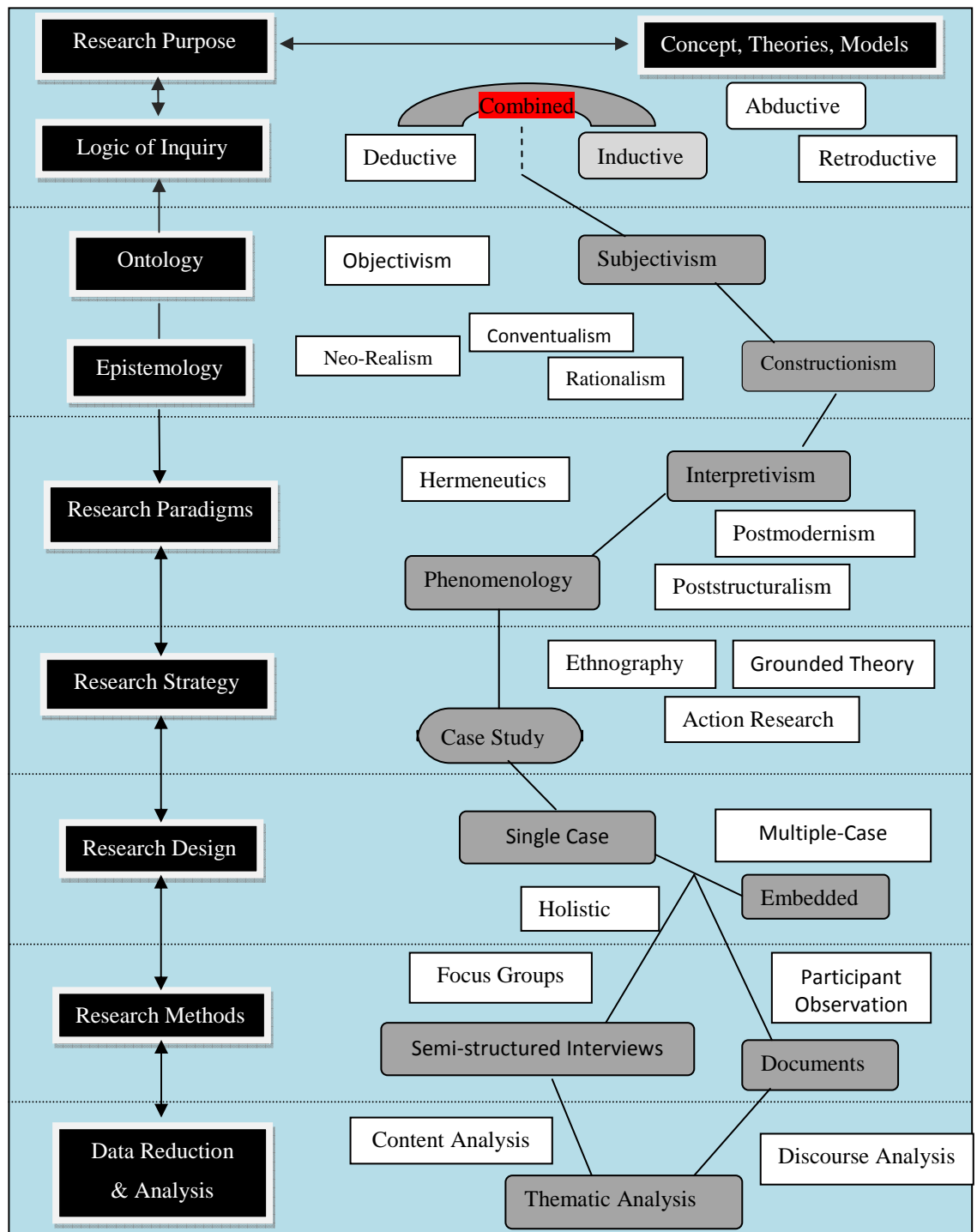
This chapter has considered the policy and academic literature surrounding clinical leadership. It was suggested that clinical leadership has become progressively more important due to a desire to incorporate clinicians, particularly doctors, into the overall management of the NHS to prevent them from using their professional power to oppose reforms. Changes to clinical practice are critical to the reform of service delivery and this cannot be achieved without the cooperation and involvement of clinicians in the process. Yet, enticing significant numbers of motivated and qualified clinicians into clinical leadership roles has not been easy as past tensions with management and strong professional identities has meant that clinicians have often been described as reluctant leaders. Moreover, balancing such dual-roles is complex and fraught with challenges.

Leadership has a better image with clinicians than its predecessor management and the NHS organisations have initiated a number of development programmes with the aim of enhancing the management and leadership skills of clinicians. However, it was noted there are limits to re-branding, to the efficacy and reach of shared leadership and the willingness of staff to treat themselves as followers when everyone else is a leader. Finally, it noted that there is a need for definitions in the field to recognise the complexity, variety, and contextual nature of clinical leadership. Chapter 5 now considers the methodology chosen for this research; an embedded phenomenological case study of clinical leadership development in the Scottish NHS.

## Chapter 5: Methodology

In chapter one the research questions and conceptual framework underpinning the study were introduced. The flow diagram below illustrates how these relate to philosophical and methodological choices made during the study to address the focal research question which are now discussed.

**Figure 5.1: A Methodological Journey**



Source: Based on Blaikie, 2009, p.33

## 5.1: Research Philosophy and Approach

An important consideration when undertaking empirical research within the social sciences is the position of the researcher in terms of ontology, epistemology, and axiology. These parameters describe perceptions, beliefs, and assumptions relating to the nature of reality and knowledge of that reality, as well as the researcher's values. All of which can influence the way in which research is undertaken. A researcher can minimise bias and ensure congruence between their research choices and the original research problem if they are aware of and acknowledge their intrinsic beliefs and preferences (Blaikie, 2009; Miles and Huberman, 1994). Figure 5.1 will be referred to throughout the chapter as it shows the methodological choices made in the current research and the relationships between them. The first three choices relating to research focus, conceptual context and logic of enquiry were discussed in chapter one. This chapter examines the philosophical and research design choices.

### 5.1.1: *Ontology, epistemology and axiology*

Underlying any research project are various philosophical assumptions about what constitutes valid research and how data about a phenomenon should be gathered, analysed, and used (Mingers, 2003). These assumptions revolve around the concepts of ontology, epistemology, axiology and methodology. Ontology refers to our assumptions about the nature of reality and what constitutes reality (Easterby-Smith *et al.*, 2002; Tashakkori and Teddie, 1998). Ontological assumptions are deeply embedded and affect what we view as real and whether we attribute existence to one set of factors over another. Related to ontology is the concept of epistemology which refers to the study of knowledge and encompasses theories of what constitutes knowledge and understanding (Mingers, 2003). Epistemology addresses the questions of: 'what is knowledge'; 'what are the sources and limits of knowledge'; 'how is knowledge acquired'; and 'how do we know what we know' (Eriksson and Kovalain, 2008). Alternatively, axiology is concerned with the individual values or ethics of the researcher and methodology refers to the approach and methods used to uncover knowledge. A researcher's beliefs about reality (ontology), knowledge (epistemology), and values (axiology) form the research 'paradigm' or 'philosophy', which guides and frames their approach to research and methodological choices (Guba, 1990;

Perry and Gummesson, 2004; Saunders *et al.*, 2003). A brief overview of relevant research paradigms is now provided, followed by a detailed justification for the positioning of the present study within an ‘interpretivist’ approach.

### ***5.1.2: Research Paradigms: A Brief Overview***

Different research paradigms (sometimes referred to as philosophies) relate to the fundamental debate within the social sciences of whether or not social phenomena can be studied using a similar approach to that of the physical sciences (Williams and May, 1996). Many classical social and economic theorists (such as: Auguste Comte, John Stuart Mill, Herbert Spencer, and Emile Durkheim) believed that it could and should be. Therefore, much of early social and economic research was *positivistic* in nature (Hughes and Sharrock, 1997). Positivism is a research philosophy (paradigm) that argues that social scientists should explore the observable social reality using highly structured methodologies and should strive towards true empirical knowledge similar to that produced by the physical and natural scientist (Saunders *et al.*, 2003). However, others argue that the very nature of human consciousness combined with social interaction make it impossible to study people or communities in the same way as inanimate objects – there are subjective elements which must be taken into account (Hughes and Sharrock, 1997; Willis, 2007). Consequently, a number of perspectives were developed under the broad heading of ‘Interpretivism’. Interpretivism seeks to gain insights into a phenomenon by taking a holistic approach that draws on the perceptions and views of the ‘social actors’ involved in the phenomenon (Bryman, 2008).

Today, in the social sciences, there are several competing paradigms. Some discussions are organised around the idea that there are two paradigms, quantitative and qualitative, but this is an oversimplification that emphasises data rather than foundational beliefs and assumptions (Willis, 2007). Research philosophies are continually evolving, and the exact number of paradigms and the names associated with them vary from author to author. However, four paradigms are particularly prominent within contemporary social research; these are positivism, critical realism, critical theory, and interpretivism (Bryman, 2008; Willis, 2007). Table 5.1 provides an overview of the key features and philosophical assumptions of each paradigm to guide discussion and situate this study.

Table 5.1: Comparing Research Paradigms

	POSITIVISM	CRITICAL REALISM	CRITICAL THEORY	INTERPRETIVISM
<b>Related Paradigms</b>	Post-Positivism, Functionalism	Post-Positivism, Social Realism, Pragmatism,	Post-Structuralism, Postmodernism	Social Constructionism
<b>ASSUMPTIONS (ontological)</b>	Objective world which science can 'mirror' with privileged knowledge	Our perceptions of reality change continually, but the underlying structures and mechanisms constituting that reality are 'relatively enduring'.	Virtual reality shaped by social, economic, ethical, political, cultural, and gender values. Crystallised over time.	Inter-subjective world which science can represent with concepts of actors; social construction of reality
<b>KEY FOCUS or IDEAS</b>	Search for contextual and organisational variables which cause organisational actions	Develop a better understanding of these enduring structures and mechanisms	Understanding the impact of power relationships in society.	Search for patterns of meaning
<b>KEY THEORIES IN PARADIGM</b>	Contingency theory; Systems theory; Population ecology; Transaction cost; Economics of organising; Dustbowl empiricism	Emergent evolution; Systems theory; Complexity theory	Neo-Marxism; Feminism; Materialism; Frankfurt School theories	Symbolic interaction; Ethno-Methodology; Phenomenology; Hermeneutics; Postmodernism
<b>GOAL OF PARADIGM</b>	Uncover truth and facts as quantitatively specified relations among variables	Explain and understand complex processes taking into account the interactions between mechanisms and the contexts in which they occur.	Encourage an informed populace through displacing ideology with scientific insights	Describe meanings, understand members' definitions of the situation, examine how objective realities are produced
<b>NATURE OF KNOWLEDGE or FORM OF THEORY (epistemology)</b>	Verified hypotheses involving valid, reliable and precisely measured variables	World exist 'out there' but our own presence as researchers influences what we are trying to measure - bias should be articulated	Ideas in relation to an ideology - knowledge is not value free and bias should be articulated	Understanding is contextual - descriptions of meanings and members= definitions of situations produced in natural contexts.
<b>CRITERIA FOR ASSESSING RESEARCH</b>	Prediction = Explanation Rigor; internal and external validity, reliability	Rigor; internal and external validity, reliability, trustworthiness, acknowledgement of potential researcher biases.	Theoretical consistency, Historical insights.	Trustworthiness, Authenticity
<b>UNIT OF ANALYSIS</b>	The variable	The process	Perceived contradictions	Meaning; symbolic act
<b>RESEARCH METHODS and TYPE(S) OF ANALYSIS</b>	Experiments; questionnaires; secondary data analysis; quantitatively coded documents Quantitative: regression; Likert scaling; structural equation modelling Qualitative: grounded theory testing	Background, academic politics, and traditional researcher skills should not define research approaches; the nature of what is to be investigated is the primary concern. Often multi-method and multi-disciplinary Theory building rather than theory testing	Action Research, focus groups, historical analysis,  Often multi-method and multi-disciplinary	Ethnography; participant observation; interviews; conversational analysis; grounded theory development Case studies; interviews conversational and textual analysis; expansion analysis

Source: Blaikie, 2009; Danermark *et al.* 2002, Gephart, 1999; Guba and Lincoln, 1995; Perry and Gummeson, 2004; and Willis, 2007.



Table 5.1 illustrates that a researcher's ontological and epistemological beliefs and assumptions effectively position their research within a particular paradigm and this in turn impacts how they approach the research topic and the methodological choices that they make to address their research question. Though, this is not a one way process, each level influences and is influenced by all the other levels (see figure 5.1). An alternative approach worth noting is pragmatism which places the research problem as central; the researcher chooses the data collection and analysis methods that are most likely to provide insights into the question with no philosophical loyalty to one system of philosophy or reality (Creswell, 2009). There is no justifiable way of asserting with absolute confidence that one paradigm is better than another. Thus, Willis (2007) recommends that researchers should 'acknowledge that the viewpoints and procedures based on another paradigm are accepted and used by 'reasonable' scholars even if they do not agree with them' (p.21). He suggests that having an understanding of different paradigms and the relationships between them allows researchers to work out in their own minds what they believe and make better informed and thoughtful choices (*ibid*). It is also important to remember that while in the table each paradigm appears to be independent the lines are blurred and perspectives overlap (Blaikie, 2009).

### ***5.1.3: Positioning this PhD Study***

Following Willis' (2007) advice, I set on a journey to learn about different paradigms to help me work out my own thoughts and beliefs and to explore how these relate to the research purpose (see figure 5.1). The objective view of the world underpinning *positivism* meant that it did not fit with the current research. The purpose of the study was not to find a direct cause and effect relationship or to test an established theory. Rather the phenomenon to be explored was complex, dynamic, and context dependent (see figure 4.1). Positivism requires that researchers are value free and study empirically observable events (Guba and Lincoln, 1994). Therefore, a positivistic viewpoint could not accommodate the interpretation of unobservable constructs or the exploration of practitioner perceptions as required in this study. *Critical theory* was similarly discounted as the study did not aim to uncover hidden power relationships or to empower oppressed members of society (*ibid*).

Choosing between *critical realism* and *interpretivism* was less straightforward as both, to some extent, are compatible with my world view and research objectives. Both share the epistemological view that knowledge is subjective and socially determined. However, critical realists argue that while our perceptions of reality change there remains a 'real' world to be discovered (Danermark *et al.*, 2002; Mingers, 2000). Alternatively, interpretivism stems from an ontological view that the world and reality are socially constructed and give meaning to people (Easterby-Smith *et al.*, 2002). The interpretivist approach is concerned with subjective, qualitative phenomena which are context rich (Godfrey and Hill, 1995). Interpretivists argue that to understand complex phenomena and patterns in social life researchers must examine all aspects of a phenomena including the meanings that social actors within the phenomena produce and reproduce as a part of their everyday activities together (Blaikie, 2009).

After careful consideration it was decided that *interpretivism* provided the best fit with both the research question and my world view as it emphasised a subjective approach which focuses on deep meanings and aims to understand what is happening in the totality of each situation (Saunders *et al.*, 2003). An interpretivist paradigm is suitable to this study as it recognises that organisational situations are complex, unique and a function of a particular set of circumstances and individuals (*ibid*). The research objectives as set out in chapter one emphasise the investigation of *how* participants of a leadership programme explain its impact on their human and social capital and *how* intellectual capital factors impact on value creation within public sector organisations. Intellectual capital is created through a context-specific and subjective process emerging from previous experiences and current events. Investigating this process requires researchers to view facts and values as intertwined and therefore does not lend itself to the scientific method of enquiry. Thus, the complexity of leadership development in the Scottish NHS and context dependency of this research aligns it with interpretivism. Moreover, the conceptual framework underpinning this research highlights that innovative performance is strongly linked to the attitudes, beliefs, behaviours and group norms of organisational members. This is important as within the socially constructed world the definitions accorded to events and process have real consequences

Interpretivism is flexible in that it allows changes in the research emphasis as the study progresses (Willis, 2007). Crucial to the interpretivist epistemology is that the researcher adopts an empathetic stance (Saunders *et al.*, 2003). Understanding the context in which the research is conducted is critical to the interpretation of the data gathered (Cresswell, 2009; Ritchie, Spencer, and O'Connor, 2003). Thus, a detailed discussion of the political and organisational context in which the NHS operates was provided in chapter one. Interpretivists also recognise that the researcher is part of the research process and seeks a subjective insider view of the phenomena (Saunders *et al.*, 2003). Researchers should reflect on and acknowledge their role, ultimately being careful not misrepresent their value judgments as scientific facts.

Interpretivists are anti-foundationalists; they believe 'there is no particular right or correct path to knowledge' (Smith, 1993, p.120). Although interpretivism is often associated with qualitative methods, interpretivists accept almost all the types of quantitative methods that positivists use, however they differ in how they interpret the results of quantitative research (Willis, 2007). Interpretivists believe that all research methods and standards are subjective therefore fallible, rather than objective and universal. Quantitative research is only one source of understanding and in many cases it is not the preferred mode of research, interpretivists are open to alternate sources of meaning, that post-positivists would regard as subjective, in particular the personal stories of experienced practitioners (*ibid*).

#### ***5.1.4: Interpretivism: A Phenomenological Approach***

Interpretivism is an overarching paradigm which encompasses further specific and focused philosophical views such as hermeneutics, phenomenology, symbolic interactionism, and ethno-methodology. Each of these perspectives suggest different approaches for interpreting the social world; yet underpinning all is the notion that our interpretations are context dependent and influenced by our background and experiences (Bogdan and Taylor, 1975; Holstein and Gubrium, 1994a). A phenomenological approach was chosen for this study, as it is concerned with discovering and understanding the perceptions of those involved in the complex and unique environment of leadership development within NHS organisations.

By focusing on social actors perceptions of situations phenomenologists' seek to describe human activity in a holistic sense. They recognise that contradictory views occur all the time and that the parties involved may not necessarily be lying since 'it all depends on where you are sitting, how things look to you' (Bogdan and Bilken, 2007, p25). Moreover, each of us comes into the research situation with our own preconceptions and presuppositions about the phenomenon under investigation. One of the greatest challenges as a phenomenologist is to put aside or 'bracket' our own preconceived ideas and open ourselves up to how that phenomenon is experienced by the individual. This requires the researcher to identify, explicitly state, and critically evaluate their taken for granted assumptions (Kvale, 1996). Throughout the study, I kept a research diary where I periodically reflected on and documented my thoughts and assumptions and how these related to the participants, phenomenon and research choices (Bogdan and Bilken, 2007; Saldaña, 2009).

Within ethnographic (social interactionist) studies researchers actively enter the worlds of the people being studied to explore the observable, but unnoticed rules people use to survive in cultures (Schwandt, 1994). Similarly, hermeneutic requires the researcher to enter into the data context and engage in dialogue with the text to obtain an in-depth understanding of the setting of the text and its meaning derived from the context (Willis, 2007). In contrast, phenomenology focuses on the individual, it studies how people actively and cooperatively construct the cultures they take part in (Bogdan and Taylor, 1975; Van Maanen, 1983). It follows then that, rather than aiming to reduce subjects to isolated variables or to members of a culture, phenomenological research seeks to understand subjective experience, gain insights into people's motivations and actions, and cut through the clutter of taken-for-granted assumptions and conventional wisdom (Kvale, 1996).

## **5.2 Research Design**

The current research originated in the policy sphere and was funded through the Scottish Government ESRC PhD programme; however I was given the freedom to develop and direct the research focus, design, and approach. There are a variety of research strategies available to researchers including for example ethnography, action research, and case

study. The selection of an appropriate research strategy is influenced by the goals of the research and the nature of the research topic (Yin, 2003). Adopting a phenomenological approach the purpose of this study is to gain an understanding of leadership development in the Scottish NHS from the perspective of those involved (Kvale, 1996). The research question centres on ‘how’ observed phenomena occur and the perceived impact on innovation within the Scottish NHS. This requires an understanding of the nature and complexity of the processes taking place. Thus, a case study approach employing qualitative methods was selected as the most appropriate research strategy for this study as it allows phenomena to be studied in context.

### ***5.2.1: The Case Study Approach***

Case study research is used to investigate a contemporary phenomenon within its real life context, and is especially useful when boundaries between phenomena and context are not clear (Yin, 2003). A research study may be exploratory, descriptive or explanatory depending on whether it is employed to answer ‘what’, ‘how’ or ‘why’ research questions (*ibid*). This research encompassed elements of all three, since the study began with an initial theory of intellectual capital development and public value creation, but it aimed to explore the complexity underpinning this relationship within public sector organisations. Both Miles and Huberman (1994) and Yin (2003) advocate that *case study enquiry* benefits from the prior development of a theoretical framework to guide data collection and analysis. To avoid the possibility of premature theoretical closure I maintained an open-mind and was receptive to new ideas emerging from the data.

The unit of analysis within a qualitative case study can range from individuals to roles, groups, organisations, programmes, and cultures. Regardless of the unit analysis, a qualitative case study seeks to describe that unit in-depth, in detail, in context, and holistically (Patton, 1987; Stake 1995). It is important to remember that a case always occurs in a specified social and physical setting, we cannot study individual cases devoid of their context in the way that a quantitative researcher often does (Miles and Huberman, 1994). In addition, Yin (2003) points out that a case may have sub-cases ‘embedded’ within then. He distinguishes between four types of case study design: single case (holistic); single case (embedded); multiple cases (holistic); and multiple cases

(embedded). A single case (embedded) study design was selected for this research rather than a multiple (or comparative) approach as the purpose was to gain a depth understanding of the single case (Easterby-Smith *et al.*, 2002; Bryman, 2008; Gillham, 2000) by examining different levels of analysis (the organisation, a specific development programme, and participants of the programme) and the relationships between them (Stake, 1995). Comparing and contrasting findings across the individual participants nested within the case (Miles and Huberman, 1994).

A key strength of the case study design (both single and multiple) is that it is a multi-method approach (Gillham, 2000; Lewis, 2003; Stake, 1995; Yin, 2003), which can incorporate various sub-methods. It can gather multiple views (Lewis, 2003; Yin, 2003) and reduce the discrepancy between what people say and what they do (Gillham, 2000). Moreover, phenomena can be observed in context (Lewis, 2003) and unique cultural and social issues can be taken into consideration (Yin, 2003).

There is debate over the validity and reliability of case study research (Bryman, 2008; Ruddin, 2006; Yin, 2003). Critics of the method have suggested that *subjective bias* is inherent within the method (Diamond, 1996: cited in Flyvbjerg, 2006). They argue that it relies too heavily on researcher judgments and as such it is less accurate than quantitative research (Yin, 2003). However, others dispute this argument stating that it neglects the rich insights that case-study researchers can gain into real-life situations (Flyvbjerg, 2006; Stake, 1995).

Yin (2003) suggests that researchers should endeavour to report case study evidence fairly and accurately. He recommends a number of ways that case study researchers can improve both the construct validity and reliability of their research. These include: drawing on multiple sources of evidence; identifying sources of bias and minimising them; developing a *case study protocol* (an overview of the case study project, field procedures; questions and report guide); and developing a *case study database* - a complete, organised and categorised store of all research data and materials. This evidence needs to be woven into a narrative account presenting what Yin (2003) calls the *chain of evidence*.

A further area of contention relates to the external validity or generalisability of case study research (Bryman, 2008; Lewis, 2003; Flyvbjerg, 2006; Ruddin, 2006). Some traditional theorists express concerns regarding the applicability of case study findings to the world in general (Flyvbjerg, 2006; Silverman, 2000). Yin (2003) states that this argument is based on a basic misunderstanding of how to use case material: *‘case studies, like experiments, are generalisable to theoretical propositions and not to populations or universes’* (Yin, 2003:10). In this sense it resembles a qualitative experiment where the researcher will analyse to create theories, not state the commonality of their occurrence (Gill and Johnson, 2002). Case study research is not sampling research; its primary objective is to thoroughly understand the nature of the cases in question (Bryman, 2008; Lewis, 2003; Stake, 1995; Yin, 2003). However, it can inform knowledge (Bryman, 2008; Yin, 2003; Stake, 1995) and present findings that are *‘analytic[ally] generalisable’* (Yin, 2003: 32, adapted). Furthermore, it is suggested that the strategic selection of (*extreme*) cases can improve the generalisability of findings (Flyvbjerg, 2006).

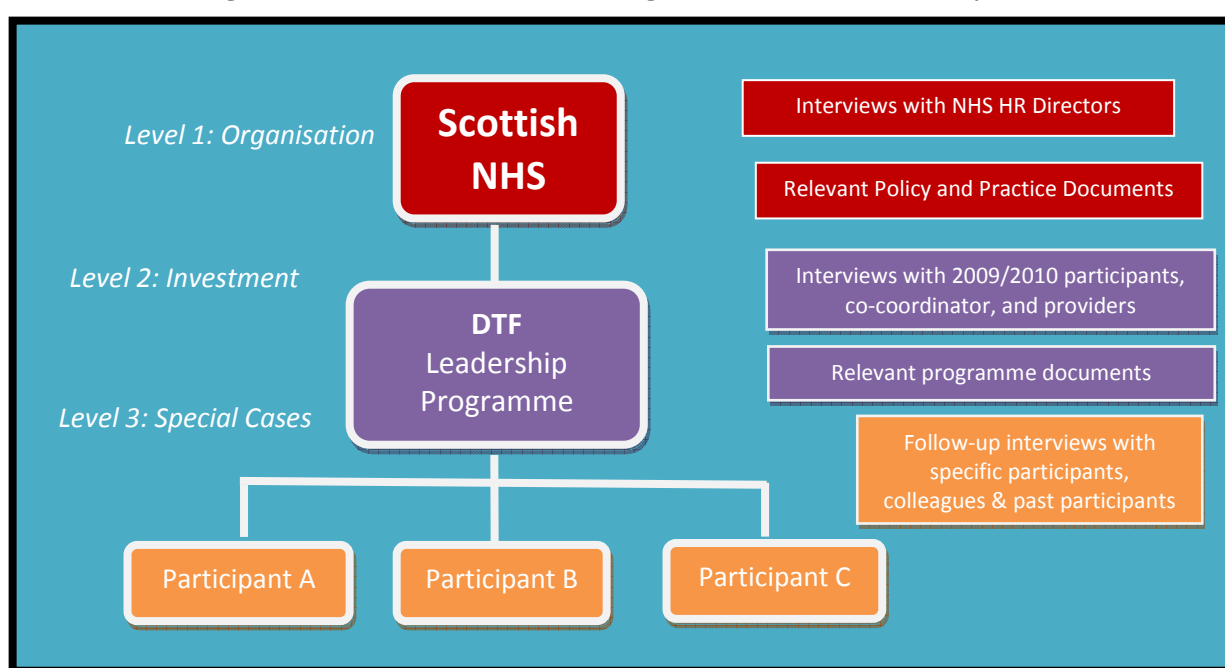
Despite these concerns, an embedded case study was appropriate for this study as it allowed me to examine leadership development within the context of a complex healthcare environment (see figure 4.1). The research objectives emphasised the need for an in-depth study which incorporates the opinions of multiple stakeholders to provide theoretical clarification. Completing an embedded case study was effective as it allowed me to explore the concepts clinical leadership, leadership development and knowledge transfer at a policy, organisational and individual level. Incorporating multiple methods the research was able to account for a range of voices and inform theory and practice.

### **5.2.2: Selection Criteria**

An important part of case study research is identifying a suitable case or cases, which satisfy the research aims and objectives. In an embedded case study design this involves deciding on a primary case then locating an appropriate sub-case or cases within it. An overview of the structure of this study is shown in Figure 5.1. The Scottish NHS was selected as the ‘primary’ public sector case in which to base the current research as it reflected the contextual elements implicit within the research purpose. It is a multidisciplinary organisation that operates in a multitude of contexts and is an important

area of public services reform. The second level of investigation involved an in-depth case analysis of an ongoing leadership development programme targeted at clinical leaders from across all areas and professions within the Scottish NHS. The programme represents a significant investment in the human and social capital of participants and it was chosen as it met the theoretical and policy criteria for the study. The final level of analysis was to follow-up with the colleagues of three clinical leaders from the programme, located in different boards, who had described particularly interesting stories or innovative applications that were relevant to the research objectives.

**Figure 5.2: Overview of Research Design: An Embedded Case Study**



Source: Authors Diagram

Adopting an embedded case study approach allowed me to gain rich insights into the leadership development in the NHS. The purpose was not to produce externally generalisable results, but to thoroughly understand the nature of the cases in question and to provide analytically generalisable findings which can inform wider theory (Yin, 2003). Nonetheless, to improve the validity and reliability of the research I drew on multiple sources of evidence and developed a *case study protocol* outlining the three phases of the case study project, the aims and objectives, interview guides and potential sources of bias. An electronic database was also developed to store research data and materials.



### 5.2.3: *Negotiating Access*

Case access was facilitated through my Scottish Government supervisor. For the initial interviews, following an email introduction from the Scottish Government, potential participants were contacted directly. In the second phase my supervisor and I met with the programme coordinator and negotiated access to the 2009/2010 cohort (completed during the study). I was then given the opportunity to present an overview of the study to the cohort and ask for their assistance. In return I produced a short (fully anonymised) practitioner report for the course coordinators to contribute to the wider programme evaluation and presented summary results back to the participants at a consolidation event in May 2010. This idea of mutual exchange is not new; however it is important that researchers are realistic and specific in their promises (Bryman, 2008; Easterby-Smith *et al.*, 2002).

### 5.2.4: *The Sample*

An important aspect of the study was identifying a sample of relevant people who would participate in the research. '*A sample is a small-scale representation of a larger grouping or population*' (Hedges, 1978, p. 57; quoted by Thomas, 2004). Generally, within case study research, the sample is selected from persons within the case setting (Easterby-Smith *et al.*, 2002). For this study, a purposive or judgemental sample was chosen as this allowed for the selection of participants who best enabled the research questions to be addressed (Miles and Huberman, 1994). In phase one, I purposively selected sample members whom I believed had a wealth of knowledge and experience of human capital management within the Scottish NHS. HR Directors were selected as the aim was to obtain an overview of the contextual issues and current focuses in people management. Phase two drew on evaluation literature and aimed to gather data from multiple stakeholders to provide a holistic examination of the selected leadership development programme. Sample members included participants from the 2009/2010 cohort, the programme co-ordinator, and programme providers (Polonsky and Walker, 2005). Additional participants for phase three, an in-depth analysis of special or revelatory cases, were selected using the snowball technique; this is where subsequent respondents were identified from referrals provided by the initial respondents (Malthotra *et al.*, 2002: cited by Polonsky and Walker, 2005).

The optimum sample size for a qualitative study is difficult to determine and generally depends on the study's purpose (Saunders, *et al.*, 2003). There are no rules with regard to the number of participants; however, it is essential that the information gathered is accurate and relevant. If the researcher hopes to make statistical generalisations a large number of respondents will be needed. On the other hand, if the purpose is to understand the topic as experienced by one specific person, this one subject will be sufficient (Kvale, 1996; Thomas, 2004). Miles and Huberman (1994) propose that: '*at each step along the evidential trail, we make sampling decisions to clarify the main patterns, see contrasts, identify exceptions or discrepant instances, and uncover negative instances where the pattern does not hold*' (p.29, adapted). Within case studies sampling is almost always nested, sampling is theoretically driven and has an iterative or rolling quality, developing in progressive waves as the study progresses (*ibid*).

In this study sampling decisions were made in relation to the study's conceptual framework and research questions. In phase one the participant selection was theoretically driven encompassing stakeholders with a wealth of knowledge of the phenomenon. In phase two, 'intensity' sampling was employed, the research focused on participants who I believed would provide a source of rich information. Lastly, for phase three snowball sampling was used to identify additional stakeholders (Miles and Huberman, 1994). At each phase sampling decisions were also guided by the principles of theoretical saturation. Data was collected until each concept had been fully explored and no new insights were being generated (Bryman, 2008). The final sample was made up of twelve board level HR managers, twenty-one programme participants, four programme providers, the programme's coordinator, and six additional stakeholders (including: past participants, colleagues, subordinates, and managers). All participants were assured anonymity; therefore, all names and references to others and places were changed. Appendix E provides participants' pseudonyms and some brief background details.

#### **5.2.5: A Qualitative Methodology**

Within an embedded case study design both the primary and secondary cases should be analysed holistically to provide an in-depth understanding of each individual case and how

they relate to each other (Bryman 2008). It is recommended that data are gathered from various sources and through multiple methods (Yin, 2003). The research questions and underpinning philosophy influence whether researchers employ qualitative, quantitative or mixed methods to collect data. This study sits within the phenomenological paradigm and it is interested in people's subjective experiences and interpretations of the world. It aims to provide rich insights into the role of leadership development in promoting value within the Scottish NHS. Therefore, I drew on in-depth qualitative methods to gather data that would allow me to investigate relatively little known phenomena through the eyes of those involved in it (Easterby-Smith *et al.*, 2002; Polonsky and Walker, 2005; Saunders *et al.*, 2003; Willis, 2007).

Qualitative research has been defined as:

‘an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not frequency of certain...phenomena in the social world’ (Van Maanen, 1983, p.9)

Qualitative methods are generally based on words rather than numbers. The use of qualitative methods can produce rich insights into complex environments (Lewis, 2003; Saunders *et al.*, 2003; Stake, 1995). They allow the researcher to understand the thoughts and feelings of respondents and can provide the depth behind numbers (Bryman, 2008; Miles and Huberman, 1994; Polonsky and Walker, 2005). This research sought to gain an understanding of the complexities involved in leadership development within professional organisations from the perceptions of those involved. By adopting a qualitative approach I was able to explore the variety of meanings associated with clinical leadership and address the fundamental issue of *how* leadership development interacts with the context to determine individual and organisational outcomes. The use of qualitative methods is in line with social constructionist literature within the field (Fairhurst and Grant, 2010; Tourish and Barge, 2010). In chapter two it was observed that leadership is a theoretically diverse field of research. This diversity is echoed in the methodological approaches employed within the field. Traditionally, much of the literature was dominated by positivist approaches in the form of hypothesis testing, self-administered questionnaires and quantitative analysis. However, the growth of theories acknowledging the social, contextual and processual aspects of leadership have led to an increase in qualitative

studies incorporating methods such as interviews, participant observation, textual analysis and discourse analysis (Bryman, 2011; Kempster and Parry, 2011). Moreover, recently commentators have emphasised the importance of longitudinal research designs that incorporate mixed methods (Day, 2011; Riggio and Mumford, 2011).

### **5.3: Methods**

A multi-method approach incorporating in-depth semi-structured interviews, document analysis, and observation of programme and policy events was employed for this study. Data was collected in three phases (see figure 5.1). Focused, in-depth interviews with selected stakeholders from the Scottish NHS, in particular members of an ongoing national leadership development programme, were the primary method of data collection. NHS and government policy documents relating to leadership development and human capital management together with programme specific documents were collected to aid analysis and contextual understanding. In addition, over a period of two years I attended a number of policy and practice events and observed elements of the programme in action. From these observations I discovered prominent issues and attitudes that I was able to further explore during the interview sessions (Lewis, 2003).

#### ***5.3.1: The Qualitative Interview***

A qualitative interview can be described as a purposeful discussion between two or more people (Kahn and Cannel, 1957: cited by Saunders *et al.*, 2003), in which, the interviewer aims to gain insight into the interviewee's perceptions of a particular topic (Kvale, 1996; Polonsky and Walker, 2005; Thomas, 2004). Qualitative interviews are particularly useful for exploratory research; this is where the researcher does not have a vast knowledge of a topic and requires the flexibility to explore the issue. This study fits into that category as the relationship between investment in people through training and development and the creation of public value is complex, but is not well defined (e.g. Marr and Moustaghfir, 2005). Citing King (1994), Hewison (2002) maintains that:

‘qualitative interviewing is ideally suited to examining topics in which different levels of meaning need to be explored ... [and is] useful in studying organisational and group identities in large organisations such as the NHS’ (p. 550).

Semi-structured qualitative interviews were chosen for this research. Semi-structured interviews are widely used in phenomenological research as they allow respondents to talk about what is of central significance to him or her rather than the interviewer's preconceived ideas (Legard *et al.*, 2003), while the loose structure ensures that all topics fundamental to the study are covered (Bell, 1999). This flexibility was essential to this study as it allowed me to explore different accounts of leadership development within the complex healthcare environment. An additional advantage of the qualitative research interview is that it allows the interviewer to observe the interviewee's body language, facial expressions and tone of voice (Kvale, 1996; Riggo, 1992). Moreover, the interviewer is able to react appropriately by possibly probing the interviewee for additional details or changing the topic if the interviewee becomes distressed or uncomfortable. Misunderstandings can be clarified as they occur. Furthermore, the interviewer can use visual or other aids to ask complex or theoretical questions (Saunders *et al.*, 2003). These benefits cannot always be achieved with other techniques such as a questionnaire or a more structured interview. Nevertheless, the interview situation comes with its own limitations. Interviewers must be careful not to display bias towards a particular view as an interviewee may respond to comments, tone or nonverbal behaviour (Bell, 1999; Collis and Hussey, 2003; Saunders *et al.*, 2003). Thus, for this study leading questions were avoided and participants' answers were clarified, rather than assumptions being made (King, 1994). To prevent confusion or partial answers the interviewer also refrained from asking multiple questions, such as, 'how did you ... and what did you decide?' (Saunders *et al.*, 2003).

A further potential weakness of interviews is that they rely on people's accounts of their actions as representing something beyond the interview situation (May, 1997). Several possibilities can arise from this. For instance, accounts may simply be inaccurate for one reason or another. On the other hand, accounts may be a genuine reflection of a person's experience, but there may be circumstances and events which surrounded the experience of which the person was not aware. Thus, it is argued that a direct and full understanding can be achieved only by studying the context and circumstances of the experiences to which people refer (*ibid*). In this study background observations of policy events, development workshops and cohort-led discussions gave me an insight into the context of leadership development in the NHS. In addition, phenomenological research aims to understand how individuals involved make sense of their world (Weick, 1995). Through interviews with

different stakeholders I was also able to study the phenomenon from multiple perspectives and account for a range of voices.

Research interviews are flexible, sensitive to context and dependent on the personal interaction between the interviewer and interviewee. Hence, a common concern in the literature is that different interviewers will produce different interviews (Kvale, 1996). However, this is not necessarily a fault, the best interviews are those in which interviewees are at ease and talk freely about their points of view, achieving this relies on the craftsmanship, empathy and knowledge of the interviewer (Bogdan and Biklen, 2007; Kvale, 1996). So rather than attempt to eliminate the personal interaction between the interviewer and interviewee, the focus should be on improving that interaction by building rapport, listening carefully and not judging interviewees. Although it is important for researchers to acknowledge these personal relationships, at the same time they must also thoroughly plan and design the interview to allow replication (Kvale, 1996). The purpose is not to change participants' views but learn their views and why they perceive phenomena that way (Bogdan and Biklen, 2007).

### ***5.3.2: Interview Data Collection***

Prior to the interviews, participants were sent a brief introduction to the research setting out the background, purpose and key themes to be covered. For this research four flexible interview guides were developed (see appendix F). There was one for the HR directors which sought to uncover how human capital investments were managed and measured at an organisational level. The remaining three guides covered similar themes relating to the leadership development programme and its outcomes and incorporated Kirkpatrick's (1994) four levels of evaluation and focused on participants' experiences of the programme, how they have applied and transferred knowledge and skills, the influence of contextual elements, and the perceived impact of the programme. However, they differed in focus depending on whether the participant was a programme member, provider or colleague/manager.

All interviews had a common opening: an introduction to the research aim and objectives, participants were then asked one or two open question to gently introduce them to the

topic. For example, programme members were asked to describe their experience of the development programme and how it related to their leadership practices within their job. The rest of the interview was based on a number of themes; which were addressed in a random sequence depending on the natural flow of each interview (King, 1994). These themes included, for example, 'learning in a multidisciplinary group', 'application of knowledge' and the 'experiences of individual elements'. It also investigated the contextual aspects that had aided or hindered the transfer of knowledge and skills into their day-to-day work. The flexible structure of the interviews allowed participants to give their viewpoint and raise topics. The interviewer also prepared structuring questions to bring the conversation back on track, when a theme had become exhausted and probing questions, to extend partial answers (Kvale, 1996).

Interviews lasted between thirty and ninety minutes depending on the interviewee and the time they had available. Phase one encompassed twelve in-depth interviews with HR directors from NHS boards across Scotland. In phase two, 21 in-depth (sixty to ninety minute) interviews with current members of the programme were complemented by five shorter (thirty to forty minute) interviews with the course coordinator and programme providers. Phase 3 involved follow-up interviews with selected case participants and interviews with additional stakeholders in their organisation such as colleagues and past programme members. For participants' convenience, the majority of interviews took place at each interviewee's place of work (Bell, 1999). After participants gave their permission, interviews were recorded using a digital recorder. Recording an interaction minimises 'infection' through interpretation which can occur when dealing with written field notes (Hammersley and Atkinson, 1995). Moreover, it allows the interviewer to engage at an interpersonal level with the respondent and concentrate on using appropriate interview techniques rather than worrying about writing verbatim notes. However, using a recorder can adversely impact the relationship between the interviewee and interviewer as there is an undue focus on the recorder or it may inhibit some interviewee responses and reduce reliability if they are unwilling to state something formally (Saunders *et al.*, 2003). Thus, in the present study to minimise restricted answers the interviewer assured interviewees that if they became uncomfortable at any point the recorder would be switched off. Shorthand notes were also compiled lest the technology failed. Interview transcriptions

were then typed-up using both the recorded conversations and the shorthand notes. Any inconsistencies or possible misquotes were then confirmed with each participant.

An important part of data gathering is trying to minimise the incidence and effect of errors on your research (Polonsky and Walker, 2005). Therefore, interviews were transcribed shortly after each interview and any uncertainties were clarified with participants. To minimise interviewer or respondent bias, prior to the interview each interviewee was supplied with a brief overview of the interview themes; however, typical responses were not suggested. Holstein and Gubrium (2004b) describe an interview as: *'more like a two-way informational street than a one-way data pipeline'* (p.298). Thus, on the day of the interview, the interviewer dressed appropriately and opened the interview professionally. I was aware that the interview was an 'interactional event' - the participants' accounts of their experiences were being *'mutually and collaboratively produced'* (Rapley, 2004, p. 16) through the interaction between us. Hence, I considered myself to be an active participant in the process, guiding the talk, showing interest and encouraging the participant, for instance through 'response tokens' (Rapley, 2004, p. 20), such as: asking for clarification, nodding, and verbal 'umm's', and 'aah's'. Such response tokens also demonstrate to the respondent that interviewer is listening and contribute to meaning construction rather than contamination (Holstein and Gubrium 2004; Saunders *et al.*, 2003).

Interviews were the primary method of data collection as they allowed me to gain an understanding of leadership development in the Scottish NHS from the perspective of those involved. However, additional contextual material was gathered through the examination of pertinent organisational documents and the observation of policy and programme-specific events. The logic and reasoning underpinning these methods of data collection are discussed below.

### ***5.3.3: Documents as a Data Source***

Organisations, and the social actors within them, produce a multitude of documents for a variety of purposes on a daily basis including, for example, reports, guides, prospectuses, and financial accounts. Moreover, they refer to and are guided by external documents such



as government reports, guides, and reviews. Consequently, it is argued that if we want to understand how organisations work and how people work within them, then it is important to consider their various activities as readers and writers (Atkins and Coffey, 2004). Documents are frequently used as a source of qualitative data within case study research (Yin, 2003) as they can be a *'rich source of information, contextually relevant, and grounded in the contexts they represent'* (Lincoln and Guba, 1985, p. 277). In other words, documents, and the processes, thoughts, and organisational activities of which they provide evidence, can offer insights into the content and the context of events in time (Prior, 2003). Documents were collected as secondary source of data for this study as I believed that these would support the interview data by providing an overview of the underpinning policy and an impression of how the programme operates without interrupting or impeding it.

The first task was to identify relevant documents and determine appropriate selection criteria. The present study aims to understand the leadership context within the Scottish NHS and how this has influenced current development approaches and 'learning' application. The main materials analysed for this study include:

- (a) Strategy and policy documents relating leadership in the Scottish NHS;
- (b) Materials provided to participants of the leadership development programme; and
- (c) Materials produced by participants that draw on capabilities gained during the programme.

Strategy and policy documents were collected from a number of sources including the Scottish Government's online publication archive, the NHS Education for Scotland (NES) website, and the NHS Institute for Innovation and Improvement resource webpage. Initial keyword searches were conducted to locate documents relating to clinical leadership, leadership development, and public value. Searches were limited to documents published between 2000 and 2011 as this provided an indication of the policy and practice guidance supporting the case development programme. At the outset of phase 2 the programme coordinator also provided programme-specific documents such as promotional material, training schedules and past evaluation reports. These helped me to become familiar with the theory and background of the programme; however it should be noted that document

selection was at the discretion of a gate keeper. Similarly throughout the research several participants provided personal and organisational texts such as reports and presentations to further illustrate points discussed within the interviews. Due to the nature of their procurement, materials from category (b) and (c) were treated as confidential data. All documentary sources were evaluated in terms of their authenticity, credibility, representativeness and meaning (Thomas, 2004).

#### ***5.3.4: Analysing Documents in Context***

Thomas (2004) distinguishes between two uses of documents in the social sciences either as a resource for research or a topic of research. As a resource, an analyst's main interest is in the contents of the documents. Whereas as a topic, it is the document itself that is the focus of analysis. For this study, documents were seen as a resource in that the 'content' of selected documents can assist in theory development. Yet, it is important to remember that the documents studied were not produced for the purpose of the study, thus relevant data may be restricted. Documents are 'social facts' in that they are produced, shared and used in socially organised ways. They are not; however, transparent representations of organisational routines, decision-making processes or professional diagnosis. Accordingly, analysis should not be confined just to the inspection of the documents themselves, but also incorporate a clear understanding of how documents are produced, circulated, read, stored, and used for a wide variety of purposes (Atkins and Coffey, 2004). It is important to be assured that a document is authentic, free from errors, and meets other criteria of adequacy (Thomas, 2004).

In order to make sense of the textual material considered within this study I produced a database of the included documents recording descriptive details for each document including: who wrote it, why it was written, who was its target audience, the style in which it was written, the language that is used, and how 'facts' were presented (Atkins and Coffey, 2004; Prior, 2003). This allowed me to consider the full context of each document when assessing its reliability and validity. Analysing pre-existing documents requires a different approach from self-generated texts such as interview transcripts. With self-generated texts researchers are able to link the interview questions directly to the research focus therefore when it comes to analysis they already have some direction. In contrast,

when using pre-existing material researchers need to be open and flexible to change depending on what is contained in the documents (Cope, 2003). Thus, in this study analysis was completed in two phases. Firstly, documents were read and examined inductively to identify key themes to be explored within the interviews. Secondly, following the interview analysis (described in section 5.4) documents were coded using the refined thematic coding frame.

Documents are a product of their author(s); they represent views and perceptions and refer to other realities and domains. However, text and documentation are not only produced, but also, in turn, are productive. Documents can lead people to act a certain way because of the way that things are structured and phrased (Prior, 2004). Thus, when studying a particular phenomenon it is important to consider documents that may impact it. For example, the NHS Scotland Leadership Development Framework (Scottish Government, 2005) and related discussion papers and reports, were important to the study as the objectives set out within the framework impacted the structure, content, and delivery of the case programme. There are a number of advantages of analysing documents in this way, for example, the documents were readily available and could be accessed at low cost, the process was user-friendly, and unlike interview responses, documents do not react to the research questions (Cresswell, 2009; Thomas, 2004). The documents also provided an insight into the context and circumstances underpinning the research and gave me the opportunity to explore topics beyond the timescale of the interview study (Thomas, 2004).

Common criticisms of documentary research tend to stem from how they are used, as opposed to their use in the first place. (May, 1997). As discussed above, it is important to recognise that documents are not neutral artefacts; analysts must be critical and consider each document in terms of its potential bias: what people decide to record, to leave in or take-out, is informed by decisions which relate to the social, political and economic environment of which they are part. To overcome this constraint, I critically read each of the documents and recorded my thoughts within the descriptive database. A further limitation relates to the selective reading of documents (*ibid*). Within this study the search criteria for policy documents focused on three main topics: clinical leadership, leadership development and public value. However as noted in the previous chapter, the complex interplay between different elements in clinical leadership development suggests that

additional areas of policy may have informed the programme and influenced the context in which participants apply learning. There are also concerns over the selection of programme and participant documents. Programme documents were provided by a gate keeper, while participant documents were received sporadically and varied depending on what participants volunteered. Despite these issues document analysis was considered a useful secondary method for data collection as it allowed me to understand the foundations of leadership policy within the NHS and the strategy behind the case development programme. Combining this data with the rich, descriptive data gathered within the interviews provided a fuller picture of the complex process of leadership development within the Scottish NHS.

### ***5.3.5: Participant Observation***

Several different methods were considered for the implementation of this study. Some methods available were obviously unsuitable and will not be discussed here. The selection of methods was primarily based upon how well methods would satisfy the underlying philosophy and aims of the study. In addition to qualitative interviews and documents, participant observation was employed to gain background information and build participant rapport. During the study I was given the opportunity to attend a number of policies and programme events as an observer. Participant observation is primarily related to symbolic interactionism and ethnography which encourage researchers to ‘immerse’ themselves within a particular setting in order to gain knowledge of phenomena in its natural setting where the focus is on the contextual and cultural elements of a situation (Gill and Johnson, 2002). However, participant observation can also be used with phenomenological case-study research to build rapport with individual participants and gain an understanding of the context and circumstances which influence members’ perceptions (Yin, 2003). Participant observation is particularly useful in exploratory research where the researcher does not have a vast knowledge of a topic and wants the flexibility to explore the issue as it provides access to the *‘insiders’ world of meaning*’ (Jorgenson, 1989:15).

Participant observation represents intensive investigation and when done properly can provide a rich source of data and give the researcher a *real* insight into the phenomena (Saunders *et al.*, 2003). There are four main forms of participant observation (*ibid*):

- 1) complete participant (involvement - covert) ;
- 2) complete observer (detachment - covert);
- 3) observer as participant (detachment - overt); and
- 4) participant as observer (involvement -overt)

Each of the forms varies with regard to the level of involvement of the researcher - *involvement versus detachment* - and the extent to which the researcher is open and honest about their role with participants – *overt versus covert* (Bryman, 2008; Jorgensen, 1989; Saunders *et al*, 2003). After a thorough consideration of the nature of the proposed research, I concluded that the *complete participant or participant-as-observer* approach would be best to gain the adequate insight into the leadership development experience. Both of these forms require the researcher to become a *fully functioning member of the group* (Bryman, 2008:299). This raises practical problems in terms of time, effort and access (Gill and Johnson, 2002; Jorgensen, 1989). Methodological issues are also raised as it assumes that the researcher's presence will not affect the dynamics of the environment (*ibid*). It also introduces new ethical dilemmas in terms of misleading participants and the potential for psychological harm (Saunders *et al.*, 2003). With adequate planning and rigour each of these issues can be overcome. However such observation studies will require significant investment in time and effort from the researcher (Yin, 2003). Consequently, it was decided that a more selective approach would be adopted for this study.

I attended a range of policy meetings, training days and discussion events relating to the 'case' development programme as well as wider leadership development in the NHS. At these events participants were aware of my presence and knew the purpose of the research. A semi-structured approach to data collection was adopted whereby key statements, activities, interactions between participants, and participants reactions to events were noted in short hand and typed up directly after the observation for future analysis. My role was primarily as an observer; however when asked for my input I responded to minimise any

impact due to the ‘strangeness’ of somebody observing (Jorgensen, 1989). Although this could be classed as ‘participant as observer’ the participant role was limited as I participated in selected activities but did not become a full member of programme. Attending these events also gave me the opportunity to build rapport with prospective research participants. During coffee and lunch breaks I made a conscious effort to engage with participants on a more personal level asking them about their experiences, explaining the purpose of the research and most importantly listening to their views.

Observation gives direct access to people's behaviour. Many researchers doubt whether what people say they have done, are doing or will do in the future bears much relation to their actual behaviour (Deutscher, 1973). Thus, the observations allowed me to gather information about how the programme actually operates, particularly regarding the process of learning through interaction. In addition, I was able to observe specific issues and attitudes that I was able to explore further in the interviews. Despite these benefits, observation remained only a small supplementary part of the current research. The observations within the study provided useful background material, yet observation is not a straightforward process. We notice only some of the things we see, we remember only some of the things we notice, and different people notice and remember different aspects of the same experiences (Thomas, 2004). Thus accurately interpreting behaviours and categorising observations is a complicated task.

## **5.4: Analytical Strategy**

### ***5.4.1: A Thematic Approach***

A major issue of any qualitative research is deciding how the data should be transformed from an extensive assortment of raw materials into a concise and meaningful description of what was observed (Easterby-Smith *et al.*, 2002; Ritchie *et al.*, 2003; Thomas, 2004). In line with the phenomenological perspective a thematic approach was adopted for this study (Kvale, 1996; Willis, P., 2001). This involved disaggregating the mass of qualitative data collected into meaningful and related categories. This then allows the data to be rearranged and analysed systematically and rigorously (Bogdan and Bilken, 2007; Ritchie *et al.*, 2003; Saunders *et al.*, 2003). As the research is explorative it was decided that an

inductive approach to the analysis would be most appropriate. A number of steps were taken to organise, interpret and analyse the interview data (see figure 5.3):

**Figure 5.3: Steps for Analysis of Interview Data**

- a. Shortly after the interviews, transcripts were produced;
- b. Initial summaries of the data were created and key quotes were noted;
- c. These summaries together with a knowledge of past literature allow key themes to be identified (open-coding);
- d. Sections of the interviews were then categorised in relation to these themes;
- e. The data were then rearranged according to this categorisation and new summaries were produced;
- f. Initial data analysis was then completed. This involved looking for patterns or relationships and identifying new themes or categories within the rearranged data (axial coding);
- g. Interviews were then interpreted by considering the data more extensively in order to uncover deeper understandings of the data;
- h. These interpretations were then tested by seeking alternative explanations and negative examples; and
- i. Finally the ideas and emergent theories were linked to past literature.

**Source: Kvale, 1996; Ritchie *et al.*, 2003; Saunders *et al.*, 2003; Thomas, 2004.**

Using the above process an initial six interview transcripts from phase one and ten from phase two were analysed inductively, rather than deductively, to allow themes to be drawn from data and not overly influenced by past research. With induction, theory building takes place after the data has been collected, and is concerned with the context in which events take place (Saunders *et al.*, 2003). An inductive approach enables new insights to be developed, the extension of existing theory, and new theory to be constructed (Miles and Huberman, 1994). In spite of this, the current author and others believe that to avoid the influence of existing theory is near impossible and would take away from an in-depth analysis (Barbour, 2001; Bryman, 2008). As such, the analysis also engaged with current literature and past research findings to encourage a conceptual dimension during the stages of theory generation (Bryman, 2008). Yet, I did maintain an open mind; ‘bracketed’ my own preconceptions and was careful not to assume that existing theory in area represented the final truth. Data was analysed as of the first interview, which allowed themes to transpire during the collection of data (Bryman, 2008; Kvale, 1996; Saunders *et al.*, 2003, Thomas, 2004).

### 5.4.2: Coding Strategy and Using NVivo

A key element of thematic analysis is the creation and application of ‘codes’ to the data. This involves grouping together different instances of datum under an overarching term to allow the description, exploration, and analysis of key themes within the data (Miles and Huberman, 1994; Saldaña, 2009). As it is important to apply codes consistently, following the preliminary manual analysis a thematic coding frame was developed (see appendix G). This sets out the emerging codes along with descriptions of their content and a brief data example for reference. Coding developed as I moved from one transcript to the next so most of the initial categories were descriptive codes or *in vivo* codes taken from the participant responses. Additional analytic codes were also applied to the data after reviewing the literature and research questions. Coding is a flexible process; the identification of categories and patterns help us begin to make sense of the data and explore how different categories relate to each (Cope, 2003; Saunders *et al.*, 2003; Saldaña, 2009). Mind maps were produced to provide an overview of the data and assist in this sense-making process (Bogdan and Bilken, 2007; Miles and Huberman, 1994).

Due to the volume of data the software package NVivo8 (and later NVivo9) was used to aid further analysis of the interview transcripts (QSR, 2008; 2010). The transcripts were imported into it as ‘sources’ and were then coded with ‘nodes’ representing the descriptive and analytic codes. Once the transcripts had been coded a whole range of queries and models could then be performed within NVivo (Bazely, 2007). One example of this is the coding tree model for leadership identity development in Appendix H. This shows the ‘tree node’ of ‘Leadership Identity’ that filters into a whole set of diverse themes / factors. NVivo also displays the number of sources that one particular code was found within, as well as giving the number of instances across all the sources. This was particularly useful in identifying recurring themes. It was these themes that helped structure the empirical chapters of the thesis. This was established through reading across the material (with the help of NVivo) rather than just reading within the material (Jackson, 2001; Miles and Huberman, 1994).



### 5.4.3: Potential Challenges

There are a number of challenges of analysing data in this way. For instance, it is difficult to take account of non-verbal cues such as silences, hesitations, and the use of humour or irony that were evident during the interviews, but which are not conveyed in the text transcriptions (Cope 2003; Kvale, 1996; Silverman, 2007). To overcome this, when exploring key themes I worked across the interview transcripts, recordings and field notes. In addition, several authors argue that during the analysis process codes must be fluid; some may need to be built upon and others disregarded (Cope, 2003; Saldaña, 2009). Thus, as the analysis evolved, categories were refined, merged, split and related to each other to produce a smaller, more select set of themes and sub-categories that represented a more accurate picture of the data. To minimise confusion, as changes were made the coding frame was updated, explanations were noted, and previously coded material was checked.

A further challenge is that coding itself is not a neutral process and different analysers may form different sets of themes as past experiences will filter their interpretations (Bryman, 2008; Kvale, 1996). Bogdan and Bilken (2007) suggest that the impact of this could be minimised by presenting some of the coding back to participants to see if they find them accurate. Thus, themes were presented back to participants in the form of feedback sessions and summary reports. These together with subsequent discussions allowed for the accuracy of the analysis to be checked with the group. Throughout the study themes were also discussed with my supervisors (Saldaña, 2009). Commentators have also expressed specific concerns over the use of computers in qualitative analysis (see table 5.2).

**Table 5.2: Pros and Cons of Using CAQDAS in Qualitative Research**

<b>Advantages</b>	<b>Concerns</b>
Managing large quantities of data Convenient coding and retrieve Comprehensive and accurate text searches Quick Identification of deviant cases More time to explore 'thick data' Playful relationship with data-enhanced creativity	Obsession with volume Mechanistic data analysis handling Exclusion of non text data Overemphasis on grounded theory Loss of overview The machine takes over – alienation from data Makes qualitative research look more scientific

Source: Adapted from: Hoven, 2003, p 472.

Proponents of computer assisted qualitative data analysis (CAQDAS) argue that it facilitates an accurate and transparent data analysis process and assists the management of large volumes of data (Welsh, 2002). However, others have suggested that computers can distance researchers from their data, encourage quantitative analysis of qualitative data, and reduce variety in methods across the social sciences (Hoven, 2003; Welsh, 2002). Although early programs were predominantly tools for data storage and retrieval rather than analysis NVivo 8 promotes closeness to the ordinal data by providing rapid access to original documents and the reorganisation of coded text. It also has tools for summarising and modeling data which allow researchers to take a step back and look across all of the data (Bazely, 2007). With regard to concerns that CAQDAS will reduce variety and encourage a more positivistic approach it is important to remember that NVivo does not actually code the data for you (Bogdan and Bilken, 2007). The thematic analysis in this study was informed by phenomenology and incorporated a flexible, reflective approach to coding. Additional interview summaries and thematic mind maps were produced to assist further analysis within and across individual texts.

#### ***5.4.5: Triangulation***

This research incorporates an element of triangulation. This is based on the assumption that different methods and sources of data can be used to understand one another (Bryman, 2008). Denzin (1978) has identified four basic types of triangulation (1) data triangulation - the use of a variety of data sources in a study, for example, interviewing people in different status positions or with different points of view; (2) investigator triangulation - the use of several different evaluators or social scientists; (3) theory triangulation - the use of multiple perspectives to interpret a single set of data; and (4) methodological triangulation - the use of multiple methods to study a single problem or programme, such as observations, interviews, questionnaires, and documents. This research incorporates elements of types (1) and (4) as a variety of key stakeholders with different perspectives were interviewed and these interviews were complemented with data gathered from documents and observations of relevant events.

Although the documents and field notes were not analysed within NVivo the themes that emerged from them were coded separately and interlinked with the code trees that were

built within NVivo. This allowed data to be examined in such a way to produce findings or conclusions that were based on several sources of information (Yin, 2003). For example, what people said in relation to events was corresponded with the field notes of those events and policy and programme rhetoric described in the documents was explored during the interviews. It is argued that such findings may be more convincing and accurate than those produced by a single source (Yin, 2003). However, others suggest that triangulation is just part of the course, if a case study design incorporates multiple sources and modes of evidence then verification should be built into data collection process (Miles and Huberman, 1994). Within phenomenological research the aim is to understand phenomena from the perspective of different stakeholders, not reality. Thus, employing multi-methods and noting inconsistencies and contradictions assists analysts to understand and account for different voices (Willis, 2001). Nonetheless, it is important to note that the very nature of qualitative research implies that there will be disparities in the collection and interpretation of data. Therefore, this research aims to gain insight to a complex issue at a single point in time and does not propose generalisability to all of the UK.

## **5.5: Research Governance and Ethics**

Ethical Considerations arise in any human subject research and organisational research is no exception. Therefore, it is important for researchers to consider the implications of their research and work to minimise the risk to research subjects and their environment. When researching within communities or organisations the researcher must remember that their presence is only temporary; whereas those that are being studied will still have to operate within the environment once the research is completed (Saunders *et al.*, 2003). Consequently, the researcher must be sensitive to organisational politics and the power relationships that exist within the organisation (Easterby-Smith *et al.*, 2002).

### ***5.5.1: Ethical Codes and Key Considerations***

There is ongoing debate about how valuable ethical codes are in relation to research. Some argue that codes can be too rigid and simplistic to deal with real cases. However, I believe that adhering to such codes can guide good practice and improve the credibility of the research with participants. Thus, I adhered to the University of Glasgow's *Principles of*

*Ethical Research* (see appendix I). Moreover, I followed the advice of Mason (1996) who suggests that researchers should be reflective in their approach and regularly re-evaluate the ethics and politics of their own research practice (cited in Easterby-Smith *et al.*, 2002)

There are six key interrelated areas of controversy within social research: voluntary participation; informed consent; researcher objectivity; data protection and retention; potential for harm; and confidentiality and anonymity (Bryman, 2008; Easterby-Smith *et al.*, 2002; Saunders *et al.*, 2003). Fundamental to each of these issues is the notion of privacy. The researcher should respect the privacy of both potential and actual participants. This means respecting their right not to participate, being honest about the nature of the research, making clear that the participant does not have to answer questions they feel uncomfortable with and managing the data gathered in a way that observes the agreed anonymity and confidentiality (*ibid*).

### **5.5.2: Ethical Access and Veracity**

Negotiating access can create a number of ethical dilemmas for the researcher. Participation should be voluntary, potential participants should not be pressurised into participation, and researchers should gain informed consent from participants (Bryman, 2008; Robson, 2002). Informed consent implies that participants should be fully informed of the nature of the research (Saunders *et al.*, 2003). The argument here is if the researcher attempts to deceive participants in some way, for instance by disguising the *true* purpose of research, they run the risk of causing embarrassment to promoters and participants of the research (*ibid*). Therefore, I was as honest as possible regarding the purpose of the research with both potential *gatekeepers* (people that I negotiated access with) and participants (Easterby-Smith *et al.*, 2002; Saunders *et al.*, 2003). For this project one of the conditions of access was that confidentiality and anonymity would be provided to participants. A number of steps were taken to ensure that this promise was met, for example: transcripts and audio recordings were anonymously and securely stored, ethical consent forms were stored separately and I was careful not to repeat confidential material to other stakeholders.

### **5.5.3: Data Collection and Ethics**

During the collection of data the researcher must again bear in mind participants right to privacy (Easterby-Smith *et al.*, 2002). Thus, within this research, during interviews I reiterated that participants had the right: to withdraw from the research at any time, to decline to respond to a question and to ask for the digital recorder to be switched off if they felt uncomfortable (Bryman, 2008; Robson, 2002; Saunders *et al.*, 2003). Within qualitative research controversial topics can arise during one interview that a researcher wants to explore further with other participants. This occurred within this study when a few of the early participants mentioned aspects that they had found particularly useful or informative as well as those that they felt were less useful or frustrating and I wanted to check if other participants had similar experiences. However, I was careful not to disclose the identity of the person who provided the inspiration either directly or indirectly (Easterby-Smith *et al.*, 2002). An additional ethical consideration relates to the objectivity of the researcher, it is important to ensure that data is collected accurately and completely (Saunders *et al.*, 2003; Yin, 2003). This issue also relates to the validity and reliability of work produced. A further practical consideration is that interviews should be arranged at a time that is convenient for participants and interviewers should aim to keep interviews within the prearranged timeframe. It is also important to show participants respect by avoiding asking questions that are demeaning or overly sensitive (Sektaran, 2000) and participants should not be pressed for a response as this may make the process stressful for them

#### ***5.5.4: Ethical Analysis, Reporting and Storing of Data***

It is important to keep ethics in mind during the analysis and reporting stage. Objectivity is particularly important at this stage as a lack of objectivity can alter conclusions and subsequent courses of action that may be taken as a result of the research (Saunders *et al.*, 2003). Thus, under no circumstances should researchers deliberately misrepresent data. Ensuring confidentiality and anonymity are also particularly important at this stage as allowing a research organisation or programme to be described in such a way that leads to competitors or other key stakeholders identifying may cause loss of business or embarrassment. In addition, it may make access difficult for future researchers, which goes directly against the general principles of ethical research (Saunders *et al.*, 2003). Furthermore, if the identity of an individual is easily identifiable it could result in personal

embarrassment or even psychological or actual harm for the individual (Robson, 2002; Saunders *et al.*, 2003). Sometimes it may be difficult to maintain the assurances given, for example, due to legal circumstances; however, the researcher must take every effort to do so.

The introduction of data protection legislation has placed renewed emphasis on the need to protect the privacy of participants when retaining data (Saunders *et al.*, 2003). Data protection principles are similar to informed consent in that they contend that all potential subjects should be given full information about the purpose of the research, the kind of data to be gathered, and the security of that data once gathered, before deciding to take part (Foy, 2004). Also, participants should have the opportunity to review the research and withdraw their consent at any point. Personal data collected about participants should also be kept securely and no longer than is necessary (Saunders *et al.*, 2003).

#### ***5.5.5: Taking Stock: An Ethical Study***

To conclude the research was approved by the Business School's Ethics Committee and was governed by the University of Glasgow's principles of ethical research (see, appendix J). Taking into account the debates above, I took a number of steps to minimise the potential for harm for both the participants and the research environment. I was open and honest about research. Informed consent was obtained from participants at the outset with each participant completing an ethical consent form. Coding was used during the gathering and processing of interview notes, recordings, and transcripts. Moreover, data has been stored and managed in a way that protects the confidentiality and anonymity of the people involved in the study.

### **5.6: Methodology Conclusions**

Figure 5.1 illustrated that researchers make a number of interconnected philosophical and methodological choices when completing social research. This chapter has attempted to guide the reader through the choices made for this study. Considering the alternative philosophical perspectives, it demonstrated that an interpretivist phenomenological approach was suitable as it fitted with my world view and corresponded with the research

objectives. Moreover, it was established that an embedded qualitative case study approach would be the most appropriate research design as participants' perceptions were required and leadership development is a complex and unfamiliar topic. In terms of methods, semi-structured interviews were proposed as a suitable means of gathering the primary data and it was acknowledged that supplementary data from documents and observations would provide useful background information relating to the research context. The case selection and sampling technique was also reviewed and an outline of the analysis process was provided. The next four chapters examine the results of the study which are discussed under three main categories: phase one -the organisational context (chapter 6); DTF as an identity workspace (chapter 7); the personal impact of DTF (chapter 8); and clinical leadership and the organisational impact (chapter 9). Chapter 10 then discusses the findings in relation to the literature and considers their implications. To conclude, chapter 11 summarises the thesis, acknowledges its limitations and makes suggestions for future research.

## Chapter 6: Phase 1 – Organisational Context

### 6.1: Introduction to HR Data

The current research commenced with the broad aim of exploring the role of human capital investment on public sector reform. The philosophical underpinnings and methodology of the study were discussed in chapter 5. It established that an embedded case study design was appropriate for the study as it allowed the researcher to examine human capital development within the context of a complex healthcare environment and facilitated the inclusion of multiple stakeholder views. A rationalisation for the selection of the Scottish NHS as the ‘primary’ public sector case was provided in chapter 5. With a view of focusing the research question and design, the aim of phase one was to gain insight into the current HR challenges and priorities within NHS Scotland. This is the first of four Chapters discussing the empirical findings of the research. The findings from phase one informed the design of an in-depth case analysis of a specific human capital investment, namely a leadership programme targeted a senior clinical leaders. Chapters seven, eight and nine are categorised thematically and examine in detail the findings from the case analysis. This chapter considers the key themes that emerged during phase one and explains how these influenced sub-case selection.

Data for phase one was primarily collected through in-depth semi-structured interviews with twelve HR Directors (and/or their representative) from eight NHS boards across Scotland. Supplementary contextual information was obtained through analysis of policy and organisation specific documents. The semi-structured interviews considered five main topics including: current approaches to development; future investment areas; current approaches to measuring investment in people; methods for assessing management and leadership capability and thoughts on how wider organisational issues impact intellectual capital development. The interviews were completed over a period of twelve months – the first six in December 2008 and January 2009 and the second six between October and December 2009. Transcriptions of each interview were produced and analysed using the thematic approach described in chapter 5. Three overarching themes emerged from this analysis: (1) *political and economic context*; (2) *HR’s priorities for managing change*; and (3) *understanding means more than measurement*. Each theme is now discussed in turn.



Representative extracts have been used to give an impression of the interviewees' views on people management within the Scottish NHS.

## **6.2: Political and Economic Context**

As a public sector organisation the Scottish National Health Service is accountable to the Scottish Government and is heavily embedded within the wider public policy agenda. Thus, it is not surprising that changes in the economy, demographics and government policy were perceived by all of the interviewees to impact the organisation's human resource priorities. Interviewees drew attention to four factors that have especially influenced their strategic planning over the next five to ten years. These included: political drivers and targets (6.2.1), Agenda for Change (6.2.2) the European Working Time Directive (6.2.3), the ageing workforce (6.2.4); and the global economic crisis (6.2.5).

### ***6.2.1: Political Drivers and Targets***

This section considers how legislation and external political targets, such as those relating to waiting times, referral to treatment, staff recruitment levels, can lead HR managers to feel that limited autonomy over aspects of their work. The interviewees suggested that this can lead to personal stress and has the potential to have dysfunctional organisational consequences. Thus, there is a need for those working in an NHS context to develop coping strategies and for policy makers to ensure that organisational targets are focused and well-defined. Interviewees discussed a variety of political drivers that influence the Scottish National Health Service's recruitment and development plans including: the commissioning levels of university education for health professionals, HEAT (Health Improvement, Efficiency, Access, and Treatment) targets, and changes in government policy following parliament elections. Almost half of those interviewed thought that it was difficult to accurately predict workforce requirements in the long-term as they are in part driven by changes in government policy. The quotation below illustrates how a specific government initiative, the Modernising Medical Career (MMC) programme, has influenced the level of demand for junior doctors in NHS Scotland.

‘At the moment we are looking at how we train doctors and the new MMC initiative to align ourselves with Europe ... the government are looking at the supply side, in

terms of the training that they directly commission, whether that is undergraduate or postgraduate level. So in health, the government will commission via the Scottish Funding Council doctors, nurses, midwifery, and dental training. They are all controlled occupations and numbers are set by the government and that in effect is our future supply chain in terms of workforce planning ... You don't want to have too many or too few. Too few is a disaster, we can't provide enough services, we have to go out and buy them and they're very expensive; or too many, you have headlines about why have we got the unemployed physios / doctors – what a waste. We're training them all, but we can't afford to employ them. And that is an impossible balance to achieve' (HRD5).

The excerpt above is of particular interest as it shows how government influences the supply of different health professionals within the NHS through the number of university places it commissions. It illustrates the potential problems that can arise when supply does not meet demand and the lack of control over the process by individual boards. The NHS operates in a political context and the statement 'what a waste' also highlights that society will judge the organisation negatively not only if there are too few staff but also if there are unemployed professionals. Government targets also shape service demand which in turn effects NHS Scotland's recruitment and development objectives. A small minority of participants spoke positively of targets suggesting they can serve a useful purpose in motivating staff:

'We are very much target driven and that is fine, the reality is people deliver targets' (HRD10)

However, several interviewees noted how the HEAT targets related to, for example; sickness absence or waiting times not only influence the organisation's objectives but also its wider culture:

'If you work in the NHS you are really busy and the pressure can be relentless – we work in an environment where we have lots of targets to meet ... it doesn't make any difference whether it is the Labour party, the SNP or anybody else for that matter that is running the health service, politicians generally like targets because it allows them to demonstrate back to voters that progress is being made, doctors quite often don't want or like targets because they argue that there can be a risk that when you strive to hit one target you are influencing their clinical judgment about what they would do and when they would do it. Also it may be that in certain circumstances you don't want to create an environment where you would be encouraging people to do things if a more conservative approach to it might be in the patient's best interests. So would you pay a dentist on the basis of the number of teeth they take out right, if you do that and it in any way encourages them to take people's teeth out

that perhaps with a longer-term , different approach might have resulted in a more conservative treatment plan' (HRD3)

The extract above is worthy of note as it demonstrates the widespread view that too many targets leads to a pressurised working environment for health care employees and poorly developed targets can result in unintended outcomes. Moreover, it also highlights the tensions that can arise due to the timescale of targets; politicians arguably are focused on the short-term while medics are focused on longer-term goals. Despite concerns of the potential negative consequences of having a target culture, there was a general feeling that this is a common aspect of public sector organisations and most people in the NHS accept the need for targets. Yet, others contended that to avoid the negative aspects of targets senior managers must build constructive relationships with politicians and act as an intermediary between them and clinicians to create meaningful and achievable objectives. Working with government in this way was related to the current policy focus on working across organisational boundaries to improve efficiency and public value. However, some interviewees also noted the difficulty in maintaining strong relations when new MSPs are elected every four years:

'I've seen the challenges I think in terms of the political drivers, you know, whether it's one or two administrations. I mean, from pre-devolution, post-devolution ... it's reconciling some of the stuff we had to do which was UK, versus some of it which is Scottish, but we're now looking at the challenges of a relatively young government and obviously you have to work with different ministers, cabinet secretaries and different director generals.' (HRD11)

The comment alludes to the election of a Scottish National Party (SNP) government in Scotland in 2007. This highlights the problems of working under different administrations with their own priorities and targets, but also, from an organisational behaviour perspective, with different personalities (Judge *et al.*, 2008). The SNP victories in 2007 and 2011 have been described as historic; prior to 2007 the party had never before bettered Labour Scotland-wide and in 2011 the SNP achieved a majority of seats under a system designed to make it unlikely that one party achieves a majority without a majority of the vote. Table 6.1 provides an overview of the Scottish Parliamentary results since devolution in 1999.

**Table 6.1: Scottish Parliamentary Election Result (MSP Numbers)**

	2011	2007	2003	1999
Scottish National Party	69	47	27	35
Scottish Labour Party	37	46	50	56
Scottish Conservatives	15	17	18	18
Scottish Liberal Democrats	5	16	17	17
Scottish Green Party	2	2	7	1
Scottish Socialist Party	0	0	6	1
Scottish Senior Citizens Unity Party	0	0	1	0
Independents	1	1	3	1

**Source: The Scottish Parliament Online SPIC Briefing Reports 1999 - 2011**

There are some important implications of a majority SNP government in Scotland. The most immediate and significant effect is that there is now a clear mandate for SNP policies. The SNP may introduce a bill to hold a referendum on independence and pursue policies for which it had insufficient parliamentary support in 2007. This could bring about further division between the Scottish and English health sectors. However, SNPs ability to pursue policy innovation is limited by the financial climate and many of its decisions will relate to which aims to prioritise or drop, rather than which new policies to fund.

The 2011 election had not taken place when the phase one interviews were completed but, as indicated in the previous quote, interviewees did highlight the difficulties in producing future plans and building relationships when the composition of government changes every four years. In 2007, 41 of 129 MSPs (31.8%) did not serve in the previous parliamentary session. Similarly, in 2011 48 of the elected MSPs (37.2%) had not served during the previous term (Herbert *et al.*, 2007; 2011). This means that often senior NHS managers have to start afresh, building new relationships and adapting their approach to match with a new agenda. One area of policy reform that has had a significant impact on human capital management in NHS Scotland is the 2004 pay modernisation agreement, ‘Agenda for Change’.

### **6.2.2: Agenda for Change**

The following section considers the role of *Agenda for Change* on HC management within the Scottish NHS; in comparison with past studies which have suggested that the system has been met with resistance (The Kings Fund, 2007) many participants viewed it as a positive influence. *Agenda for Change* is a national pay system that has been implemented

throughout the UK; it covers all non-medical staff in the NHS, including qualified nurses, and aims to deliver consistent and fair pay to staff based on the principle of ‘equal pay for work of equal value’ (NHS Scotland Management Steering Group, 2009). The system provides common terms and conditions for all staff and is supported by the NHS Job Evaluation Scheme and the NHS Knowledge and Skills Framework (KSF). KSF provides a framework for the review and development of each staff member and is the basis for determining an employee’s pay and career progression within Agenda for Change (Department of Health, 2003).

As with previous research (e.g. The Kings Fund, 2007) some interviewees mentioned issues that they had experienced during the implementation of the system in terms of getting staff on board and having the resources to process the vast amount of data required. However, most interviewees spoke positively of the system and advocated KSF as a key means of evaluating training requirements, and engaging staff in performance management.

‘The knowledge and skills framework, which is in Agenda For Change, I think begins to help us with that [overcoming staff mistrust of performance management] because that allows people to have meaningful discussions with their staff around their development needs, now that doesn’t directly relate to their performance but it sets a culture that might be a little different than what we have had in the past and for the first time it is systematic and covers the whole of the workforce with the exception of doctors and senior managers so I think that gives us an opportunity.’ (HRD1)

In one board KSF was also promoted as a catalyst for greater managerial and leadership training and development.

‘we’re hoping to bring some of that through the knowledge and skills framework and the personal development plans ... but the struggle is that it is very hit and miss here around people development ... the technical [clinical] side is very, very good and it is very well established, but that is pretty well it as far as the development goes which I think is quite narrow, quite limited - we need to explore our leadership capabilities within the organisation.’ (HRD2)

The quotation above illustrates the impression given by a small number of interviewees that in the past the focus has been on developing clinical rather than leadership capabilities. One explanation put forward was that education and training for health care professionals

is heavily regulated through government legislation and numerous professional bodies such as the British Medical Association, Royal College of Physicians, and Royal College of Nurses. This brings the discussion to an area of legislation that has heavily influenced human capital management within the Scottish NHS over the last few years, The European Working-Time Directive.

### ***6.2.3: European Working-Time Directive (EWTD)***

This section reflects on the perception that external legislation such as the EWTD can create new demands, challenges, opportunities, and choices for NHS HR managers. In addition to Scottish Government and internal NHS strategies, interviewees noted a range of external factors which have also influenced human capital management within the Scottish NHS, not least is the need to comply with legislation.

‘But there’s a whole range of other external factors that suddenly come in, like MMC, like working time, which are not Scottish Government controlled factors. In fact the timetable for implementing a lot of this is out of our control. So MMC is UK wide driven by pressures internationally. Working time is a European piece of legislation that we have to implement’ (HRD5)

A key area of legislation that they have had to implement in recent years is the European Working-Time Directive which was introduced in the UK in 1998 to regulate the amount of time spent at work in order to protect the health and safety of the workforce. The Directive stipulates that a person's average working week must be no longer than 48 hours in seven days. Working time includes job-related training, travelling time and paid overtime, but excludes normal travel to work, breaks when no work is done and voluntary unpaid overtime. Workers are entitled to a minimum rest period of 11 consecutive hours in every 24, as well as a rest break during working time if they are on duty for longer than six hours. They are also entitled to a minimum uninterrupted rest period of 24 hours in every seven days. Night workers are entitled to extra protection. Average working hours must not exceed 8 hours per 24-hour period.

Two important test cases provided further clarification. Firstly, the SIMAP judgement by the European Court of Justice in 2000 defined all the time that the worker is required to be present on site as actual working hours for the purposes of work and rest calculations.

Secondly, the Jaeger judgement in 2003 confirmed that the above should hold even if the worker is allowed to sleep when their services on site are not required. These clarifications have had a profound effect on workers who are required to be resident on site when on call - particularly junior doctors (Blake, 2010). Consequently, doctors in training were given special dispensation to comply in stages: the working week for junior doctors was limited to 56 hours in 2004 and the 48 hours week was fully introduced in August 2009. Since full implementation the Directive has received criticism with regard to the ability to provide junior doctors with sufficient training and the effect of shift patterns on patient safety (see, e.g. Royal College of Surgeons (2009) for an evaluation).

Despite these criticisms interviewees described ways in which they have managed implementation of the directive within their boards by thinking innovatively and looking for alternative solutions. The following excerpt illustrates one innovative approach:

‘The multidisciplinary team is absolutely critical. I think what has been quite useful for us at the moment, you know the European Working Time Directive, where we had to *get all* the rotas to 48 hours, well the solution here, and some consultants would tell you the solution is more consultants, but we can’t afford them. So we have had to think more laterally, and it has been things like using nurse practitioners, using allied health professionals, using GPs with special interest, using junior doctors, whatever it might be, using things differently, being imaginative in terms of all of this and we have brought in sixty new staff, but they are by no means all medics, they all come from different disciplines. So I think you have to think differently and more holistically about how you deliver care.’ (HRD12)

The statement above emphasises the perception that to cope with contemporary workforce challenges HR managers in NHS Scotland need to think innovatively and deploy the health care professionals differently. On the other hand, it also raises the issue of extending the work of other professions, the training this requires and the potential for work intensification so that everyone is doing more.

#### ***6.2.4: An Ageing Population***

A further external challenge which several interviewees raised, especially in the early interviews, related to the impact of an ageing population on strategic planning within the Scottish NHS. Participants saw the demands of the ageing workforce as significant but they also saw it as an opportunity to develop new ways of organising services. Scotland is

experiencing major demographic change. The population is both ageing, driven by rises in life expectancy, and shrinking as a result of falling birth rates. Between 2008 and 2033 the number of people aged 60 and above is projected to rise by 33% and the number aged 75 and above is projected to increase by 84% (General Register Office for Scotland, 2009). This creates two main issues for the NHS in Scotland. The first relates to the increased demand created from an ageing population and the need to redistribute care provision to meet this demand. This was illustrated by one interviewee when he explained his board's approach to overcoming the predicted demographic challenges:

'Now, if you look at the demographics of the population of Scotland and the health needs of the future, it's going to be around people with what you would say is co-morbidities - lots of things wrong with them, getting older, and the vast majority of Scotland will be older with lots of things wrong with them. And the real focus for care in the future is going to be around delivering care in the community to people with long-term conditions, so that could be asthma, it could be chronic obstructive pulmonary disease - COPD - it could be cardiac issues, it could be obesity, it could be, etcetera, and chances are you'll have one or more of them by the time you reach your late 50s...' 'So we're doing a big piece of work around that in our board and it's about providing education and training for professionals to train patients to do that, but also about joint training between professionals and carers and patients, and it's really been quite interesting. But given the demographic changes, if we don't do that then the danger is we'll be swamped with people looking for a bed in a hospital, and to do that we need to work with the voluntary sector, and with social care.' (HRD5)

On the other side, the second issue relates to the NHS's own workforce. Recent reports have predicted future skill shortages in the sector. For example, in 2008, a Royal College of Nursing Scotland Report stated that one in four nurses working in NHS Scotland was aged 50 or over and that three out of ten community nurses are due to reach retirement before 2018 (Buchan, O'May and McCann, 2008). Similarly, recent NHS workforce figures showed that approximately 36% of the GP workforce and 35% of the Consultant workforce were aged 50 or over in 2010 (ISD, 2010). These figures highlight the issue expressed by many of the interviewees in relation to the need to succession plan for the next generation of doctors, nurses, and allied health professionals.

'If you look at the demographics in terms of Scotland's future population ... the population that is going to be elderly is set to grow exponentially but the numbers of young people is set to decrease so the question becomes where are we going to get our future employees from' (HRD3)



Since the early 2000s there has been increased Government interest in the retention and recruitment of older workers (aged 50 and over) to meet potential skills shortages and provide ample public services to support the increased demand on health services, social care, and the changing educational and learning requirements of an ageing population (McGoldrick *et al.*, 2008). This has been supported through various public policy seminars (e.g. the ESRC Scottish Government Seminar: *Talent Management and the Older Workforce*) accompanied by policy reports and strategies (e.g. *All Our Futures: Planning for a Scotland with an Ageing Population*). However, it was noted by the interviewees (especially those in the second wave) that economic and financial pressures have had to take precedence.

‘Before it was about, we're all fighting for a diminishing pool of talent, and we have to take every school leaver in to supply all our various professional groups. And we're trying to, I mean, how do you manage that message with the one at the moment which is, actually, we're going to have to turn off the tap for recruitment for a few years ... Do you stop your pre-registration supply for nursing, your undergraduate medical programme? Because if you turn off those taps, because it takes so long for people to go through the training ... you're talking a 5, 10 year gap before you get that back on route. So part of what we're trying to do I think is how do you, again, balance that short term? And that's always... I don't know if you're speaking to Board X, but X managed to find a bit of money. They've introduced a controversial scheme to enable a number of people to kind of stick their hands up and get a package and go. And that's fine, because they're leveraging out some resource in a oner. We're not doing that here, partly for the earlier reasons that we need to be satisfied before we start losing people that we're losing the right ones in the right way.’ (HRD11)

The statement above highlights that the issues relating to ageing population remain; however they has been superseded by efficiency priorities. It notes that individual boards have adopted different approaches to deal with these challenges. Some have promptly offered redundancy packages while others are taking more time as they want to ensure that the best people stay. The use of the metaphor of ‘turning off the recruitment tap’ also highlights that stopping recruitment now will have long-term impacts in terms of training and succession planning. The following section discusses more fully the perceived effects that the recent economic crisis has had on people management within the NHS.

### 6.2.5: *Global Economic Crisis*

The economic and financial constraints were mentioned throughout the research in relation to workforce planning, recruitment and retention, job security and having to make tough decisions. However, as the phase one interviews progressed the effect of the global economic recession on public sector organisations became more noticeable. In the Scottish NHS, pressures to overcome the underlying deficit alongside a reduction in the devolved budget and plans for future budgetary cuts had led HR managers to move away from a focus on demographic challenges towards ‘doing more with less’ and ‘cutting out waste and efficiency savings’. The excerpt below illustrates some of the key challenges that the boards are currently facing.

‘The challenge for us going forward is how do we ensure that we provide the best, highest quality, lowest cost or best value for money services to the population? And doing it currently in a climate where the years of growth that we've enjoyed over the last six or seven years are now coming to an end ...even paying your pay bill based on the money you get through the door is very difficult. So in reality, we're talking about a significant chunk of savings to be made. And from my point of view, philosophically, it's about how do you position that and engage the workforce in a conversation or a focus on how we spend our 650 million better as opposed to just focusing on how do we take 30 million out. ... Before we start taking people out of the system, I think we need to understand better whether we're spending our money in the right way. And that's an, intellectually an easy conversation. In practice, it's difficult because it's like shifting results from high tech acute hospital into community towards healthcare ... So we have just instigated a, not a freeze, but a cool ... what we're saying is, actually, managers, you need to start taking some immediate measures in terms of slowing recruitment.’ (HRD11)

The emphasis on spending money more effectively is particularly interesting considering the government’s ‘austerity’ measures and views on cutting out what is seen as ‘bad’ spending, i.e. waste. Interviewees described a range of initiatives, beyond restricting recruitment and introducing voluntary redundancy programmes, which they are implementing to overcome the financial challenges including the adopting a lean process agenda and restructuring service delivery:

‘In terms of the public sector it is depressing, it is challenging because we are already hearing about massive cutbacks ...So there is a massive challenge in the NHS over I think the next ten years, it won't pass any faster than that and I think what we will be looking at is definitely doing more with less so that is why service improvement with

a lean agenda is going to be absolutely critical. Getting staff to take out waste and duplication' (HRD12)

Nonetheless, the majority of interviewees acknowledged that implementing change within the NHS can be difficult and can meet resistance from staff due to a sense of 'change fatigue' and scepticism amongst employees - in particular clinicians - of the value of further reforms (see chapter 4). The word 'depressing' emphasises that cuts and uncertainty have reduced motivation amongst employees and managers. In addition, participants remarked that removing waste is easier said than done when employees are happy with the existing methods.

'Public sector organisations are in a difficult place because they've got a service to deliver within budget, we've now got savings to make and you're not going to please people if what pleases people is status quo.' (HRD7)

'I don't think the NHS has a real problem in terms of resourcing because we are incredibly well resourced, if we got rid of this 20% of waste, right, we could deal with the increase of activity which is going to come demographic changes and the older population, but the problem is that I am not sure if there is a real will to cut out that waste because ... consultants have always done it this way, nurses have always done it that way. So that is why it is going to require a complete culture change' (HRD12).

Due to the increased impact of the global recession on public services in the UK during 2009 it is not surprising that 'doing more with less', 'having to make tough decisions' and 'efficiency reforms', were key themes to emerge from the analysis. The quotations above are important as they illustrate some of the challenges discussed in chapter four relating to changing clinical practice within a professionally-dominated bureaucracy. The following section discusses how the interviewees hope to overcome these challenges.

### **6.3: Managing Change: Key Priorities for HR**

In spite of the economic backdrop all of the interviewees perceived that there is a need for NHS Scotland to continue to invest in its people. They believed that this was best accomplished through training and development initiatives that set out to enhance employee engagement, overcome resistance to change and retain talented employees. This was clearly illustrated by the following quotations:

‘What we do is invest heavily in education and that, because it's fundamentally important not only that we have an organisation which is agile, but flexible. ... We still have to do all the good things rather than just taking out various cuts across the piece.’ (HRD11)

‘There’s a whole range of things that enable people to recruit and retain good talent but in tough economic times it is retention that is critical in terms of the organisational climate and culture.’ (HRD7)

As illustrated by the comments above, most interviewees were keen to point out that in times of austerity the focus moves away from recruitment to retention. Moreover, several participants noted that HR has a role in promoting a dynamic culture and supporting individuals through change and uncertainty. Three interrelated investment areas were consistently cited as central to the future success of the Scottish NHS. These were developing leadership capability (6.3.1), engaging employees in change (6.3.2), and promoting social capital and team working amongst staff (6.3.2).

### ***6.3.1: Developing Leadership Capability***

As was noted in chapter four, the development of effective leadership is a key agenda item for NHS Scotland. Several interviewees supported this message when they proposed that competent leadership and management was central to overcoming the current economic challenges and taking the organisation forward. One HR director put this succinctly when he said:

‘Everything comes back to one common denominator, and it's about leadership and management. Leadership in terms of the culture of the organisation and management in terms of competence and capability ... we're encouraging people to fly.’ (HRD11)

The phrase ‘encouraging people to fly’ is interesting given the constraints mentioned in section 6.2. When probed P11 acknowledged that this was easier to say than to do but he believed that effective leadership was at the heart of getting people engaged in the organisation’s vision and helping them to understand where they fit in the bigger picture. It was argued that the style of engagement and the skills and abilities of leaders, particularly those in line-management roles, can have a strong effect on employee engagement and performance. It was anticipated that through developing the leadership

skills of middle managers and senior clinicians they could achieve greater local ownership for change.

‘Ultimately the extent to which you can harness your human capital is either enhanced or not by the way the person is line managed on a regular basis ... that day-to-day life experience I think is critical ... we’ve got a leadership programme just now that’s about skilling up newly appointed team leaders ... two senior people on our team are going on the programme ... I’m expecting a benefit, not only within the team, but in terms of the organisation’s objectives where we’ve got lots of redesign’ (HRD7)

The suggestion that the personality and approach of an individual leader can influence an employee’s motivation and performance emphasises the continued support for leader-centric theories of leadership (see sections 2.3.1 and 4.2.1) within NHS Scotland. Yet, the focus on line-managers reflects the current policy agenda of engaging clinicians in leadership (see section 4.4) and critical theory argument that leadership should be distributed throughout the organisation (see section 2.3.3). Several interviewees explained that often, in their experience, good team leadership not only motivates employees, but also improves patient care.

‘I think if we can improve what goes on at ward and department level and the effectiveness of, for example, local line managers then I think we have a better chance of improving the patient experience’ (HRD1)

Consequently, a key priority across NHS Scotland has been to develop initiatives and programmes that enhance leadership competence throughout the organisation, not just at the top. Interviewees described various training initiatives that have been developed both within their own boards and nationally to meet this objective. It was emphasised that courses and programmes have tended to focus on developing people management competencies such as influencing, motivating, and empowering staff through effective team-working.

‘The first part of lean is to identify your process and identify what in that process adds value and what doesn’t. ...In terms of leadership development, it is absolutely critical that you have an engaging and empowering leadership style to enable frontline staff to make those changes’ (HRD12)

‘We have the leadership programme for the middle ranking managers in the organisation and it looks at team working ... the component parts of what makes up a

good team, be clear about your objectives, have your vision, make sure you cascade the objectives setting through your team, have regular meetings, face to face contact.’ (HRD9)

A small number of interviewees mentioned that the focus on leadership is relatively new and that in the past management and leadership training, especially for clinicians, has been limited. One HR manager specifically emphasised this when she described how clinicians were often promoted to managerial positions based on their clinical experience with little or no management training. Discussing how she was planning to introduce a new strategy to improve this she said:

‘I’m in the process of developing a leadership and management strategy ... most of the people I have spoken to, and it is only anecdotal, have said to me that that they have never had any support as management goes.’ (HRD2)

Linked to this others emphasised that ensuring clinicians who take on managerial or leadership roles have the relevant skills and competences is crucial. It was asserted that clinical managers can find it difficult to reconcile two often competing roles:

‘I think a middle management role in the NHS; particularly a clinical middle management role is a very difficult role. Whether it's about doctoring background or whether it's nursing or AHP or whatever, these roles, I think when you speak to people sometimes they feel like they get kicked from both ends, from their peers or who were their peers who think they've sold out and also the more senior managers who expect them to deliver and sort out the problems that exist’ (HRD4)

Noting the challenges involved in clinical leadership, some interviewees felt that a more strategic approach has to be adopted when recruiting and developing clinical leaders. An individualistic approach which considers not only an individual clinician's skills and capabilities, but also their willingness to learn and suitability for the role was recommended. It was proposed that some clinicians will feel more comfortable in a leadership role than others. There was an impression that some individuals will have the personal skills required to adapt and succeed in a new role, while others would struggle as they do not have the necessary skills. Equally, others may not be motivated by leadership positions as they perceive them to be in conflict with their clinical identity. This relates to the theory on engaging clinicians in leadership and the struggles that clinicians face when they take on a dual-professional identity (see chapter 4). Moreover, it also highlights the external social influences on an individual's identity, the sense that clinical leaders were in

the ‘in-group’ but once they move over they are considered to be in the ‘out-group’ by former peers (Loder and Spillane, 2005; Tajfel and Turner, 1986). Thus, HR and OD managers must ensure that a move into leadership is appropriate and provide tailored training. It was also observed that additional organisational support is required to ensure leadership is embedded in practice. This brings the discussion to the second investment area, employee engagement.

### ***6.3.2: Employee Engagement***

A second related area which was high on the participants’ agenda was promoting employee engagement. Engagement goes beyond job satisfaction and is not simply motivation; it involves a combination of commitment to the organisation and its values alongside a willingness to help out colleagues (CIPD, 2010). Although a relatively new concept within NHS Scotland, the statement: ‘you won’t get anywhere without staff being on board’ (HRD8) reflects the general belief that to effect change, staff must understand and believe in it. If not, progress will be hindered due to both open resistance and the more subtle effects of disenchantment. Interviewees described two main approaches that they utilise to engage staff. The first involved providing training to help staff adapt to change and new ways of working; while the second emphasised the importance of a charismatic and empowering leadership style.

‘Up-skilling ... moving people place to place ... we’re reacting to that positively by running very short courses, awareness sessions that meet the needs of staff (HRD8)

‘Leadership is about engaging and enabling staff and it is really about empowering staff to work more efficiently’ (HRD12)

Although formal data collection through tools like the staff survey provide useful information which give the board an indication of how engaged its workforce is as a whole, it was noted that those motivated to respond may not provide an accurate representation. Moreover, it was felt that both line and senior managers also have a role to play in keeping individual employees informed of current strategies and working with them to overcome any challenges that they are facing.

‘We periodically have a staff survey and that is one way of getting information back from staff about what they think about what is going on in the organisation. I personally don’t think that it is a particularly good way of getting information from staff and it certainly shouldn’t be the only way we get information from staff ... the employee director and I have been doing a series of road shows with members of staff, managers and trade union figures where he and I are out talking to literally hundreds of people about what the boards plans are in a variety subject areas and engaging groups of staff in debate about what we think are the big ticket issues for future but also giving staff the opportunity to raise any questions.’ (HRD3)

Linking back to the target culture it was recognised that there is a tendency to concentrate on the bad cases. Speaking of the sickness absence target of 4% one interviewee explained this when he said:

‘The bit that's missing from the conversation at the moment is actually we're focusing all our energy on that end of the telescope, 4% of it. There's about 96% that we're missing. And in terms of coming back to our context for the conversation, if we don't focus on the 96% ...if you have engaged employees, in other words, staff who have pride for the organisation, advocate, go the extra mile, discretionary effort, then it has a huge impact in terms of - you can even track it to patient mortality and morbidity, and if you do that, actually, whether people hit 4% or 4.2% almost becomes irrelevant, because the productivity gain on the rest of it is significant, completely outweighs it.’ (HRD11)

The excerpt above demonstrates the view of many interviewees that spending time engaging all staff, not only in their work, but also in the organisation’s objectives has a greater impact on productivity than focusing on nominal targets. It was suggested that building social capital and team working across professions would improve employee engagement and potentially productivity.

### ***6.3.3: Building Social Capital***

‘Healthcare in the future increasingly will be provided by teams of people working together rather than individuals working in specific departments’ (HRD3)

The quotation above introduces the third area that was frequently cited as an important factor in the current strategic planning of NHS Scotland. It was asserted that there has been a move towards multidisciplinary teams and a focus on whole system working where everyone involved understands the complete patient journey, not just their individual part. Consequently, nurturing collaborative working across professions and departments has



become an increasingly important priority for HR. This relates to the literature on developing relational coordination (shared goals, shared knowledge and mutual respect) across different professions within healthcare (see section 3.2.2).

‘On the referral to treatment, the 18 week target, and previous targets I think have very much focused on the outcome but in order to achieve referral to treatment it involves the whole patient journey. So the way in which that whole patient journey is organised I think is beginning to shift, so I think from that you will begin to see a lot more work around processes and the way that people relate to each other across different parts of the NHS’ (HRD1)

As a rationale for focusing investment in this area, interviewees described examples of how developing strong multi-disciplinary relationships across NHS departments has been shown to improve both efficiency and patient care:

‘The multidisciplinary team is critical ... you have to think differently and more holistically about how you deliver care ... we have a big intake of mainly elderly people on a Saturday afternoon into [hospital A], through A&E and we created a multidisciplinary team and we actually managed to defer an awful lot of the admissions because what we were doing was sending them to the right area, we weren’t sending them into the hospital, we were sending them out to the community again, getting the district nurses involved, GPs involved’ (HRD12)

The emphasis on collaborative working varied across boards with some interviewees stating that the focus was very much on developing the individual, while others highlighted that there was a clear ethos within their organisation that encouraged team working, cooperation, and the development of communities of practice where professionals can learn from each other:

‘There is a very strong focus on the individual and for me I think there needs to be a much stronger focus on the collective and what the collective can achieve. I think that that is an untapped resource (HRD2)

‘There is quite a kind of networking culture I guess perhaps because of the geography people have to work together and get on and not only I suppose within the organisation but also with voluntary organisations, the local authorities, other boards ... there are all kinds of joint working that is going on with other organisations both locally and across NHS Scotland.’ (HRD6)

Beyond internal relationships several interviewees stressed the importance of working across organisational boundaries and building strong partnerships with external parties.

The excerpt below demonstrates the array of stakeholders that managers in NHS Scotland engage with on a regular basis:

‘Local government are a key partner for us because of the interface between health and social care ... We have relationships with all of the universities and colleges in our area ... a significant amount of time is spent dealing with MPs, MSPs, MEP’s; who all have a series of questions on behalf of their constituents in relation to the provision of healthcare services. Um, we work with other government bodies, I mean the Scottish Government Health Department, at St Andrews House, where the minister and her civil service colleagues make policy decisions about the NHS which we then have to enact. We have a close working relationship with them and indeed our colleagues in the NHS in England, Wales, Northern Ireland and from the department of health in England. Ehm, and there will be a number of private sector organisations that from time we come into contact with, not least of which will be the pharmaceutical industry (HRD3)

Interviewees particularly emphasised the importance of working closely with the local authorities to ensure that there is consistency between health care and social care. This was related to the earlier concept of whole system working and taking a holistic approach to care. The HR managers and directors described a variety of ways in which they encouraged partnership working with local authorities through integrated teams and joint training. However, it was acknowledged that working across organisational boundaries is challenging, especially when the local authorities themselves face massive cutbacks over the next few years. It was also noted that due to logistics, relationships often have to be built and nurtured through virtual means rather than in person. This can present HR with challenges in terms of training and development.

The two quotations below illustrate that developing employees’ social capital as well as their human capital has become a key priority for HR managers in the Scottish NHS.

‘ So from an HR perspective I think it is critically important to invest in the way that people interact with each other their values and all of that’ (HRD1)

‘So the HR role then is about our human capital working in a way that promotes social capital so it is about the learning development of our staff’ (HRD7)

A number of the interviewees linked achieving these social capital objectives to effective leadership. The following statement illustrates the view that effective leadership requires awareness of others objectives:

‘An effective leader will take time to understand the drivers of individuals from other areas or groups and understand how these impact on the initiative that you are trying to take forward’ (HRD10)

This can be linked to the relationship between leader development and leadership development discussed in chapter three. Interviewees described various HR initiatives that they have in place to promote collaboration including working with specific teams on their interrelationships and helping individual employees to identify their priorities and see how those fit into the wider system. Four interviewees also linked team working initiatives to ongoing work within their board into how work can be completed differently to improve efficiency within NHS Scotland:

‘The other thing that we are doing around wider team stuff is the whole look at competency development which is about getting the right person to do the right thing and not think too rigidly around well its always been a nurse or it's always been a porter. To actually say what is it that needs to be done, what are the competences that are needed to deliver that, and then think who is best person or what is the best role to deliver that competence and that may exist just now and it's a case of just saying to someone either you can do it or it may it involve someone taking on more skill development or role development or training or whatever.’ (HRD4)

The statement above links in with the earlier discussion (6.2.3) which suggested that to overcome current human resource challenges NHS managers must think creatively and consider alternative ways of working. It also highlights the perception that staff development and training is needed to facilitate these changes. Nonetheless, it is interesting that they use the term competency as competency based education has received criticism within the literature as it ignores the learning process, the complexity of knowledge transfer, more subtle intangible outcomes and the role of existing power and social relations on development (Bolden and Gosling, 2006). Section 6.3 has provided an overview of three HR priority areas: developing leadership capabilities; engaging employees in change; and promoting collaborative working. Interviewees asserted that they hoped that investing in each of these areas would enhance the skills and agility of the workforce and increase the efficiency and effectiveness of the Scottish NHS as a whole. However, most interviewees acknowledged that accurately measuring these perceived effects is difficult. Thus, the following section considers the general feeling amongst

interviewees that they would like to understand more clearly the outcomes of the investments being made.

#### **6.4: Understanding is about more than Measuring**

The final theme to emerge from the interview discussions related to approaches to human capital measurement and data collection within the Scottish NHS. It was stated that each board collects a range of data related to its employees such as staff in post, vacancies, use of bank staff, staff turnover, sickness absence rates, and pay costs. The interviewees acknowledged that this gave them some insight into the structure and cost of human capital within the NHS. However, almost all noted that despite the plethora of workforce data collected they often feel like they are ‘drowning in data, but thirsting for information’ (HRD5). Interviewees offered a number of reasons for this inconsistency including a lack of analysis expertise, doubt over the accuracy of data collection methods, poor data management systems, limited specificity of data, difficulty in measuring intangibles and not knowing what to measure. Following the analysis these issues have been categorised according to four themes: availability of skills base (6.4.1), investment in systems (6.4.2), the challenge of measuring intangibles (6.4.3), and a desire for greater understanding (6.4.4). These are now discussed in turn.

##### ***6.4.1: Availability of Skills Base***

As mentioned above, interviewees cited a range of challenges which they face in relating specific investments to staff, team, and organisational outcomes. However, the most prevalent challenge raised was regarding the time and resources required to prepare and analyse data. It was suggested that there is a lack of expertise at board level, especially in smaller boards, to transform the data collected into accessible and informative material.

‘We have quite a lot of workforce information, but I guess the bit that is missing for me is how to translate that information into or that data into useful information intelligence that can then change the way we might do things. (HRD6)

The quote above illustrates that almost all of the interviewees expressed a desire to better understand the data that is currently collected. Interviewees suggested a variety of ways in which data collection and analysis could be improved, one widely held view was that the introduction of an NHS Scotland wide HR IT system would reduce the time and resources required and improve the accuracy of the data collected. This relates to theory on the strategic value of web 2.0 and eHR (see, Martin, and Reddington, 2010)

#### ***6.4.2: Investment in Systems***

Six of the interviewees claimed that there was a need for NHS Scotland to invest in its IT and HR systems. It was argued that present data collection methods are often piece meal and overly complicated. Currently, if data is required centrally, HR asks staff members to report back information using either paper or electronic forms. Thus, it was suggested that more robust data could be gathered through IT systems that gather data automatically. One interview illustrated this idea with the following example.

‘One example is if you want accurate data about absence you ask people to, in the old terms, clock in and clock out, or you introduce a flexitime system that allows people to clock in and clock out and it generates the data you need. And because we don't do that a lot of data collection around a lot of people issues is not very robust; if you have an HR system you begin to build that up.’ (HRD5)

Interestingly, for the most part, the desire for investment in an HR IT system was more prominent in the early interviews. One possible explanation for this is that given the wider economic pressures and the costs involved in upgrading these systems meant the issue was seen as less significant for those interviewed later.

‘There needs to be some investment I think in systems, eh, IT systems in particular. The NHS has never had a comprehensive HR system. It has attempted to develop systems at various stages and I have been in the NHS for twenty years now and at various stages we have attempted to introduce an HR system but the cost and the complexity of it has often kind of defeated us just because of our size and organisation. So I think there is an issue about having better data that you can more easily use to manage / measure performance. A lot of our time is spent in cleansing data and analysing data’ (HRD1)

The above passage demonstrates the view of many of the interviewees that current approaches to data collection within NHS Scotland lack sophistication. It was believed

that a more comprehensive system would reduce the time required to cleanse and analyse data and help ensure that the data being collected is accurate, relevant and appropriate. However, it also outlines the difficulties in terms of cost and complexity of designing and launching such a system across NHS Scotland. Despite the costs involved, several participants proposed that if the systems were in place to provide more reliable data which could inform process redesign then this in turn would have a positive impact on patient experience. This relates to the next section which examines perceptions on measurement and linking investments in people to organisational performance.

#### ***6.4.3: The Challenge of Measuring Intangibles***

During the study interviewees were asked to describe current approaches to measuring performance and what they regarded as successful outcomes of staff training and development. A range of employee outcomes (such as improved motivation, enhanced skills, and more effective working) were cited as indicators of training performance. Some interviewees also linked investments in people to wider organisational performance and patient outcomes:

‘A high performing service is one with good outcomes and few complaints. We can’t measure profits, but I think you can begin to measure patient outcomes and how they relate to staff as well as to systems and processes’ (HRD 1)

The statement above illustrates that there was a desire amongst interviewees to connect HR investments with organisational performance. The quotation below reiterates this; however it also illustrates the view of several interviewees that this can be difficult as in the past HR’s primary focus has been on employees’ experience.

‘My sense is that we should start by measuring patient outcomes and from that then analyse whether engagement is important to that ... when you talk to Staff, about their experience as an employee of the NHS they tend to about issues, the more global issues, so they will talk about ‘agenda for change’ and the impact that has had on them, they will talk about the kind of working environment. But very seldom do they talk about patient experience and so I think if we can move to a system whereby the patient experience is the thing that the organisation is focused on’ (HRD1)

The quotation above demonstrates the aspiration of many of the interviewees to broaden the focus from employee outcomes to patient outcomes. Although almost all of the

participants described ways in which they were already trying to measure this link, it was generally accepted that the methods used could be more systematic.

‘So we try to make I suppose the tenuous links between investments in staff and individual, team and organisational performance, but we don’t it measure very well.’(HRD6)

These measurement difficulties may be due, in part, to them asking the wrong questions. It was suggested that the outputs that are easily measureable are not necessarily the best indicators of performance. The following statements illustrate that linking specific investments to overall performance is difficult as public value outcomes are a result of several interrelated factors.

‘There can be many different causes of sickness absence and there are so many different interventions that we are making but trying to identify which intervention is making the most difference is extremely problematic, because its multi-causal. There’s not one cause-and-effect.’ (HRD6)

‘I think the challenge of having these public value type outcomes is that the can that they can become so loose that they can almost become meaningless ... the biggest tension for me is how you choose something that you really want to go in depth when you really want to get impact and really want to make a long-term difference, so you don't end up doing all the superficial things.’ (HRD2)

Both statements confirm the challenges involved in measuring the effects of specific interventions; however the second excerpt depicts the concern expressed by a number of interviewees that focusing on those aspects of performance that are easily measurable can give superficial results. This also links back to the pressures for short-term wins from politicians versus the long-term view of the HRD managers discussed in section 6.2.1. Thus, it was generally thought that more work could be done on understanding processes to allow more meaningful measurement.

#### ***6.4.4: Desire for Better Understanding***

The challenges involved in measuring the intangible aspects of staff, team and organisational performance led nine of the twelve interviewees to suggest that they would like to understand more clearly what is happening on the ground:

‘I guess you need a human being to make sense of what you think may be happening on the ground’ (HRD6)

The quotation above illustrates that gaining this detail would require a move away from generic measures to more qualitative analysis of specific interventions. It also acknowledges the complexity of the environment and suggests that it requires judgement and weighing multiple sources of information (Weick, 1995). This can be challenging for both professionals - such as doctors from a scientific, positivistic background - and politicians who covet ‘hard, objective’ data (Berg *et al*, 2000). This view was further emphasised by HRD8 who when discussing existing data collection within their board mentioned:

‘They’re all quite tangible measures and quantitative type measures. And the next step, I suppose, but it’s a challenge for the NHS, is the qualitative type’ (HRD8)

The statement above alludes to the opinion that, due to the resources required, gathering such qualitative information can be difficult for large organisations like the NHS. In spite of this, it was generally felt that having an enhanced awareness of how particular investments in, for example, leadership development relate to individual, team, and organisational outcomes would improve future HR management and measurement.

## **6.5: Phase One Conclusions**

This chapter has provided an overview of the key themes that emerged during interviews with human resource directors and managers in NHS Scotland. Section 6.2 considered the current political and economic context influencing HR management within NHS Scotland. Due to the time period in which the interviews were conducted it is not surprising that at the outset there was a focus on talent management and coping with an ageing population, but as the study progressed this was surpassed by a push for ‘austerity’ measures and removing waste to overcome economic challenges. Section 6.3 discussed NHS Scotland’s current HR priorities. It was noted that in times of austerity the focus moves away from recruitment to retention and from stability to change. Interviewees believed that developing the organisation’s leadership capabilities (particularly those of clinical line managers) would provide a means of engaging employees in change and encouraging collaborative working which they hoped would in turn increase the efficiency and



effectiveness of the Scottish NHS as a whole. Lastly, section 6.4 reflected on the difficulty involved in measuring the impact of these investments in people and the interviewees' desire for an in-depth understanding of how investments in for example leadership development transfer into the organisation.

These findings set the context for the second phase of data collection and influenced the overall direction of the research. It was decided that an in-depth case analysis of a specific leadership development programme for senior clinical leaders would allow the researcher to explore leadership development in the Scottish Health Service from the perspective of those involved, thus delivering the research objectives outlined in chapter one and addressing the issues highlighted by the HR directors (see chapter 5 for overview of methodology). Data from the study was analysed thematically as the research progressed. Various themes emerged from the analysis and these have been since categorised under three main topics: DTF as an identity workspace, personal impact, and organisational impact. Chapters 7-9 now discuss these in turn.

## Chapter 7: DTF as an Identity Workspace

### 7.1: Introduction

The previous chapter provided an overview of the thematic results from interviews with HR directors and managers in NHS Scotland. It considered the political and professional context underpinning human capital management within the health service and noted that a key priority for HR managers was developing the leadership skills and capabilities of the organisation's clinical managers. These findings informed the direction and design of the study's main level of analysis: an in-depth examination of participants' accounts of the impact of the *Delivering the Future* (DTF) leadership development programme. This chapter and the subsequent two chapters present the empirical findings from this case analysis. Addressing the first sub-question, this chapter examines the role that leadership development programmes can play in shaping participants' leadership identities at an individual, relational and collective level. Chapter 8 builds on this to consider in more detail participants' accounts of the impact of DTF on their human, psychological, and social capital. Chapter 9 then explores the role of organisational context on learning transfer and intellectual capital development. The aims of this chapter are twofold. Firstly, it examines interviewees overall impressions of the programme and the learning process in relation to identity construction. Secondly, it discusses the participants' experiences of the practice-based elements of the DTF.

### 7.2: Overall Impressions of DTF

#### *7.2.1: Positive Impressions: Enhanced Knowledge and Confidence*

On the whole, the DTF programme received positive feedback from participants. The general perception of those interviewed was that DTF meets its objectives and is well managed and coordinated. The statements below summarise the feelings of many of the participants.

‘The programme has been a great success for me. In terms of the overall entrants and their skill set and the completers and their skill set. The cohort at the beginning and the end had a different kind of skill set - a better understanding of their own strengths

and weaknesses, a better understanding of leadership as a concept, leadership for NHS Scotland, and for a greater or lesser extent a better understanding now on how to get things done, and how it sits in the strategic planning of NHS Scotland' (P4)

The above excerpt illustrates a common belief that participating in the programme had enhanced participants' skills and abilities, improved their self-awareness and given them a clearer understanding of the broader political and organisational context in which they work. Although, prior to commencing the programme, all of the participants had been in some form of leadership or management role for a number of years (ranging from two to fifteen); most had no or little previous training in leadership. Many had had to effectively learn on the job while also balancing their clinical responsibilities.

'I think a lot of clinicians, like myself, often fall into leadership and you don't really receive an awful lot of training in what's right and what's wrong ... so this was a fantastic opportunity' (P2).

A consistent view was that the programme had complimented and enhanced learning that they had gained on the job. In some areas it had given them confidence in their approach, while in others it had exposed more effective ways to manage situations. Enhanced confidence was considered as a key benefit of the programme:

'Well it gave me the understanding that I was looking for, and it gave me a massive amount of confidence in myself. The one thing that it did was it made me realise that I could achieve much more than I ever thought I could' (P13)

The perception that the programme had enhanced participants' knowledge and improved their self-confidence in their leadership skills and capabilities is particularly relevant to the development of a leader's identity at an individual level (DeRue and Ashford, 2010); this theme is revisited in chapter 8. Most participants asserted that DTF had provided a rich and challenging learning experience.

'It was thoroughly enjoyable - I wish I could go back and do it again, and just take time out really to savour the immense richness and learning' (P11)

'I have absolutely loved every single minute of it ... it certainly stretched me, I am well out of my comfort zone ... I really valued the whole experience.' (P20)

The statements above together with use of the words such as: ‘fantastic’ and ‘success’, as in the previous quotations engender a positive image of the programme. However, participants also noted that it had been a challenging learning experience which had stretched them.

### ***7.2.2: The Delivering the Future Journey***

A popular metaphor used by participants was to describe participating in the programme as being on a ‘learning’ journey. This relates to the suggestion that development programmes can act as ‘identity workspaces’, where participants can work on and co-constructed their leadership identities (Carroll and Levy, 2010; Petriglieri, 2011). In line with the extant literature on leadership identity development (e.g. Lord and Hall, 2005; Day and Harrison, 2007) participants regarded DTF as an intensive, iterative and transformational journey which had helped many move from being a novice who was faking or ‘play-acting’ at leadership to having individual and relational credibility in their leadership role. A number of participants described feeling like they had to tear down their previous conceptions of leadership at the outset so that they could start at the beginning and open themselves up to new challenges; working their way through their development and slowly evolving as the programme progressed.

‘I found it really challenging personally in the beginning, because I was very open to wanting to understand what I could do better, and I describe it a bit like I had deconstructed myself, and then the first half of the programme I’d say was about putting myself back together. That sounds quite dramatic it’s not meant to be, but it is almost like, you know, I’d really opened myself up to lots of things, and then I had to put it all back together again. The second half of the programme really has been about really building on that and understanding how I can do things better, and putting that into practice’ (P6)

The statement above alludes to being on a dynamic, iterative journey and the impact of that journey on participants’ skills and abilities. However, it also illustrates that the notion working on one’s leadership identity is not easy and can incorporate deconstructive elements as it involves changing one’s mental schemas, existing paradigms and entrenched logics. This is important as the existing literature has focused on the development, regulation and maintenance of leader identities (Carroll and Levy, 2010; DeRue and Ashford, 2010). This process of deconstruction and unlearning had affected people

differently: some spoke of the exhilaration that had come with being awakened to new ideas while others referred to the emotional tensions and struggles that they had experienced including feeling exhausted by the process and a sense of loss at having to take apart their previous theories of leadership and sense of selves. This may have been particularly evident in the current study as the clinical participants often had strong professional identities and were well-regarded within their professional community. The process of identity reconstruction may have been particularly challenging for them as it involved giving up an established and successful work identity and moving away from their community of practice (Beech, 2011; Greenwood *et al.*, 2011; Wenger, 1998). Leadership theory, at least at the outset, was viewed by many as new vague, fuzzy and strange to them:

‘I was slightly overwhelmed by it because it is a bit of an information overload initially, and it does move at quite a pace. Some of the learning techniques were new to me, so I found that quite daunting. But as the weeks went by, and I began to relax into it’ (P13)

‘It has been hard work; it has been physically exhausting, which surprised me. ... I have never experienced that level of investment in me in my life’ (P7)

‘I still considered myself to be a clinician, I was quite isolated in the role I was in and I was looking for an opportunity to build a network ... So really, I came into the programme looking for a network of clinical leaders to support me, and to allow me to develop further.’ (P6)

The first two statements above illustrate that some participants had found the learning process overwhelming and exhausting; yet they also refer to the benefits attributed the programme. In spite of the challenges participating in the programme was generally considered to be a luxury and a reward from the organisation for their hard work. The third excerpt is illustrative of the view that DTF was thought to help participants develop a network of peers who enhance their strategic thinking and understanding of how NHS Scotland operates and help them psychologically move from ‘clinician’ to ‘leader’. This relates back to the notion that it is difficult to build an identity in isolation as identity construction involves social and relational processes (see section 3.2.3). Moreover, it highlights the role that development programmes can play in providing participants with a new community of practice that encourages collective sense-making and identity construction (Carroll and Levy, 2010; Siebert *et al.*, 2009; Weick, 1995).

It was observed that being given the opportunity to take time out to focus on their personal development and reflection is unusual and refreshing. A number of participants noted the advantages of feeling like they were in a safe environment where they could exchange ideas and reflect on their own strength and weaknesses. Protected time and reflection were recurrent themes throughout the interviews with many participants stating that they appreciated being able to step back from the demands of their work and focus on how work more effectively.

‘One of the really valuable things that it’s given me is actually time to think about leadership strategies. I think when you’re working, what you’re driven by, really, is the demands of the service and the demands of the kind of policy from Scottish Government that needs to be met. You’re constantly chasing targets and meeting the objectives that the board sets for your services. What that leaves is very little time, really, to reflect on how you’re doing that ... I think what *Delivering the Future* has given me is an opportunity to step back from that and to think about managing meetings, to think about how to engage staff, and serve and redesign processes properly.’ (P12)

‘I think there’s something really, really powerful about having time out of work ... I think we get, in the NHS and my experience and I’ve worked 25 years in it, you get so sucked into the process of just getting things done that sometimes I don’t think you take the time to sit back and reflect and think about where you are going with your career, what next, what other opportunities do I need to think about, so I do think the protected time was a big part.’ (P14)

The notion that DTF was a place where participants could step back, reflect and exchange ideas with a group of peers is important as personal reflection and social relationships are key elements of identity work and social identity construction (Avesson *et al.*, 2008; Beech, 2008; Carroll and Levy, 2010; DeRue and Ashford, 2010; Petriglieri *et al.*, 2011). Nonetheless, some interviewees cautioned that the programme is only one part of participants’ wider leadership journeys and identity construction:

‘I think, that’s where, probably, a lot of people have historically gone wrong, is the day they think they’ve become the expert, is probably the day they should pack their bag and go home because I think we’re always learning and developing, it’s a journey, isn’t it. Leadership is a journey too. You move from one role to the next role, to a different position, with different challenges and hopefully you then have, kind of, like a toolkit of strategies and coping mechanisms that are going to support you to be effective in your role as a leader. And then we all have our moments

where it's all, oh, my God, too much! Which is the human factor's element, isn't it, in all of this, I suppose' (P14)

Interviewees often explained how DTF fitted in with their own leadership journey. They described the path they had taken, for example, starting in a clinical role then moving up the ranks in their organisation into management and leadership positions; their drivers for applying to DTF; and their future plans and additional development aims. This relates to the proposition in the literature that leadership identities change over time in relation to the social context and are stimulated and shaped by interactions with others (Carroll and Levy, 2010; Day and Harrison, 2007; Denis *et al.*, 2001).

Participants also noted that given the challenging and demanding nature of the programme it was important that individuals completed the programme at a time that was convenient professionally and personally. The following excerpts from P2 and his OD lead demonstrate that although managers and colleagues can recommend DTF it is individual participants who must engage in the programme as it will encroach on their private/family life.

'It's something that I'd known about for a couple of years. Our OD lead had discussed it with me a couple of times and asked me to apply but it was never really the right time. I was made aware of it last year as well and I put myself forward as a candidate ... My expectations were probably coloured a wee bit by speaking to people who had been on the programme before, everybody had said positive things about it but they had said that it was a lot of work and you would get more out of it if you definitely committed to it, and I think that's why I had resisted in previous years because it just wasn't a suitable time ... it goes into your personal time.' (P2)

It took a lot to persuade P2 to go on that national programme ... it is the same old story though people who are very, very busy and contribute a lot find it difficult to take time out for development but what they soon learn is that development is what enables them to deliver excellence and actually sustains their performance rather than it being something extra.' (3-OD-p2)

Several participants asserted that it had been difficult to balance the demands of the programme with professional and personal commitments. On a personal note, many declared that the support that they had received from their spouses and families had got them through. Others mentioned the importance of completing the programme at the optimum point in their career:

‘I had got to that point in my career where I was beginning to think where do I go and what do I do next.’ (P20).

‘When the programme was very first launched for Cohort one I was in the interview selection process and to cut a long story short, I got a new post during our internal selection which did take me a little bit away from my clinical leadership focus. So I sort of parked it, always knowing I would go back to it.’ (P17)

The preceding statements demonstrate that most participants felt that completing the programme at time which they had been able to engage in it had enhanced their learning and provided a new direction to their career. The second quotation highlights the importance of being in a position that facilitates the direct application of learning from the programme. This is related to both the learning transfer literature and collective identity formation (see sections 3.2.3 and 3.44).

### ***7.2.3: DTF’s Identity and its Impact on Participants***

DTF’s external image (i.e. its identity) was also found to influence the construction of participants’ leadership identities. On the one hand, the positive external image and reputation of DTF had enhanced participants’ personal credibility with important others. However, on the other hand, some participants noted that ambiguity surrounding DTF and limited understanding within the workplace of the learning provided and the organisational support needed to embed learning. These alternative views are now discussed in turn.

#### ***7.2.3a: Positive - Credibility***

Both the participants and members of the programme team noted the strong identity and positive external image of the programme.

‘I feel incredibly privileged to be working on the programme ... competition for places is quite intense ... [it] has a strong identity and a strong process befitting of a strategic national programme’ (C3)

‘On a personal note, designing a programme which is externally evaluated as being excellent is really rewarding’. (C5 – Coordinator)

‘The programme seems to have a fairly high profile within government ... if you say ‘I’m on the leadership program’, folk seem to realise that that there has been a fairly robust mechanism to actually allow you to be selected to the programme and once



you have been on the programme you've actually been exposed to not only the networking, but a whole load of tools, which you can use in your work' (P3)

As shown in the above quotes there was a strong view that the programme had a positive external reputation as an effective development initiative that attracts high calibre leaders from across Scotland. Due to the programme's high profile and the limited number of places available candidates have occasionally had to apply on a number of occasions before being selected. In the current study three participants had applied previously and been unsuccessful. The strong competition for places on DTF was viewed as a testament to its success; it was believed that the focused recruitment and selection process leads to those who are selected being highly motivated and having a real desire to learn and develop. The programme's reputation was also thought to have a knock on effect for individual participants' reputations as there was a view that getting on the programme meant that they were going somewhere, thus reinforcing participants' leadership identities. Within the current study a desire for self-development was a key driver for many of the participants. Many wanted to get back to a learning environment and to challenge their assumptions while others noted the benefits of study and development that were relevant to their daily role. In addition, there was a strong sense that completing the DTF programme would enhance not only their current role but also their career development.

'I thought it was exactly what I needed for my professional development at that time and I also saw it as a big ticket to career development. I knew if I got it, it would set me off on a pathway to developing my career.' (P21)

The phrase 'big ticket' highlights the view that the programme's prestige within the NHS would lead to the enhanced credibility and legitimacy of participants. It also illustrates that the programme sets expectations, namely that after completing the programme participants will get a promotion or lateral move, which may or may not occur in practice.

### *7.2.3b: A Sense of Mystery*

Despite this positive image, participants also referred to a sense of mystery and ambiguity surrounding the programme. Prior to commencing the programme many participants had spoken to individuals on past cohorts and to members of the programme team to get a

sense of what to expect. Nonetheless, several participants suggested that at the outset they were unsure of what to expect, with one participant describing it as a 'secret society'.

'I spoke to people who'd been previously, but it was all of a bit of a secret society - all I got was, 'oh, you'll love it and it will definitely be great for you', but nobody said exactly this is what you'll do and this is what you'll get out of it, apart from help to develop you as a leader ... I suppose that it is quite difficult to define specifically what it is you get' (P1)

The phrase 'secret society' draws connotations of conspiracy, mystery, subterfuge, deception, exclusivity and hidden specialist knowledge. It was felt that these associations can have both positive and negative effects on DTF's reputation and participants' credibility and collective leadership identities. Some interviewees proposed that the elusiveness and mystery surrounding the programme further enhanced the exclusivity and credibility of DTF. In contrast, others suggested that limited understanding at board level about the details of the programme together with a lack of appreciation as to how it impacts participants' skills and knowledge was detrimental to learning transfer and personal credibility within their organisations. Many felt that a more open approach and formal acknowledgment of the education received would enhance both the programme and participants' credibility.

'So, I didn't really know anything about the programme, to be honest. I had a vague notion ... I think there should be more promotion of it. People need to understand a bit more what it is and what it can do, and the benefits that it has given to people ... I think another thing that would be useful would be if there was some kind of recognised award at the end of it.' (P13)

A further participant cautioned against becoming an elitist group, she felt that putting on airs and graces and focusing on individuals who have participated in the DTF programme limits the learning and support that could be gained from other leaders in the organisation and may lead to resentment from colleagues. The phrase 'elitist group' also has negative connotations for participants' relationships with followers as it suggests that there is the potential for narcissistic leaders who downplay the follower's role.

'One of the things that I think we need to be very aware of is that we're not seen as an elitist group, because people will find that quite challenging ... it's not the only leadership programme that there is; it is a leadership programme and there will be many other leadership programmes. It would be helpful to have perhaps more

integration with the people who have been on the other leadership programmes, but I understand that one of the things that would constrain them, as it has constrained me, is their time.’ (P10)

In the extract above P10 argues that it would be helpful if there was more integration between different leadership programmes within the NHS as this would open up a wider network for knowledge sharing and encourage mutual respect between groups. However, she acknowledges that leaders within the NHS are restricted by time. The programme team also noted the potential for opening up DTF but also cautioned that practically it was quite difficult. Despite the mystery surrounding the programme many interviewees stated that they had entered the programme with an ‘open mind’ and welcomed the surprises. It was implied that adopting a flexible approach and not entering the programme with fixed ideas allowed participants to make the most of the diverse learning experiences. Nonetheless, in an attempt uncover some of the mystery the following section explores participants’ experiences of the practice-based elements of the programme.

### **7.3: Elements of the Programme**

As was mentioned in chapter 1, *Delivering the Future* runs over eighteen months and incorporates various developmental experiences which aim to embed learning within a participant’s ongoing work and help them work on their leadership identity. Formal classroom-based leadership master classes are complemented by supplementary activities including action learning, coaching, mentoring, 360-degree feedback, and work-based projects. The following sections consider participants’ views and experiences of the different elements of the programme and how they complement one another.

#### **7.3.1: Synergy**

Not surprisingly, due to the different personalities of the participants, there was a perception that certain elements of the programme had been more effective for some than others. Nonetheless, there was a common belief that it is the multifaceted nature of the programme that makes it particularly useful as a space for identity work.

‘I don’t think there is any part that I didn’t get something out of. And to some extent I think it is the sum of the parts as well that makes it work. I mean, there is no doubt

that ultimately you have an awareness of your own self, which I didn't have to the same extent before. The entire programme is such that it introduces you to new information and new skills' (P7)

'Some sessions were personally more helpful than others, but I learnt huge amounts... I'm not saying that I've turned into this wonderful person, but I absolutely know now where I'm going and how to get there, and I know what I need to do to make things better.' (P11)

It was widely believed that that no single part of DTF makes the programme a success rather it is the cumulative power of the combined components. Participants acknowledged that the variety of development approaches made for a challenging programme; however stated that they complemented and enabled each other. Similarly, when discussing the practicalities of completing the programme, participants alluded to the time commitment involved and the need to balance multiple responsibilities. Yet, a consistent view, as illustrated by the comments below, is that for it to be worthwhile individuals must commit to the all aspects of the programme.

'If you're going to commit to doing the programme, it's really important that you actually do it, because I don't think you get as much out of it if you dip in and out.' (P12)

'Balancing commitments is challenging, but you have to be willing to take the challenge in order to change in the long-term ... you get what you are willing to put in ... it's your own development so it's up to you to learn' (P18)

### ***7.3.2: Action Learning Sets***

One area of contention for participants was the process of selecting their action learning sets (see section 3.3.5) at the initial development centre. Potential issues are captured by the following comments:

'I do think there was a bit of the three days that was a bit pretentious and was unneeded, for example, the action learning sets, we were all just stuck in the middle of a room and told to sort out our own groups' (P1)

'The curious co-ordinating of getting people into their action learning sets ... it was interesting for a couple of hours, as an exercise in terms of your own personal development, but you ended up with people that perhaps were not best in line with you, people with different roles and responsibilities, different sorts of meetings, different sorts of decisions ... I found myself in a group that was very, very

personable, lovely people but in terms of pure benefit of ALS I wasn't quite so sure about it.' (P4)

The above statements note the awkwardness that many participants experienced during selection process. Several participants compared it to the unease associated with team sport selection and choosing partners at a school dance. On the one hand, some felt under pressure to choose a group quickly so they were not left behind. On the other hand, others viewed the process as beneath them and infantile. Nevertheless, a small number of participants believed that while the selection process had been challenging it had been worthwhile as it had led them to work with a variety of individuals with different experiences. Moreover, it was felt that the process itself had generated trust between group members, thus giving them a safe environment in which they could share ideas experiences.

'That was my first action learning set. What a lot of people found quite challenging was how you selected your action learning set and I didn't have any clear tactics ... but what emerged from the whole process was a very strong, really trusting group.' (P8)

Beyond the initial selection process there was a widespread believe that the action learning sets were a helpful addition to the programme that encouraged knowledge sharing and collective learning:

'It's about this very trusting environment that's been created or that we've managed to create in our action learning set, where you're able to actually express some quite personal fears that you maybe would be a bit more reluctant to do with people back in base. So that was one important thing.' (P15)

'So the action learning set was better than I had anticipated, ironically people don't talk about their projects at work what they talk about is their personal difficulties with other colleagues, and managers and staff ... after a while people become very open and comfortable and honest with one another' (P21)

Both the excerpts above illustrate that many participants viewed their action set as a safe, supportive environment where they could discuss their professional and personal struggles. This relates to the suggestion in the practice-based learning literature that learning groups and cohort learning can create a new learning community for participants where they share knowledge and experiences and construct shared meanings and practices (Carroll and

Levy, 2010; Cunliffe, 2008; Raelin, 2000; Siebert *et al.*, 2009; Petriglieri, 2011). Linked to this, others proposed that being part of a dynamic group had stimulated greater learning and enhanced their awareness of how to manage different personalities. However, it was acknowledged that diversity within the group can also lead to disagreements and unproductive discussions. This relates to the pros and cons of diversity in networks more generally (see section 3.3.7). The personal and emotional nature of some of the issues raised also meant that action learning was not always viewed as an easy process.

‘I enjoyed them. I found them stimulating. It was really useful for me to see how other personality types engaged and managed. It was also useful as an introvert to learn techniques of managing extroverts.’ (P10)

‘The Action Learning Set was interesting. You’ll get different responses to this from different people. I think it took a bit of time for us, the Action Learning Set, to work, and I think really quite different personalities, which is quite good and quite helpful in a lot of ways. You learn to work with people and to understand people who have very different perspectives from you, which is quite valuable. But, in some ways, it can be quite hard work, I think there were times for me where the action learning set felt as if it was harder work than the benefit I was getting out of it.’ (P12)

Ultimately it was argued that the value achievable through action learning depends not only on composition of the group, but also how engaged and committed individuals are in relation to the learning process:

‘I think the action learning set tended to be a wee bit haphazard at times ... everybody was frightened that they might upset someone ... you tended to hold back a wee bit which is not what it’s about ... what is really useful for me in action learning is people challenging you and saying that’s not good enough ... I think, it’s all down to the mix and whether you gel.’ (P1)

ALS groups were facilitated by the programme’s coaches and good facilitation was cited by both participants and programme team members as key to collective learning within the group. This is in line with the literature which emphasises the importance of facilitators who promote personal and collective reflection and encourage action (Conger and Toegel, 2003; Raelin, 2006). Coaches explained that action learning was a co-created process and it was necessary for them to vary their approach in relation to the make-up and needs of the group.

### **7.3.3: Coaching**

Overall, the coaching element of the programme received positive feedback. It was seen as a positive indulgence that allowed participants to reflect and focus on their individual learning objectives in a safe environment.

‘Having a coach one to one was extremely luxurious. To have that two or three hours where the focus was on your development was excellent ... it really helped my self-awareness, it was extremely helpful.’ (P8)

‘There was real trust between the coach and I, [...] made you work hard and reflect but didn’t give you the answers.’ (P11)

The emphasis on reflection is important as reflecting on practice is thought to be central to critical learning and identity reconstruction (Cunliffe, 2002; DeRue and Wellman, 2009; Hurd, 2009; Petriglieri, 2011). Participants spoke of having ownership of the process, being able to work through issues that were of concern for them, and gaining self-awareness from the conversations. Some likened it to therapy or counselling, while others focused on how it had complimented other elements of the programme and helped them apply learning within their workplace. Where participants did raise concerns over the helpfulness of the coaching sessions, these tended to be related to prior expectations of a ‘sports’ type coach who would guide, direct and encourage participants in a focused manner:

‘I found coaching a bit too non-directive and a bit too much like counselling and probably not that encouraging and bit unfocused’ (P21)

### **7.3.4: 360 Degree Feedback**

An element that received universal endorsement from participants was the 360° feedback process (see section 3.3.2). Most participants were nervous at the outset; however after receiving their results some spoke of gaining an immediate confidence boost, while others outlined how their initial results had set them on a journey of change.

‘The 360° that really helped me, I picked a really difficult bunch of folk ... so I had to prepare myself psychologically for the worst and actually it was the complete

opposite. I mean all my scores were very high. And actually, I kind of, came away from it on a real positive – a bit of a confidence boost’ (P14)

‘When I got my first 360° feedback, I was pretty devastated because a few people said that I wasn’t open and honest and I found that really cut against my core values ... I took being direct and having a direct, aggressive communication style as being honest, whereas I now realise that actually giving people the space and time to communicate is probably more honest... If we want to talk about change through the programme have a look at my first 360° and have a look at my second 360° – they are chalk and cheese’ (P17)

The statements above illustrate the relational aspects of leadership; gaining feedback on how followers and others in the organisation regarded them was for some a positive experience which reinforced their leadership identity (Day *et al.*, 2009). However, for others it was an emotional experience which caused many to question their self-identity and make a conscious effort to change (Conger and Toegel, 2003). It was felt that completing the 360° at two points in time gave participants an opportunity to reflect on how they had developed during the programme. Constructive feedback gained from the activity gave participants’ personal insight into their external image, learning style and management approach. This enhanced understanding allowed them to more accurately focus their development to target specific issues. Yet, others noted that because of the multi-rater design of the 360°, participants can also receive conflicting feedback due to people’s different preferences regarding, for example, engagement and communication.

### **7.3.5: Mentoring**

One aspect of the programme that was rarely mentioned without prompting was local mentoring (see section 3.3.3). The programme’s promotional material talks of fostering local ownership and the importance of selecting a mentor who will provide support and guidance locally during the programme. However, when probed about their mentors many participants gave vague non-committal answers. For example, when asked if they had a local mentor participants replied with brief answers such as:

‘I don’t know my sponsor is the chief executive and she mentions from time to time ‘how it is going?’ (P4)



‘Well, I did, but there’s been so many people that I’ve used, I haven’t just used one person ... I must admit, at the beginning I thought, I’ll have this one person that I admire and I’ll be like them, but it hasn’t worked out like that.’ (P11)

The responses from the two participants above highlight that for many participants the mentoring relationship with their nominated mentor was limited and ambiguous. The second statement emphasises the importance of informal mentoring relationships and drawing on the expertise of different people depending on the situation. Yet some took a more negative view conveying their disappointment that formal mentoring had not worked for them. This is noteworthy as positive inter-personal relationships with others in the organisation is crucial to developing a leader’s identity at a relational level and the sustainability of that identity over time (Cunliffe and Eriksen, 2011; Carroll and Levy, 2010).

‘I chose a mentor from within the board and it was someone who I thought would be useful both because of her experience in a similar role, but also because of the part that she played nationally...’ (P15)

*Interviewer: Did you draw on her during the programme?*

‘I would say the most disappointing aspect of the programme was the success of the mentorship arrangements because the way that that mentorship process was viewed meant it was very difficult to get access to the person on a regular basis. If there was any part of the programme where I felt as though I was relatively unsupported and that was unsuccessful, it was the mentorship arrangements’ (P15)

*Interviewer: Why was that do you think?*

‘I think there were two things ... I think that a lot of it was workload-driven and that people just physically couldn’t make the time to be able to contribute and I think that part of it is possibly leadership style as well, of the mentor I chose, who doesn’t tend to do one-to-ones very well, or regularly – as I now know.’ (P15)

The passage above notes that the mentor did not always view the role as a priority leaving the participant feeling unsupported. Problems with access and ability appeared to be a common problem for participants with many noting the difficulty involved in identifying someone with the time and skills required to appropriately mentor them:

‘To be honest ... I don’t mean this to be a flippant statement, but I’m not sure if our senior management team or executive team have, either the time or the inclination to help mentor and take people under their wing for the future.’ (P17)

A few participants had more positive experiences of mentoring, though, similar to the findings of Ragins *et al.* (2000), informal mentoring relationships that had been built up throughout their career were often perceived to be more valuable than those selected for the programme.

‘I’ve got a really good mentoring relationship with my line manager so I *get all* the coaching I need from him to be honest and he is very, very good ... he’s got a high opinion of me and he points out my mistakes without pussyfooting around whereas my coach probably was a bit too nice to me and maybe wasn’t direct enough about picking up my weaknesses.’ (P21)

It was argued that mentoring relationships should be built on mutual respect and, as emphasised in the above quotation, it is important that the elected mentor possesses the skills and capabilities required to communicate and impart wisdom and is able to provide constructive feedback (positive as well as negative). Linked to this others noted the unique learning gained from short-term shadowing of successful leaders following the programme.

### **7.3.6: Work-Based Project**

The project (see section 3.3.6) is also worthy of note. Most participants enthusiastically described the projects that they had undertaken, with many explaining how being on the programme had led them to approach tasks differently. The projects were led by the participants, sometimes with input from their senior managers, and emerged out of issues that they were facing in the workplace. In general they aimed to help participants use ‘content’ knowledge in their work, thus helping them to become a ‘leader in action’ which helped them to further establish their identity as a leader within the organisation (see. e.g. Haslam *et al.*, 2011). The short excerpt below from a senior manager in P10’s board illustrates the view that projects were often thought to provide direct organisational benefits.

The work-based projects are key to showing them how the more theoretical stuff can be part of their job ... P10’s has been a great success with real deliverables for the organisation (3-SM-p10)

However, throughout the interviews it became apparent that there were issues relating to the reflective report that accompanied the project. Both the coaches and participants mentioned that drafts had often submitted late and reports had varied in quality and length. Numerous participants mentioned that they appreciated the flexibility of the programme team, but a few suggested that perhaps the design could be improved:

‘The project has been funny; I don’t think they have actually cooked it properly. They have not really followed up on it. We had to submit it at six months and then at a year and I put a fair bit of work into it at six months and I asked for some feedback on it and the feedback I got was, ‘well that is fine’... so I think they could of made that a little more formative and I think because there wasn’t much feedback, a number of us just haven’t really finished it off and I know that that is the same on previous cohorts. So I think they have got something not quite there because by in large we are a group of folk who do deliver.’ (P3)

The programme team confirmed that there has been some ambiguity over the project with uncertainty among participants over the degree to which it should focus on personal development or service improvement. This relates to the debate amongst commentators as to the importance placed on individual reflection and learning versus achieving organisational outcomes in work-based learning (Costley, 2011; Garnett, 2001). Due to this feedback, the programme team have attempted to better position the project in practice for subsequent cohorts:

‘We are spending much more time on making certain that the learning from their internal project is absolutely embedded into their day-to-day activity.’ (C4)

It was suggested that placing greater emphasis on learning transfer and providing formative feedback would improve the status of the project in the minds of participants and help them to engage their organisations in the process. This is in line with DeRue and Wellman’s (2009) proposition that for projects to deliver optimal results they have to incorporate elements of challenge, support and assessment.

### ***7.3.7: Policy Focus - Quality Strategy***

A distinguishing element of the *Delivering the Future* programme is the link that it has with a current policy development. As such, cohort four was involved in the consultation process of the recently published Quality Strategy for NHS Scotland. Initially, most

participants enjoyed the process of meeting Scottish government officials and having the opportunity to influence policy development.

‘Each of us on the cohort have been designated as interim quality champions for the quality health care strategy...that will be supported...I have got a meeting with the directors in the next couple of weeks to take that forward.’ (P8)

‘Being involved with the quality strategy has been quite good because we have been able to view at quite close hand how the strategy was developed, how it has interwoven with the Scottish Government, how it is consulted upon and how you can influence these things.’ (P4)

Some participants engaged in the process more than others. During the programme, a number of participants from cohort four were involved in developing a collaborative workshop which brought together policy makers and DTF alumni to clarify the role of clinical leaders in the delivery of the quality strategy and to discuss appropriate indicators for each of the six quality pillars -person centred, clinically effective, safe, equitable, efficient, and timely. As an attendee at this event the researcher was able to observe a range of formal and informal interactions between the DTF participants and policy makers. An important theme to emerge during these discussions was that quality in the NHS is a multifaceted concept that can be difficult to measure as often it encompasses both tangible and intangible elements. Policy makers spoke of the need for a national strategy to provide continuity. However, the clinical leaders cautioned against patronising clinicians who may argue that they always strive to provide a quality service and do not require additional formalities. Others suggested that for the strategy to succeed local leaders will have to engage with individual staff members so that they know what their contribution is and that their contribution is valued. Despite appreciating the opportunity to contribute to these policy discussions, some participants expressed frustration that many of their suggestions had not been incorporated into the published strategy. There was also a feeling among some participants that, to its detriment, the strategy almost over shadowed the rest of the programme:

‘The first session we did on the quality strategy, I think went very well, our first kind of consultation on it. And it was really instructive being in at the ground floor of how the government develops its strategy. It then took on a little bit of a life of its own that I wasn’t quite so drawn to. I thought we had got all our points made, really, in that first session and we kept kind of coming back to it in different guises’ (P5)

As part of the process, members were also named as quality champions for their boards. In theory this was a success for participants with it being: ‘something else to put on the CV’ (P21) and some boards responded positively; however in other boards the announcement met resistance and animosity leaving participants unsure of their position.

‘It went down like a lead balloon here that we were to be the quality champions and that we were chosen to be to begin with.’ (P6)

In spite of these concerns, the programme team pointed to the importance of this element of the programme in terms of learning transfer, policy formation, and the kudos that participants gain from working with policy makers in this context.

‘One way that I think the programme really does encourage learning transfer is that each cohort focuses on a policy issue, for example, Better Health Better Care or the NHS Quality Strategy.’ (C2)

‘In the programme we try to engage with policy as it unfolds and our participants and alumni are often consulted about policy developments ... taking the lead nationally.’ (C3)

The statements above suggest that the opportunity to contribute to and frame policy is significant as it allows participants to actively apply learning from the programme and build their personal credibility with both NHS colleagues and government policy makers. This relates back to fulfilled expectations and the notion of giving learners the opportunity to use their knowledge highlighted in the AMO theory of performance (e.g. Argote, McEvily and Reagans, 2003). It gave them the ability and the motivation to lead, and then gave them the opportunity to lead meaningfully. This also highlights the role of this policy involvement on participants’ leadership identities. To some extent it had enhanced their self-belief and reinforced credibility with others. However, it should be noted that in this policy context they were regarded more as clinicians than leaders.

## 7.4: Conclusion

This chapter has presented participants’ views of *Delivering the Future* in relation to the suggestion that development programmes can act as workspaces. One interesting finding was that there was a sense of mystery around the programme which was thought to

enhance its credibility but also hindered comprehension at board level of the programme's significance. Nonetheless, it was stated that participants were grateful for the opportunity to focus on their own development. The programme's component parts were compared and contrasted and it was noted that although some elements were appreciated more than others it is the learning combination which makes the programme effective. It was suggested that the residential design and the inclusion of softer elements such as action learning and coaching produced a trusting environment where participants could share issues and learn from each other. There was a belief that they were on a learning journey and to succeed they had to first prepare themselves for new challenges and commit to the programme. Finally, it was noted that participants had asserted that the programme had been more practical than previous management or leadership training they had received and suggested that they have been able apply learning within their work. The next chapter addresses the first part of the focal research question introduced in chapter one. Specifically, it considers participants' accounts of the impact of DTF on their human, psychological, and social capital. Chapter nine then builds on this by considering the role of organisational context on learning transfact and intellectual capital development.

## Chapter 8: The Personal Impacts of Development

### 8.1: Introduction

This is the third of the four empirical chapters which present the findings from the study. Chapter six considered the political and professional context underpinning leadership development within NHS Scotland. Chapter seven then examined participants' overall perceptions of the *Delivering the Future* programme with regard to identity work, content, and applicability. This chapter addresses the first part of the research question which focuses on participants' accounts of the personal impact of the programme. In the literature chapters it was proposed that leadership develops over time and effective leadership development aims to improve both human capital (e.g. self-management capabilities, leadership knowledge, communication skills) and social capital (e.g. productive relationships and networks, trust, and knowledge exchange) (Day, 2000; 2011). Moreover, it was predicted that human, social, and organisational capital interact and complement each other to generate intellectual capital, which, in turn, drives innovation and organisational value (Garavan *et al.* 2001; Subramaniam and Youndt, 2005). Social constructionist theory also indicated that leadership identity is dynamically co-constructed at three levels: individual, relational and collective. This led to the suggestion that a further dimension, psychological capital (e.g. self-efficacy, hope, optimism and resilience), is important to leadership (Luthans, Youssef and Avolio, 2007). Therefore, this chapter explores participants' accounts of the impact of the programme on their human, psychological and social capital. Following this, chapter nine discusses the organisational factors thought to influence participants' ability to apply and share learning from the programme.

### 8.2: Developing Participants' Human Capital

'It's about more than promotions; it's about enhancing us to do our existing jobs more effectively' (P18)

Participants were asked how participating in the programme had impacted them personally. The statement above reflects the strong belief amongst interviewees that the success of the

programme should not only be measured on promotions, but also on how it has enhanced participants' knowledge, skills, and capabilities to allow them to master their current roles. In that regard, participants noted the self-understanding and leadership skills they had gained and provided examples of how they are working smarter through, for example, planning and reflecting before acting or delegating work so that they can focus on the more strategic elements. A range of human capital attributes were considered to be enhanced by participating in the programme. The following sections consider the four core dimensions mentioned during the interviews: self-management capabilities, social capabilities, work-facilitation skills, and creative and innovative applications.

### ***8.2.1: Self-management Capabilities***

Chapter two suggested that a dimension of human capital which is particularly pertinent to effective leadership is a leader's self-management capabilities, in particular their self-awareness and self-regulation (Goleman, 1998). Thus, it is interesting to observe that all participants cited increased self-awareness, self-understanding, and self-management as important learning outcomes from the DTF programme.

'One area that exceeded my expectations is around self-awareness - I have learnt a lot about myself.' (P21)

'I've learned more about my own behaviour and my own traits and how that impacts on other people' (P18).

Referring to the whole programme as well as specific elements, such as the 360° feedback, coaching, and Myers Briggs master class (on understanding yourself and others) participants spoke of having a greater understanding of their strengths, weaknesses, and leadership preferences. For example, referring to the coaching experience, P13 stated:

'It's the most rewarding experience ... it does make you sit up and look yourself in the eye and sometimes you don't like what you see, but it's helped me – I don't know what my staff would say – but it's helped me to be a much better manager and to see where I could perhaps tackle things differently.' (P13)

The statement above reflects the widely held view that taking part in the programme had given participants the opportunity to examine their inner selves and overcome emotional



hurdles in a safe environment. This led them to have a more honest understanding of their abilities and limitations. However, as mentioned previously it had also created tensions for participants as it involved them deconstructing their existing identity and letting go of previous beliefs. Nevertheless, participants suggested that having increased self-awareness had also helped them to overcome their personal worries and insecurities. They suggested that this had allowed them to work more strategically and draw on people with complementary skills and abilities.

‘I recognise my strengths ... I’m much more comfortable in my own skin in terms of what I do. Some of the things that I got really stressed about, I really understand now why, and it’s perfectly natural and I don’t worry about it anymore. I am much more able to be strategic than I was previously.’ (P6)

‘I certainly have greater awareness of where my strengths are, and greater awareness of where my limitations are, and a greater – not a greater appreciation – but a greater ability to happily pull in people who have got skills beyond mine, and not feel inferior because of it.’ (P7)

During the interviews participants spoke of having a greater appreciation of how their behaviours impact on their colleagues. They proposed that having a greater understanding of their own feelings and behaviours had helped them gain insights into the feelings and behaviours of others. These insights, in turn, allowed them to target and modify their approach to suit the preferences of different people. This links to the concept of ‘emotional intelligence’ discussed in chapter 2 (section 2.3.1), theory in this area asserts that a leader’s ability to perceive, control and evaluate their emotions can influence leadership outcomes (Goleman, 1996; Walter *et al.*, 2011). Participants also spoke candidly of their limitations and how they are managing situations differently due to increased awareness.

‘I recognise that I need to do a lot better with my teams around my listening skills. I’ve worked really hard through the individual coaching around my own self-awareness and how I can maybe improve some of my personal skills to help get the best out of my managerial team below me ... I’ve accepted that criticism is useful ... I think much more about my impact on others as I love doing things at the last minute that’s my personality. If I’ve got a project to do I’ll do it the weekend before, whereas some of my managers [who she is responsible for] are completely different and need things two weeks in advance ... So I’m much more aware now that a fortnight before I need to say, this is the agenda, these are the things that I’ll be looking for so that people have got time to think about that.’ (P1)

As in the above extract many participants acknowledged that receiving constructive criticism had led them to reflect on their practice, build in planning time, and avoid impulsive actions. This reflects the importance of feedback and reflection to effective learning (Cunliffe, 2002; DeRue and Wellman, 2009) and highlights the relational aspects of identity deconstruction and reconstruction (Beech, 2008; 2011). In particular, the statement acknowledges that leadership is a two-way relationship between leaders and followers (Kellerman, 2008). A further area of self-understanding that many participants referred to was the insight they had gained into their leadership and learning preferences.

### **8.2.2: Social Capabilities**

As noted previously, participants remarked that reflecting on their own strengths and weaknesses and how they impact others had consciously led to them to adapt their behaviour and endeavour to improve their personal skills. One area of social skill development that was cited as particularly valuable was enhanced communication skills. Several participants described how they are attempting to communicate more effectively with their staff and others in their organisation:

‘Learning from the way that other people say things and thinking: Oh, that’s a good way of expressing it ... something I probably got from the programme is how you communicate concisely and in an ordered fashion because I tend to do big picture thinking so everything just comes tumbling out and that’s how I think. It’s finding ways to overcome that and make point one, point two ... making sure that the message is put forward in a stronger way.’ (P2)

The statement above demonstrates the widely held belief that observing how speakers and other participants communicate helped participants become more focused and strategic in their own approach. Others observed that they had learnt the importance of listening and reflecting on what has been said before reacting. Participants stated that even small changes in their communication style had been recognised and appreciated by their staff and senior managers. For example, describing a conversation with his Chief Executive, P17 said:

‘I had a discussion with my Chief Executive and said; so what do I do different now that I’ve been on the leadership programme; have you noticed a change? And she said: *I do notice a change, but it’s not what you do or what you say, it’s what you*

*don't do and what you don't say now that's so much more important. People are listening to what you've got to say, because you're not ranting and raving and going off, your communication style is a lot softer so people will listen to what you've got to say ... your message is more meaningful.'* (P17)

The excerpt above emphasises that followers do not automatically follow. Leadership is co-constructed between both leaders and followers and is grounded in social interaction. Thus, followers will only follow if they relate to the leader (see section 2.3.2). The comment above suggests that adopting a less aggressive communication style had led P17's employees (followers) to react most positively to his suggestions. This view was reiterated in the results of his second 360 where employees said that they now had more respect for P17 as a leader. Several participants proposed that they now seek to inspire and motivate others, stating that in the past they had often adopted a more confrontational, authoritarian approach. In some ways this relates to the transformational and charismatic perspectives (see section 2.3.1). Fourteen participants also noted that they had learnt the importance of subtly targeting their message, approach, and style to the preferences of the audience. It was suggested that adapting their style in meetings and presentations had helped them engage their staff and managers in change.

*'Now I find myself asking or thinking about what's my target here, what's their personality and preferences, and how should I try and influence them to the best of my ability. My behaviour in meetings has changed, much less confrontational, much more trying to understand the perceptions of other people in the meeting, and much more understanding that there is more than one way to skin a cat.'* (P4)

*'I'm in a much better place now, personally; much calmer, much more in control. Things get frantic, but actually I, myself, am more able to cope with it...I'm more willing to tackle the difficult decisions and the difficult discussions that come with them ... the importance of maybe not being quite as direct; of asking the right question to get the right answer.'* (P10)

The quotations above are important as not only do they illustrate the perception that communications should be matched to the preferences of the listeners, but also the notion that being more mindful in their interactions has helped some participants to influence people within their organisations and beyond. Thus, facilitating change initiatives that would otherwise have been difficult. This relates to the psychology literature on mindfulness which suggests that individuals who engage in active reflection and information processing while performing their current tasks and have a level mindfulness

are better able to self-regulate their actions and manage their social relationships (Brown *et al.*, 2007; Krieger, 2005). Linked to this, others noted that given the current financial climate and potential cuts within the NHS it is important to engender a collaborative and trusting environment within their teams. It was suggested that this is, in part, achieved through honest and open communication and encouraging others to step back and consider the positives rather than get caught up in the negatives.

### **8.2.3: Work-facilitation skills**

In addition to self-management and social capabilities, it was felt that the programme had provided participants with the knowledge and skills to help them work more effectively and efficiently. Interviewees provided various examples of how they are working smarter through, for example, planning and reflecting before acting to get the most out of people, and delegating work so that they can focus on the more strategic elements. There was a sense that previously planning had been seen as a secondary consideration for some participants. It was asserted that pressure to perform and deliver targets meant that time spent planning was considered wasted time.

‘I always used to feel very guilty if I was spending any time planning and thinking, and actually I don’t feel guilty anymore, and I do allocate time to plan’ (P11)

The statement above illustrates that, in the past, participants sometimes felt guilt at taking time out to plan. Others expressed feelings of inadequacy and a sense that they should know the answer without planning. This can be related to participants’ lack of previous leadership training discussed in chapter seven. Despite these past views several participants stated that since completing the programme they appreciated the need for planning and preparation.

‘The other thing that it’s done for me is to give me a greater understanding of the importance of strategic planning, because I find a lot of talking and not doing very frustrating ... I find that if I’m challenged around a meeting, I plan what I’m going to do. If I have a difficult conversation, I plan the conversation using the skills... now I’m asking the right questions rather than telling people what needs to happen I coach them to understand and agree what needs to happen.’ (P10)

The excerpt above is important as it conveys that reflecting on challenging situations and developing a plan for dealing with them has improved participants' performance. It also links back to targeting communications effectively. Several participants stated that being on the programme had taught them to take a step back and reflect before responding rather than reacting immediately. It was implied that often this allowed them to work around challenges. A popular perception was that being on the programme had also helped participants to prioritise and delegate work.

'I'm not a planner but I'm much better now... partly to do with my mentor sitting down and saying: right what have you got for the month, what have you got for the fortnight, what have you got for the week ... I've got a huge job and I've got a finger in lots of pies and I would take on quite a lot myself which is where the errors came in. I'm now probably much better at delegating and prioritising which is good for my personal sanity and also good for my managers because in the past I would delegate and then if I didn't like how it was done I would do it myself which probably drove them mad.' (P1)

As in the above quote, interviewees explained how specific experiences on the programme, for example, discussions with their action learning set or advice from their coach or mentor had taught that it was important entrust others with work. However, several participants, especially those in remote locations, mentioned that simply being on the programme and having to balance multiple commitments meant that they had been required to become more organised and delegate work to others. Many acknowledged that before DTF they had tended to take over and attempt to find solutions themselves which had left them and staff frustrated. It was implied that through DTF they had learnt to be clearer with staff from the beginning as to what was expected.

Four of the twenty-one participants also stated that prior to commencing DTF they had struggled to clearly define their role and had found themselves holding on to clinical tasks that were no longer in their remit. Giving staff more responsibility was said to be beneficial for both participants and their staff. On the one hand, participants maintained that adopting a more strategic approach meant that they were more effective and had a better work-life balance.

'I think that oddly enough I've got a greater appreciation for the need to have a better work-life balance' (P7)

'I have been a bit more comfortable with actually doing less and leading more ... my workload has probably gone down by about 20% in the past two years and my income has probably went up by about 20% and there is not many people who can say that and that was as a direct result of the programme so I was letting go of stuff that I was getting bogged down on' (P21)

On the other hand, it was suggested that giving others more responsibility was a useful in terms of employee development and motivation.

'I saw that what was really important was not to do things myself, but to really encourage others to take on roles and to stretch and develop themselves' (P3)

Yet, it was acknowledged that increased responsibility has to be supported by the organisation. This was emphasised by P10 when she said:

'I basically walked away from a job until the other people understood that they absolutely had to stand up and do it. I have negotiated with my manager increased time so that other consultants can pick up some of my clinical work; and I'm in the process of appointing clinical leads with more direct responsibility for their clinical area.' (P10)

The statement above was given in response to the interviewer asking how P10 had managed the process of delegation. It is interesting for three reasons. Firstly, it shows that in order to motivate others to take on new responsibilities P10 had to first remove herself. Secondly, it notes the importance of the organisation being on board and providing the time and resources for others to take on greater responsibility. Thirdly, it illustrates the perceived importance of clinical leadership distributed throughout the organisation. This highlights each element of the ability, motivation and opportunity learning framework (Argote, Mcevily, and Reagans, 2003).

#### ***8.2.4: Creative and Innovative Applications***

A further area of human capital considered to be central to effective leadership is creative and entrepreneurial thinking. In the interviews with the programme team it was highlighted that it is not enough to think creatively leaders must act:

‘A strong feature of the programme is connecting the learning to the real thing – so encouraging participants to occupy a strategic leadership role in a meaningful way, not just getting their head round it, but also being able to take some action.’ (C1)

The statement above is from one of the coaches and demonstrates that participants are expected to become strategic leaders who actively employ knowledge and skills developed in the programme. The expression ‘occupy a strategic leadership role’ links to notion that leaders must demonstrate appropriate skills and attributes and be endorsed by others to embed their identity as a leader at a relational and collective level (DeRue and Ashford, 2010). Accordingly, participants described ways in which they have innovatively applied knowledge both through implementing specific tools from the programme and by thinking outside of the box, taking time to reflect and bringing in advice from others.

‘Well we had a day with Eddie Obeng and I found that really superb, it was all about means, ways, and techniques of getting engagement. It was particularly helpful with the situation I was in [...] and I am about to enter into a new situation in [...] where it's going to be invaluable, with service reorganisation. My clinical leader and I have talked about some of the things that came out of that. We have had some useful discussions about the ways forward and how to overcome difficulties in the group. So it's been very useful.’ (P9)

A number of participants spoke of how they had attempted to apply techniques and theory from the programme within their work. The example above refers to a master class provided by Professor Obeng whose project management work focuses on how to survive and thrive in complex, fast-changing environments (2002). Participants spoke of learning to control their emotions and attempting to emotionally engage colleagues in projects through collaboration rather than fear. It was proposed that engaging key stakeholders in change encourages creativity and helps leaders overcome challenges and gain momentum with difficult initiatives.

‘I've used the course to support me, and my action learning set, to develop this workforce tool ... we've engaged with all teams and practices ... It was still difficult to do, it's more about overcoming challenges’ (P16)

‘We're now thinking about really developing more of that intensive home-based kind of support that we haven't been able to do before ... I've chosen the working group in terms of representation ... I've been doing more work around, I think, getting people to talk together, being very clear about what the role is, getting people to think about being creative and to kind of take hold of it much more’ (P12)

It was suggested that by encouraging ‘joined-up’ working and adopting a proactive approach rather than having to react to crises participants have been able to deal with complex problems and implement long-term changes. Multiple participants also referred to Grint’s (2008) research on wicked problems and the need to tackle complex issues with a range of solutions. In addition, to describing the application of specific tools and theories, participants gave various examples of new projects and initiatives that they have developed to deal with particular challenges within their organisation. One such example is provided below:

‘Well, as part of the HEAT target achievement; a big redesign is required because we’ve got huge variation across the region. We’ve got limited money. We need all the three main partners – health, social care and the voluntary agencies – all to be working together towards achieving this single target. ...I’ve done two consultations so far; the first draft consultation which did noise people up a lot, it wasn’t my intention but it did ... I got some feedback and I’ve done a second revision which has gone out ... I’m doing a lot more consultation, within an agreed timeframe, than I’ve done before ... I’m much more consultative, collaborative, engaging with my senior management team who then engage their other teams so the whole tree of the organisation is engaged. It is working very well in the directorate... I need all the directorate staff and the other partners to be buying into a new vision of how services will look.’ (P5)

The statement above is useful as it illustrates the feeling amongst participants that if they are to achieve change they must work with a range of individuals and organisations. Several of the interviewees noted that effective leadership within the health service involves, in part, persuading and convincing others to support initiatives which can be particularly challenging in the context of a professional bureaucracy where everyone wants a say. Accordingly, it was also stated that introducing change initiatives can be a lengthy and laborious process as it takes time to work through the bureaucracy within the NHS. This connects with the view in the training literature that it is important for participants of development to be given the opportunity to apply learning when the return to their workplace (Argote, Mcevily, and Reagans, 2003).

‘It’s been a long time getting to this part, partly because of going through the NHS process and confirming funding for the project but we are now at the stage that software is going to implemented in nine months time so we will be beginning practically to change how the service works internally as well as how it presents its self.’ (P9)



Many participants stated that completing the programme had helped them overcome their frustrations with some saying that being on the programme had given them the confidence to implement small and large changes within their teams and organisations. Others said that they have found it easier to adopt an understated approach to new initiatives, slowly nurturing people through the different stages rather than presenting them with grand aspirations at the outset which they claimed can scare people off and lead to resistance.

### **8.3: Developing Participants' Psychological Capital**

As mentioned above, when asked about the personal impact of the programme participants spoke of having enhanced knowledge, skills and abilities. Yet, almost all also stated that completing the programme had increased their confidence in their existing skills and abilities. This relevant to the identity change process; confidence (self-efficacy) is a key element of an individual's psychological capital and is a crucial component of the first level of a leader's identity, that is, the individual must believe that they have the skills and abilities befitting a leader (see section 2.3.2) The other aspects of psychological capital of: hope, optimism and resilience were less prominent in the interview discussions but a small number of participants alluded to looking forward to the future, career goals and overcoming challenges. Each dimension of psychological capital is now discussed.

#### ***8.3.1: Self-Efficacy and Confidence***

Self-confidence is closely related to self-awareness if an individual has a firm grasp of their capabilities they are less likely to set themselves up to fail by, for example, overstretching on assignments (Goleman, 1998). Several participants stated that the programme had helped them recognise the strengths that different people have and appreciate the value of different leadership skill sets which had enhanced their belief in their own competence.

'I think it has given me a better understanding of my strengths and weaknesses ... more self-confidence because the things I've found difficult work wise are things that my peers have found challenging as well (P9)

'We all have our own doubts and insecurities, and it was absolutely lovely to go into this fold, really, and just meet people that held senior positions, that had really good

reputations, you knew they were good at their job, and to find out that actually they had the same fears and anxieties as you.’ (P11)

‘It gave me the confidence to try new things out and confirmed that the direction that I was travelling in was actually ok.’ (P20)

The quotations above highlight the perception that learning alongside a group of their peers and observing that they had similar concerns and insecurities actually boosted participants’ self- confidence. It showed them that the skills and abilities that they had learnt on the job were relevant and encouraged them to be open to new approaches.

‘I’m extremely happy in the role that I’m doing at the moment, and I’m still challenged by that. I think personally I’m a lot happier at work, or I put myself under less stress, I’m not as hard on myself. I now know that it’s okay to say, I’m not looking forward to that meeting, it’s going to be difficult. And I now know that I have to think, well, why is it going to be difficult, and what are you going to do to overcome those difficulties? Where before I maybe thought, oh, it’s because I’m not good enough, that meeting’s going to be difficult, or I don’t have the knowledge and skills to drive forward that agenda. I would never really think that now, I’d think, yeah, it’s going to be difficult, it’s okay to think that, that’s great to be aware, have insight, but also, on the back of that, I’ll have a strategy how to deal with potentially difficult situations.’ (P11)

The extract above demonstrates that increased self-confidence led several participants to state that they were happier in their work and more able to accept and deal with their weakness, allowing them to manage challenging situations rather than get overwhelmed by them. There was a sense that many participants have felt able to be a lot braver in their work. Participants described a variety of situations where they had overcome personal fears and external resistance to, for example, present challenging material, introduce new initiatives, and support others through difficult circumstances. This impression was reiterated by a member of the programme team who proposed:

‘There are a good number of people that I am coaching who have been a lot braver than they would have been had they not been on the programme. So for example, they will have input to policy debate that may have been, or are quite controversial, they have been proactive in designing some things that may have been pretty unpopular but they’ve been able to influence people to get to point where they can actually get some traction on something that would have been considered a immovable beast before. So I have worked with participants who say without a doubt that they have managed to change big things as a result of having increased self-confidence, and greater skill and knowledge about how to go about influencing situations’ (C1)

It was evident from all the interviews that increased self-confidence was considered to be a fundamental benefit of participating in the programme. A number of participants suggested that having increased confidence had also helped them build plans for the future and become more resilient in their role.

### **8.3.2: *Hope: agency, pathways, and goals.***

As a component of psychological capital, hope has its theoretical foundations in positive psychology and refers to having a positive motivational state and aspiring and planning to meet goals (Snyder *et al.*, 1991: cited in Luthans, Avey and Patera, 2008). It consists of three major conceptual foundations: agency (goal directed energy), pathways (planning to meet goals), and goals (*ibid*). Within this study several participants stated that they were ambitious and that they had moved positions regularly throughout their careers. Many maintained that they would not have got to the position they are in within the organisation without being highly motivated and adopting a positive mentality. However, when asked how the programme had impacted their future aspirations a number of participants said that it had helped them to clarify where they wanted to be in the future.

‘When I started the course all I wanted to do is cope with the job I’m doing just now ... I can almost see beyond the job I’m doing now, to say, right, where actually do I personally want to be, rather than where the job takes me.’ (P10)

‘It’s actually made me realise very firmly that my future career is very much in this direction rather than the clinical direction now. I would love to be able to commit to a career in medical leadership ... I suppose, it’s also made me realise that I’m fairly driven by nature and fairly ambitious, as well, which I don’t think I fully appreciated.’ (P15)

Both quotations above show that participants were actively thinking of the future, many strived for more senior, influential leadership positions while others expressed a desire to get back to their clinical routes. The first statement illustrates the feeling amongst some participants that in the past they have got caught up going for the next promotion because that was expected rather than making a conscious decision to go down a particular career path. **In contrast** the second emphasises the clarity and drive P15 has gained from completing the programme. Another area where participants felt the programme had helped

them gain focus was around their personal development. Several participants noted that they were more willing to seek out opportunities relevant to their needs.

‘It has given me the wherewithal to decide whether I want to continue with coaching, whether I want to continue with further development, and also how to access that and how to get it done. A big part of the learning was how to get things done.’ (P4)

As demonstrated in the statement above there was a belief amongst a few participants that the programme had given them the means by which to identify their developmental needs and the credibility and influencing skills to access resources to overcome them; however, others noted that they struggled to obtain organisational support for further development.

### **8.3.3: Optimism**

A third aspect of psychological capital is optimism. The extent to which participants expressed optimism about the future was mixed and appeared to be related to the level of organisational support they were receiving within their boards. Nonetheless, both the participants and programme team agreed that the programme opened up new opportunities.

‘The DTF programme aims to develop a pool of talent at a strategic level that are of the calibre to be future, for example: medical directors, nursing directors, etcetera. In this regard it is very effective as if you look at the evaluations, 80% of participants take on promotions or significant additional responsibilities within their existing positions following completion of the programme.’ (C2)

‘I probably would have looked for promotion even if I hadn’t been in this but I think being in this leadership programme will stand me in better stead if I go for a promotion’ (P1)

The first statement by a member of the programme team highlights the succession planning objective implicit within the philosophy of DTF. The high percentage mentioned suggests that participants very much expect promotion and it has become part of their constructed world view. It is assumed that participants will take on additional responsibilities, make the most of their skills in national secondments and aspire to promoted posts. The second quotation illustrates the suggestion that many participants had always been focused on their career development and aspired to the next position. However, completing the programme had enhanced their confidence and credibility as clinical leaders so it was anticipated that

they would get to where they wanted to be sooner. Several participants stated that were not sure what they would do next; however, they felt that there were more options available to them since completing the programme. In addition to being optimistic about their future career, a number of participants were confident that they would be able to deal with challenges and make valuable changes in their organisations. Arguably, a key task for NHS Scotland will be managing these expectations to ensure that participants remain motivated.

Conversely, a small number of participants suggested that the knowledge gained on the programme had led them to realise that they were ‘fighting a losing battle’.

‘Since I’ve had my 360 feedback and I’ve worked through again some of the frustrations that I have and I recognise that it’s time to move on, that I’ve done what I can in the role I’m in and I’m constantly pushing against the boundaries and I get frustrated because I can’t get anywhere. But that’s mainly because of the position I’m in. It’s nothing to do with my own ability ... I don’t have the level of authority’ (P6)

The statement above highlights that frustrations in their work have led some participants to (optimistically) strive towards promoted posts where they have the autonomy to implement change; while others are (pessimistically) becoming disillusioned and struggle to see a productive way forward. This theme will be revisited in chapter 9.

#### **8.3.4: Resilience**

The fourth aspect of psychological capital, participants’ resilience to bounce back from adversity and proactively adopt positive change also seemed to relate to the level of support participants received from their organisation. This may be because an individual’s resilience is influenced by their level of optimism (Luthans, *et al.*, 2007). Yet, a number of participants noted that completing the programme had made them stronger leaders who were more able to adapt to a variety of situations.

‘I think the other thing it does it develops your emotional resilience a wee bit because you’ve got to face up to meeting 24 new people, you’ve got to do a project, you’ve got to do a presentation, you’re got to speak in big groups and you’re challenged all the time. It does make you much stronger in terms of how you behave and how confident you are.’ (P1)

The statement above notes that many participants believed that being challenged on the programme had enhanced their emotional resilience as they had had to deal with situations outside their comfort zone. Resilience can also be related to participants' self-management capabilities discussed in section 8.2.1. Several participants asserted that having a greater awareness of their own strengths and weaknesses together with a deeper understanding of the policy environment in which the NHS operates has helped them deal with complex situations. Similarly, others discussed how the skills and knowledge gained on the programme together with support from their coach and action learning set had given them the confidence to undertake and tackle new challenges.

'It's given me confidence and practical skills to take on a significant role ... frankly, I would have really struggled here. I do have still times when I'm still struggling with various things, but having the skills and having the support from coaching and others in the action learning set and others in the wider cohort has been fantastic.' (P3)

#### **8.4: Developing Participants' Social Capital**

In chapter two it was proposed that there is a growing desire to equip leaders with the skills to generate, utilise and maintain social capital. The perceived impact of the programme on participants' communication skills was discussed in section 8.2.2; however personal communication skills can also enhance working relationships, resulting in increased social capital. Consequently, it was not surprising that nineteen of the twenty-one participants associated improved social capabilities with more productive interactions and networking opportunities.

'Networking and knowing people's agenda is important in this job and I've always spent quite a lot of time trying to get the communications side of things right, but the programme enhanced my understanding of how to engage with people' (P2)

'It was a real opportunity to connect with people from other health boards and to talk to them, really, around their experiences of clinical leadership roles in other health boards. And just to explore, I suppose, a bit the differences and the similarities between the role that I have within this board and the role within other boards. I think as much as anything it was a networking opportunity. It was about making contact with people at similar levels, as I say; in different areas of health ... it's quite useful' (P12)

A common theme to emerge from the participant interviews was gratitude for the relationships and network ties they had built as a result of the programme. Leaders build social capital through their interactions with followers and others in the wider social environment. The creation and maintenance of trust is considered an important part of social capital which encourages cooperation and knowledge exchange. Both the programme team and participants suggested that through its design DTF fosters both individual and group-level social capital. Several interrelated themes emerged following the analysis of the transcripts including: peer support and collective learning; the advantages and disadvantages of diversity; collaborative projects; nurturing local relationships; credibility and extended networks. These are now discussed in turn.

#### ***8.4.1: Peer Support and Collective Learning***

An important theme to emerge was that the structure and design of the programme create a trusting environment where participants could share ideas, work through problems and learn from each other. This is significant as social capital develops as leaders have purposeful conversations and share important stories. Several participants spoke of being in isolated roles within their organisation and appreciating the opportunity to expand their networks and gain a new supportive peer group.

‘For me, the most important aspect of it has, without a doubt, been the peer support and networking opportunities.’ (P15)

‘I think what the leadership course encourages you to do is to speak out and express your views to quite a critical audience, but in a protected environment’ (P2)

‘You evolve a relationship and a trust. You can’t prescribe that; that had to evolve.’ (P7)

Participants referred to the programme as a safe environment where they could speak their mind and be challenged by their peers without worrying about negative ramifications. It was believed that the action learning and coaching elements of the programme had helped to promote good working relationships (and in some cases close friendships) amongst the participants. Nonetheless, it was acknowledged that it had taken time for the cohort to ‘gel’ and feel comfortable with each other. Yet, once trust had been established knowledge exchange and collective learning occurred. This social context also facilitated peer-

identification and the contributed to the relational construction of participants' leadership identities (Wenger, 1998). Building on her earlier statement expressing gratitude for new networking opportunities, P12 went on to say:

'... I think, when you're developing services in health, to have a broader perspective and to know what's going on in other acute services and other community services ... there's a kind of shared learning aspect to that ... an opportunity, to develop that kind of shared knowledge. .. I think I do have a better grasp of the different health boards and the different cultures in them.' (P12)

The quotation above demonstrates the view of many of participants that they had been able to learn valuable knowledge about clinical leadership in other boards and gain a broader appreciation of healthcare delivery across the Scottish NHS. In addition, a number of participants stated that having the peer support from those in their action set and across the wider cohort had helped them deal with unusual and stressful situations that they had experienced while on the programme. This was emphasised by one participant when she described how she had dealt with a particularly difficult personal experience:

'It was really useful to have that body of people completely removed from my situation that I could share the angst with because it was quite stressful, really.' (P5)

This highlights the sense of community within the group and the social and collective aspect of learning and leadership identity construction (Carroll and Levy, 2010; Siebert *et al.*, 2009; Weick, 1995). In a similar vein, a few participants stated that the support they had received had helped them coach members of their staff deal with difficult situations. Others noted the how they had enhanced their skills by observing, for example, their peer's communication style or learning approach and attempting to replicate it. This relates to the network theory of contagion (Burt, 2001) which suggests that shared behavioural norms develop within close social units as individuals observe peer behaviour and regard it as 'proper', that is, befitting of the group or community. Linked to this is the assertion that learning within a multi-professional group had enhanced participants understanding of the whole patient journey and how different professions contribute to that journey.

'I also learned that the health service was more about people than I had previously realised. I hadn't realised that the dynamics between the different people in the health service were so important to delivering the service. So that was a bit of an eye opener.' (P21)



The quote above highlights the idea that participants gained insight into the complexity of the health service and the interdependencies between professions across. This can be related to Gittell's (2000; 2009) concept of relational coordination, discussed in chapter four, which suggests that interdependencies among health care providers are dynamic and interactive. This brings the discussion to the next subtheme: the strengths and weaknesses of diversity.

#### ***8.4.2: Advantages and Disadvantages of Diversity***

Relational coordination comprises of both communication and relationship dimensions (Gittell, 2009). It stresses the importance of coordinating care through effective communication and social capital dimensions, such as: shared knowledge and mutual respect. The programme documentation emphasises that the multi-disciplinary nature of DTF encourages knowledge exchange and an opportunity to challenge preconceptions. This aim was reiterated by members of the programme team. For instance, one member of the team stated:

‘I think the multi-professional aspect is really important ... they can learn from each other and it creates a multi-professional network that can ultimately help participants improve service delivery’ (C2)

The statement above alludes to the overarching objective of the programme to build a multi-professional network that can learn from each other and work together to enhance public value. This is based on network theories of brokerage which recommend individuals gain access to information by working across structural holes between two or more networks (Burt, 1992; 2001). It is assumed that bringing people together from different boards and professional networks enhances information flow and increases the social capital of participants. Programme participants were guided by different professional logics which impacted their priorities. Likewise, their leadership experiences varied in relation to the size and structure of their board and their position within it. Participants spoke of the benefits associated with being part of a diverse cohort in terms of learning from each other; thinking outside the box, and understanding the challenges that other professions face:

‘I think the multidisciplinary element was very important because I think as doctors we need to spend more time chatting to our allied health professionals ... doctors act as leaders and don’t take on the comments of others ... it gave me an appreciation of the stress and pressure other healthcare professionals are under. I think often you think that your own profession is the only one that is really stressful and busy until you see how other people have busy and stressful jobs and also how they handle things. It was also quite eye opening to see how other healthcare professionals handle particular issues’ (P19).

As in the preceding extract, participants observed that the opportunity to liaise with senior clinical colleagues from a range of service areas and from a number of health boards was helpful as they gained a broader perspective and appreciation for the work of their colleagues in different professions and areas of the Scottish NHS. A few participants took a stronger view, for example, one stated:

‘Being challenged in a group of my peers ... renewed a passion in me for healthcare that had not withered as such, but become a bit jaded. It certainly rekindled that and made me want to leave where I am just now and do something more, something different.’ (P13)

This emotive statement portrays a view that the relationships and peer-support that develop from the programme actually can enhance participants psychological capital giving them hope and drive for the future. Others expressed less tangible feelings of value. The statement below illustrates that it is often difficult to explain the learning that occurs through interactions within a group context. Several participants attempted to explain this by suggested that learning occurred through an iterative process where one person would present an idea or issue and others would add to and adapt it through a sort of negotiation process until a new more effective idea or solution emerged.

‘There was such a mix of people that everybody’s viewpoint was quite often really different and coming from a very different place, but collectively it all made such sense, and the learning opportunity was just out of this world. It is really difficult to explain actually.’ (P13)

Despite recognising the advantages of having a diverse group of colleagues, the following excerpt illustrates the feeling of some participants that excessive diversity within the cohort sometimes made it difficult to fully understand the specific issues facing other participants. This relates to the notion that individuals socially construct their world in relation to their

membership of important groups and their views may be in conflict with those outside of the group (Giessner *et al.* 2009; Hogg, 2001; van Knippenberg and Hogg, 2003)

‘We had very varied roles - that was one of the things I actually found a little bit frustrating about the programme ... I think the ability always to network with other people can never be underestimated ... but I can see pluses and minuses of having multi-disciplinarity. I think it’s good to have good representations, but when everybody’s got such different roles it can be hard to relate.’ (P14)

This view was echoed by a small number of participants and by one member of the programme team who suggested that the range of professions occasionally led to the dynamics in the room being counterproductive. Nonetheless, others maintained that learning to work with the array people in the programme had taught them how to work with and manage difficult people in their teams and work groups.

#### **8.4.3: Collaborative projects**

‘What the programme does is it brings together 24 leaders across the NHS who will ultimately share work issues and it provides the opportunity for them to collaborate ... The establishment of working relationships and friendships is something that cannot be taken away and that will lend itself extremely well for future work. It doesn't matter what I will be doing there will always be somebody within an NHS board in a senior position that I can speak to get advice and guidance from.’ (P8)

The statement above introduces the notion that despite concerns over diversity the programme provides a direct network of individuals from across the Scottish NHS that participants can draw on during and after the programme. All participants stated that they felt comfortable contacting fellow participants for advice about particular issues due to the trust and relationships that had been built during DTF. The multi-professional, multi-board nature of the programme was thought to be particularly valuable in this regard as it opened up new avenues of information that could enhance service design and implementation.

‘I think collectively, there’s an awful lot of support that we could give each other, which ultimately, and in terms of networking, moves the services forward, and just makes things better for patients, and hopefully cuts through a lot of red tape, hidden agendas, that type of thing.’ (P11)

‘It’s just about being able to contact people who have done this elsewhere that was really helpful ... it’s just much easier, really, to kind of pick up the phone or to email and to say, do you know anything about this in your context?’ (P12)

The first quotation illustrates a belief that the strong, supportive ties developed during the programme had the potential to assist participants to overcome bureaucracy and improve patient care. Similarly, the second emphasises that participants felt comfortable sharing their experiences and knowledge with others on the programme. Several participants emphasised that they had shared tools or initiatives while others spoke of trialling new ways of working based on recommendations from others in the cohort. There was a sense that this was a two-way relationship with people reporting back their experiences which in turn enhanced the effectiveness of the original initiative.

In addition, a number of participants described how after meeting on the programme they are working across boundaries on joint projects. For example, representatives from a national board, two local boards, and a special board are currently developing a trial programme to assist patient care in remote and rural areas which would not have been contemplated if the different members had not met on the programme and got chatting informally over coffee. Despite many people taking advantage of the opportunity to share information and set up joint projects. A few interviewees cautioned that they had actively sought out useful collaborations and to be successful everyone involved must be fully committed.

#### ***8.4.4: Credibility***

Beyond the immediate cohort, there was a sense that DTF had given participants the credibility to approach people such as past participants or senior individuals within the NHS or Scottish Government for advice and assistance.

‘The programme seems to have a fairly high profile within government ... there is a recognition that there has been a fairly robust mechanism for you to be selected to the programme and ... that you've actually been exposed to not only the networking, but also a whole load of tools, which you can use in your work.’ (P3)

‘It gave me the confidence to go and approach people like Kevin Woods or Derek Feeley or Harry Burns; it gave me the opportunity to go and speak to these people,

but it also gave me a confidence in what I was actually saying, because of the learning on the programme.’ (P13)

The statements above relate again to co-constructed nature of leadership and identities. They highlight the interplay between an individual’s self identity and their social identity (Beech, 2011). Participants stated that the confidence they had gained while on the programme had left them feeling empowered. Many described feeling like it had given them not only permission to be themselves, but also permission to be ambitious and enquiring. Thus, they described how they had taken it upon themselves to push open doors by requesting meetings with their chief executive or asking to shadow prominent leaders within and outside of their organisation. Alternatively, others noted that the programme itself had raised their personal profile prompting others to view them as leaders which, in turn, had exposed them to new opportunities.

‘I suppose the other thing that surprised me was how many doors the leadership programme opened ... it really raises your profile somewhat artificially maybe, but just from being on the programme, getting to go to some pretty high level events and people immediately think that you are credible ... getting into pretty high level meetings; health board meetings, audit committee meetings, staff governance all the sort of top, strategic meetings at board level that normally someone at my level in the organisation wouldn’t get anywhere near ... and even though I was an observer, shadowing ... quite often my views were sought as a clinician at the table. Yes, that is one of the things that I have learned ... clinical leaders are probably much more highly valued than board officials and bureaucrats.’ (P21)

The excerpt above makes a number of interesting points. The proposition that the programme raises participants’ credibility and standing amongst their senior managers is important as being endorsed by important others (e.g. staff, peers and managers) is crucial to the construction of a leader’s identity at a relational and collective level. Yet, this is an iterative process, over time their self-belief and identity changes and this is reinforced by others. Others’ behaviours gives credibility to the participants’ views of themselves and change their socially constructed worlds. In contrast, the suggestion that perhaps people’s perceptions may be artificially raised alludes to feelings of discomfort or uncertainty over the validity of such an endorsement based on the programme. One reasoning for this might be that the participant seeks to balance influence with humility. Nonetheless, the statement also illustrates the gratitude of those participants who have been invited to the top-table and been asked for their strategic input. Moreover, the last statement highlights the

perception that clinical leaders are perceived to be more credible than managerial leaders. This opinion resonated with several participants who suggested that their clinical grounding and patient focus makes them valuable additions to strategic discussions as they can easily identify the practical implications of different proposals. Perceptions of clinical leadership in NHS Scotland are revisited in chapter nine.

A further related argument offered by the programme team was that credibility of participants in a government sphere can be related back to the successes of past participants:

‘There have been some real stars come through the first five cohorts ... it has been picked up by the policy makers and recognised by the policy makers ... So we have built relationships in various parts of the Scottish Government that have allowed our participants to support and shape the work being done by the policy makers and that then becomes a revolving door because the more they can add value the more the policy makers are coming and asking them.’ (C4)

#### ***8.4.5: Extended Networks***

Through each other participants have found that they also have access to a wider network across the NHS. Several participants described instances where they have not only drawn on the skills and knowledge of fellow programme members, but also their colleagues and acquaintances, making statements such as:

‘I think that wider network and sharing of information is a real positive for the course.’ (P1)

‘For me, I think the biggest benefit was networking and relationship building. Within the cohort I’ve now got pretty good relationships with a whole host of folk in every board of Scotland, and in all sorts of different areas. So if I have an issue with [...] I can pick up the phone to [...] and say who is best person to speak to about X? What are they like and how would they like it pitched - is there anything that you think I should say? That is invaluable.’ (P3)

It was proposed that DTF has given participants a sense of legitimacy in accessing people beyond those in their common circle. As in the above quotations, several participants’ argued that knowing who to speak to and how to approach them had helped them to interact and share information more effectively and efficiently. This efficiency was

believed to be a consequence of gaining informal access to colleagues which assisted the development of early trust and rapport. Likewise, participants said that they would feel confident recommending DTF participants to their colleagues. This peer endorsement is important to both a leader's identity and social capital. A further aspect of the wider network that was mentioned by both the participants and programme team relates to the DTF alumni.

'So the most important aspect, as I see it at the moment for *Delivering the Future*, is about the 120 DTF alumni and getting them to work together and embed the knowledge that they have gained, well, leadership they have gained through the programme.' (C4)

The above statement by one of the coaches emphasises the desire to encourage interactions across past cohorts. Although the programme team have recently set up a virtual network with a small number of participants from each of the cohorts, several participants noted that ties and relationships across the cohorts are weak and could be developed. This relates to the literature on virtual networks and virtual communities of practice which suggest that a lack of time, competing priorities and limited personal motivation are significant barriers for knowledge sharing (Ardichvili *et al.*, 2003; Gammelgaard and Ritter, 2008). Participants did observe that on occasion the programme team organise special events to which all cohorts are invited.

'There have been a number of one-off events which have been advertised for everyone who has ever been on the programme and even though as I said it was hard work to go and do, to get the protected time for this, I have been along to two of those and that was really quite interesting because you did get a chance to meet folk from previous cohorts ... that just gives you another network of people so when a member of staff moved from ... I knew that this person was a very able person because of what [...] had said. So I was able to welcome this person' (P3)

The statement above demonstrates that such alumni wide events can be valuable as they create an additional opportunity information sharing. The researcher was able to witness this first hand at the DTF alumni event (discussed in chapter seven). At this event she observed participants from different cohorts discussing the changing curriculum of DTF but also asking colleagues for advice on particular leadership issues that they were currently facing. However, as noted in the above quote, due to existing organisational commitments clinical leaders find it difficult to allocate time to regularly attend such

events. Although ties across the entire alumni are weak one area where many participants are attempting to strengthen relationships is in their own boards.

#### ***8.4.6: Nurturing Local Relationships***

Within a number of individual boards, participants from different cohorts have formed 'working groups'. Some interviewees have joined existing groups established by their predecessors while others have taken it upon themselves to engage others within their boards. There are also differences in the dynamics of the groups and the support that they have received, but they generally meet every few months to take forward strategy and provide support and advice to each other. Although, participants proposed that these working groups provided a source of productive interaction they could also have negative and de-motivating effects if some individuals from prior cohorts have not been able to use their newly acquired skills and knowledge. Others have also taken elements of the action learning process back to their local colleagues.

'Yes, we meet on a regular basis and we set that up - all six of us who've come through it so far. We discuss frustrations that we have locally in terms of trying to lead pieces of work that we've got, some of the things that we'd like to see changed and improved on. We have had discussions with our OD lead here as to where we can contribute more strategically as a group ... I guess perhaps some of the disappointment is that they're not perhaps using us, but for now we are taking forward our own projects ... under the radar ... we've got an action learning set locally with some of the other people on the leadership cohort to look at how we might keep this work going.' (P6)

The excerpt above illustrates the usefulness of such local working groups for productive discussion and collective learning. It suggests how being part of a group helps them overcome some of their personal concerns and advance initiatives, but it also hints at a desire to contribute more strategically and a belief that they should avoid drawing attention to innovative projects as it may result in resistance. Although some local groups are already providing forums for change, others are facing issues with commitment and finding it difficult to engage participants and managers in the process:

'We have tried on several occasions to meet as a group, but people have not been able to attend for one reason or another and had to cancel at short notice. So we have tried, but it's just not worked ... people absolutely are up for it, but actually in reality,



when it comes, there's some sort of crisis that takes you away ... I have to say that our OD has been very helpful, so I probably have more to do with the OD department than I did before; I probably understand a little bit about what they try and achieve.' (P10)

The quotation above highlights the difficulties that some participants have found in trying to organise meetings, some are receiving limited support from their senior managers and local OD department while others are finding that there is a lack of commitment among past participants who have now moved on to commit. Everyone is busy and often other priorities supersede. These competing priorities and lack of commitment may undermine the strength of the group over time. Based on this experience a number of participants, including P10, noted the importance of gaining the engagement of senior managers when introducing new initiatives.

'I think the other thing I've learnt is the importance of senior engagement. You can do things, but actually you need the senior people behind you and that's very important – especially when you're doing massive bits of difficult redesign ... the importance of senior sponsorship.' (P10)

The statement above refers to the importance of working closely with senior managers. However, nurturing effective relationships and interactions with staff and peers is also considered to be a central dimension of a leader's social capital. Thus, several participants emphasised that they are also building dyadic relationships with their colleagues.

'The person who introduced me to the programme, I work very, very closely with, and I do get, and I hope she does as well, but I personally get a lot of support from her and a lot of help, and she's a colleague that I go to and I trust, and I would bounce ideas off her, and I hope she has the opportunity to do that with me sometimes.' (P11)

This type of knowledge exchange is more informal and sporadic but was perceived to be equally valuable by participants. As noted above there was a strong perception amongst participants that their organisations could use them more strategically. One explanation for this is that the participants had formed a community underpinned by shared meanings and expectations (Carroll and Levy, 2010; Wenger, 1998). The statement below, from a colleague of P10, illustrates that these shared meanings may be unsettling for others in the organisation.

As a board we have had five or six people go through the programme and I think it can be a bit disconcerting for other colleagues ... those involved have to be mindful that whenever you put a cohort of people together and they are exposed to something which only they're exposed to, there is a tendency to start to share a view of leadership - which others haven't got...and, actually, the challenge is for those individuals to share more proactively with the rest of their colleagues, the learning from the programme, in terms of, leadership, theory, methodologies, etc. I know that P10 has made a real effort to share what she learnt, you know, not in derogatory or undermining way. (3-GM-p10)

This observation echoes P10's concerns over becoming an 'elitist group' and relates to social categorisation theory and the notion of 'in-groups and out-groups' (Giessner *et al.* 2009; Tajfel and Turner, 1986; van Knippenberg and Hogg, 2003). It suggests that local alumni groups may reinforce the sense of 'us and them' which can be detrimental for the organisation and suggests that is important for those who have been on programmes to actively share what they have learnt with others. One way in which some participants are attempting to engage their staff and colleagues is by introducing localised action learning sets across their teams and boards.

'I approached people at my own level in the organisation initially, and I asked if they had any experience of Action Learning ... and very few of them had any knowledge ... I tried to describe it as best I could and asked if any of them would be interested, or if they felt there were any of their staff that would be interested in participating. Some were keener than others ... but some of did come back to me and said that they would like to participate in it themselves and they had one or two members of staff. So, we dipped our toe in the water and formed an Action Learning Set. There are eight of us in it at the moment and we've met twice so far and it's actually working really well. I'm facilitating it ... we set some ground rules when we first met, and we've started bringing issues to the group for discussion ... because we are just a small organisation, what you tend to find, though, is the issue that you bring to the group may directly involve someone else who is in the group.' (P13)

The excerpt above illustrates the potential value of local action learning in that it encourages open communication and reflective thinking. However, it also alludes to the limitations that come with closed networks (Burt, 2001). Nonetheless, these groups represent a real attempt by participants to engage those outside the programme in learning. There was a sense that some colleagues and staff members had been more interested in the process than others and it was noted that keeping participation voluntary was key to success. It was believed that such action learning and working groups had enabled learning from the programme to be shared within participants' organisations. However,

the interviews were completed early in this exchange process and it would be interesting to explore the longevity of these groups.

## 8.5: Conclusion

This discussion has attempted to present participants' accounts of the impact of the programme on their human, psychological and social capital. However, during the analysis of the interview transcripts it became apparent that social capital, psychological capital, and human capital are not fully independent of one another. This is reflected in the fact that some leadership competencies could be coded as either human capital, psychological capital, or social capital. This was the case for communication skills which could be viewed as either a human or social element as communication skills reflect an individual competency as well as a relational ability for engaging others. Likewise, a leader's self-management capabilities were considered to be a key component of their human capital but it could also be argued that it is part of their psychological or social capital.

In spite of these difficulties in classifying the effects the chapter showed that participants of *Delivering the Future* believed that it had had a great impact on them personally, making them more effective leaders. Most notably it was cited that the programme had enhanced participants' self-confidence and self-management capabilities. This allowed them to feel more comfortable in their role as a leader and helped them understand when it is important to step back and bring others in. Enhanced social capital through increased credibility and the availability of information from both close and extended networks was considered to be a key benefit. It was believed not only to reveal new pathways for participants personally, but also to provide opportunities to collaborate and produce more efficient and effective services. Chapter nine now considers how different organisational factors were perceived to influence the transfer of personal outcomes into organisational outcomes. In addition, it explores perceptions of clinical leadership in NHS Scotland and the role of DTF in participants' wider development.

## Chapter 9: Clinical Leadership and Organisational Impact

### 9.1: Introduction

As the last of the four empirical result chapters this chapter addresses the second part of the research question, introduced in chapter one, relating to the organisational factors that influenced participants' accounts of impact and learning transfer. This chapter considers two main topics. Section 9.2 begins by exploring the organisational factors thought to influence leadership development within the Scottish NHS. Building on this section 9.3 examines the role of the organisational context on participants' accounts of learning transfer and organisational impact.

### 9.2: Learning in the Context of the NHS

In the literature review it was suggested that leadership develops over time and outcomes are dependent on the physical and social context in which it takes place (Day, 2011; Porter and McLaughlin, 2006). Moreover, in their review of the literature Hiller *et al.* (2011) highlight the socially constructed nature of both leadership and outcomes. They stress that choices of criterion relating to, for example: theoretical perspective, type of data and time frame have important implications for defining and interpreting leadership; depending on the criteria used, leaders can be seen as effective, ineffective, or neither. Moreover, effectiveness is in the eye of the beholder; as noted in the literature review, clinicians may see it one way while senior managers, politicians and boards may see it in another. In view of these contextual issues, chapter six explored the policy and economic environment influencing human capital development within the Scottish NHS. Chapter seven then considered the learning context within DTF through participants' accounts of the programme and its role in their wider leadership journeys. However, when evaluating 'off-the-job' leadership development it is also important to understand the organisational context in which participants interact and lead. Chapter six noted that the priorities of the Scottish NHS are influenced by changes in the wider political and economic environment. It was proposed that the global recession of 2008-9 and subsequent sovereign debt crisis in 2010 had led to a focus on minimising waste and spending money more effectively. This has several (potential) implications for those working within the health service including

increased fear and uncertainty due to the threat of job losses, job redesign, and service reorganisation. Thus, the following sections consider interviewees' views on: working in the health service; the current leadership discourse; drivers of clinical leadership; historic power relations; and managerial support available following development.

### ***9.2.1: Working in the Health Service***

As the organisational context plays an important role in shaping leadership behaviour and outcomes (Porter and McLaughlin, 2006), participants were asked about their experiences of working in the NHS and how the organisations they work for have been supported to manage and lead change. At a general level, participants spoke of the challenges, such as slow decision making and the power struggles that can occur in bureaucratic and hierarchical organisations.

'Everybody except the Chief Executive has got people above them ... it is interesting I've got a General Manager and I've got a Assistant General Manager that I report to ... it was a bit messy, really, I mean not well thought through – in the previous organisation of the NHS they were peers and then they were reorganised for [A] to report to [B] which was never going to work ... conflict and politics from the past' (P5)

'Parts of the public sector are very traditional. Still parts of it, I think, are strongly unionised. What's probably helping a little bit is some of the external factors. The economic position is helping my agenda as well because people are realising that there isn't money in the system any more. So either we reform or someone will reform for us and my view is we're better in the driver's seat than someone else ... I won't shy away from that resistance, which I think is important.' (P18)

The first statement describes how past reforms and restructures have led to P5's two direct managers having a difficult working relationship which she believes has an impact on both decision making and innovation across the organisation. The second emphasises the traditional unionised context and the entrenched resistance to change within the NHS, but suggests that economic uncertainty has led employees to accept that reform is inevitable. Moreover, it also reflects the view of several participants who argued that they saw setting the direction of reform as central to their role. This resonated with the views of the NHS HR Directors who suggested that in the current climate clinical leaders can play a key role in engaging employees and directing change. When asked about the changes that she had observed between cohorts C4 said:

‘They need to be able to manage ambiguity and uncertainty far more than the ones coming in cohort one ... the recognition a couple of years ago that money was going to get tighter and tighter. So they are working in a really very difficult environment and it is not going to get easier for a while.’ (C4)

The statement above illustrates the perception that external climate has meant that participants in cohort four and five have faced more complex leadership dilemmas than those in previous cohorts. Two important dilemmas were highlighted by the interviewees. The first related to the challenge of providing safe and reliable services with reduced staff numbers, while the second noted the difficulties involved in motivating and engaging staff in uncertain times. Nonetheless participants maintained that within the Scottish NHS there exists a culture of openness founded on professional accountability and patient safety. Thus, it was argued that being honest and transparent with employees has helped participants overcome these challenges.

### ***9.2.2: Leadership as a Discourse in the NHS***

So where does leadership fit within this environment? In chapter two, it was proposed that the context in which leadership occurs is subjective and socially constructed by participants, including leaders and followers (e.g. Fairhurst, 2009). Therefore, leadership identities are context specific and shift over time and across situations (e.g. DeRue and Ashford, 2010). This was particularly evident in the case of clinical leaders who must adopt a dual identity (see chapter 4). During the interviews participants were asked how the programme related to their broad experiences of leadership in the Scottish NHS. The statement below from P14 illustrates that in some respects leadership is a relatively new discourse within the NHS:

‘Leadership is a new theme in the NHS. I mean when I nursed, many, many years ago, it was all about management’ (P14)

In general, this leadership discourse was viewed as more acceptable to clinicians than the previous management discourse of the 1980s and 1990s. There was a suggestion that management encompasses more mundane tasks while leadership holds more prestige and influence. This relates to Martin and Learmonth’s (2012) suggestion that that the discourse

of leadership can help clinicians construct a self-identity that reflects supremacy, prestige and authority as it does not hold the same negative connotations as the former discourse of management. In the literature clinicians are often put forward as reluctant leaders, but, the group of clinical leaders in this study appeared to be relatively engaged. As all of the participants were in senior leadership positions in some ways it is not surprising that they welcomed this leadership rhetoric. Participants had a variety of motivations for going into leadership including both positive personal and organisational outcomes. There was a strong belief that having a clinical background gave them insight into the complex systems within the NHS which meant that they could make more informed decisions than their non-clinical counterparts. This relates to the negative connotations of management highlighted above and supports the view that some clinicians regard health service managers as under-qualified and lacking the skills to provide direction to clinicians (Dickinson and Ham, 2008). However, the limited level of development that participants had received prior to commencing DTF suggests that in some boards the practice of leadership had received only limited attention. This was summed up by a colleague of P17 in the follow-up interviews when she said:

‘There is a strong emphasis on leadership but I am not sure how well we equip people for it ... I mean we are getting better because we are developing a leadership programme so I think in the last eighteen months that has changed and it will improve – but I think it’s been restricted to one or two folk a year who are getting some kind of leadership development whereas I think that we are now have about 200 managers and leaders across the organisation that have been through some kind of leadership programme in the last year’ (General Manager, colleague of P17)

This passage illustrates the view that in the past leadership development has been patchy. It also alludes to a conceptual difference between leaders and managers within the organisation. This was reiterated by an apparent wariness amongst the participants to call themselves managers. However, on questioning most admitted that their role comprised of both management and leadership tasks. The statement also critiques the elitist nature of national programmes targeted at the selected few and supports the growth of more distributed leadership. This, along with others highlighting how participants were sharing learning and engaging their staff in leadership (see section 9.3.8), relates to the current emphasis on distributed leadership in the policy and academic literature (Grint, 2010). However, it also raises questions as to the extent to which this rhetoric is being put into

practice with NHS Scotland as those selected for the programme were already in fairly senior positions.

### ***9.2.3: Clinical Leadership: Ambition and Credibility***

As this study is particularly interested in clinical leadership participants were asked about the challenges and rewards of moving in to a leadership role, learning on the job, and adapting to a new culture. These are important themes in the emerging literature on clinical leadership, which suggests that many clinicians are reluctant to become involved in running the NHS for a variety of reasons, such as negative perceptions of management, ambiguity surrounding dual-roles and the potential loss of respect from professional colleagues, preferring instead to retain their professional identities and alignment with colleagues and patients (see chapter four).

‘I went from being a clinician to that managerial post and that that was a big change in my life as well because I learnt through probably getting things wrong.’ (P1)

‘So it was a very different role and it was a bit of a culture shock.’ (P5)

These short statements illustrate that moving into a leadership role had represented a considerable change which had taken participants away from their comfort zones. Balancing their professional and leadership responsibilities had been difficult at times, but it was asserted that overcoming these challenges has also been rewarding.

‘I think for everyone in the NHS the work is very demanding ... my role is a bit crazy... it’s challenging ... it’s very different, no two days are the same, and that’s what I love about it ... It brings a lot of pressure, but I think that I am also very fortunate to be working in this area. I mean I could still be back on the labour ward delivering babies.’ (P14)

The statement above is indicative of the view of several participants who maintained that moving into a leadership position had provided them with a more challenging and fulfilling role. The last sentence is particularly interesting as it highlights the psychological move within the participant away from the purely clinical mindset. Cohort four comprised of clinical leaders from a range of professions including ten allied health professionals, eight medics and six nurses. Participants also varied in the extent to which they balance clinical



and leadership duties. Approximately half of the participants spent at least 40% of their time on clinical duties, while the other half are primarily leaders with no or limited clinical duties. One explanation for this is the level at which DTF is directed, by the time individuals are in senior leadership roles and eligible for the programme they have worked their way up through several levels of hierarchy and moved away from their clinical focus. Another explanation is differing levels of financial rewards and prestige across different professions. It tended to be those in more highly paid professions such as medicine, pharmacology, and psychology who retained clinical duties and were part-time clinical leaders whereas those in less financially rewarding professions such as nursing, dietetics, and physiotherapy were in full-time leadership roles. There was an identity element to these decisions. At an individual level participants felt that giving up their professional identity was or would be emotionally difficult. Likewise, at a relational level, participants spoke of a desire to retain a clinical dimension to remain at the forefront of their field and to credibility with peers. This highlights the different aspects of an individual's identity, in particular, the role that group membership can play on an individual's beliefs and practices (Giessner *et al.*, 2009; Sveningsson and Alvesson, 2003). Moreover, it illustrates that different professions are guided by different logics which influence their social constructions and their resultant decisions (Greenwood *et al.*, 2011).

Not unexpectedly, participants argued that both types of clinical leaders can bring real benefits for the organisation. However, participants' in each group tended to think that their configuration was more useful. For example, those in full-time roles suggested that they were able to deal with the more strategic aspects of the organisation while those in joint roles emphasised that maintaining their clinical knowledge and legitimacy with clinical colleagues had helped them to engage them in change and be more effective.

'I think it is important because it means that you never lose sight of real life. It's actually very difficult maintaining a senior leadership role and a clinical role at the same time because you pulled in so many directions. But to be honest even if the clinical aspect is even just low key it is very important because otherwise you enter into a sort of stratified area where the atmosphere is very different and where awareness of what life is like on the frontline of the NHS begins to go. So I think it's important for managers to have clinical experience and some clinical input still.' (P9)

A common belief amongst the interviewees was that as clinical leaders remain grounded in their clinical profession and understand the effects of decisions on patient care they are

regarded by those on the front-line as more credible than general managers. It was suggested that not only can they use their professional networks to engage others in change, but their experience also gives them licence to counter unreasonable demands. This suggests that participants believed in their abilities, thus enhancing their leadership identity at an individual level. Moreover, the perception that they had more legitimacy with clinical colleagues also adds to their identity at a relational level (DeRue and Ashord, 2010).

‘In effect what it means is that when I say something they understand that I know where they’re coming from. It’s quite interesting when you’ve got leaders who are a bit further from the ground and you say: you just lost the clinical team because you’ve lost the reality of what it’s like to be on the ground floor...and you can also challenge them - you can say, well actually, why? You’re challenging is much more directive and valuable ... but if you’re going to have doctors as medical leaders, and I absolutely feel they have to be, you have to give them the time to do it, and that is the issue’ (P4)

The passage above highlights the perceived credibility that comes with clinical leadership positions; yet it also notes the challenges pertaining to the availability of organisational support and balancing multiple commitments.

#### ***9.2.4: Relations with Managers***

Although the credibility of clinical leaders was acknowledged in the follow-up interviews with selected peers and managers it was also argued that clinical leaders sometimes use their clinical objectives as a convenient excuse to avoid making difficult decisions. By the same token two participants emphasised that relations with general managers are not always harmonious and there is potential for hostility and resistance if a general manager perceives a clinical leader as a threat to their authority. This is interesting as it contrasts with the literature which suggests that there is animosity and power disconnects between clinicians and managers in the NHS (MacIntosh *et al.*, 2011). However, it should be noted that participants were only briefly asked about their relations with peer-level managers.

‘... a manager was hugely threatened by my role because they saw the management of their service as contradictory to my leadership role; which in my head I saw it entirely complementary, because I’m not here to manage the operational delivery of the service; but I am here to lead on the direction of travel. That conversation

highlighted to me that actually there was a mismatch between clinical leadership and management.’(P7)

Most participants argued that both clinical and managerial leaders should be trying to achieve the same overall objective - an efficient and effective health service. This was reiterated in the follow up interviews with selected colleagues. However, the statement above illustrates the residual tensions that exist between managers and clinicians within the NHS. Consequently, both participants and their colleagues suggested that there was a need for better training and development at a board level to help both clinical leaders and general managers appreciate how their roles complement and reinforce each other.

‘There is also a need for training that helps people back at the base understand the function so that they don’t regard it as contradictory to their management role.’ (P7)

It’s about working in teams in an integrated way so programmes should be multi-professional and not make any distinction between a manager and a clinician who have been employed in a leadership role (3-OD-p2)

Equally, it was noted that occasionally there can be misunderstandings and a lack of tolerance across different clinical professions. Accordingly, several participants maintained that being on a multidisciplinary programme had helped them to appreciate the stress and pressure that other healthcare professionals are under (see section 8.4.2).

‘As a nurse you come through the ranks and some doctors have that handmaiden stereotype - seeing nurses as subordinate - and that’s quite difficult, you’re dealing with quite arrogant consultants and GPs in this culture. We are trying to break through that with roles such as the senior charge nurse, but I think this programme helps you with that because it lets you understand where everyone else is coming from and why people behave in a certain way, and that probably gives me a lot of confidence.’ (P16)

As noted in the passage above it was generally believed that having a clearer understanding of the whole patient experience and the contribution of different professionals would improve the influence of the leader and enable them to win the ‘hearts and minds’ of employees. This relates again to the historic tensions within the NHS and the perceived power disconnects between different professions (Blackler, 2006; Speed, 2011; Walshe and Chambers, 2010). Nevertheless, it was noted that leaders also have to

make difficult decisions, especially in a tight economic climate that people will not necessarily appreciate or support.

‘I think that often when you take on any sort of leadership role; you have to stick your head above the parfait. You have to make hard decisions sometimes and many of your peers don’t understand what you are doing. You will get people saying ‘Oh, you’ve gone to the dark side’ or ‘you’ve joined the enemy’, and I think doctors, in particular GP’s, like to be liked but sometimes you have to make hard decisions and sometimes people say pretty hurtful things about you.’ (P3)

This comment from P3 evidences the historical lack of respect for managers among clinicians (MacIntosh *et al.*, 2011) and for clinicians who cross the line (Llewellyn, 2001). It illustrates that peers do not always appreciate clinicians who reduce their clinical practice to take on formal leadership roles and clinical leaders need to be prepared for these challenges. This lack of appreciation may also have an effect on participants’ leadership identities; some individuals may become more resilient but others may feel undermined and revert back to their clinical mindset.

### ***9.2.5: Organisational Support: Exit Strategies and Subsequent Learning***

As leadership development is thought to be most effective when learning experiences are embedded within the organisational context (e.g. McCauley 2006) a key objective of this study was to examine how the NHS boards are supporting and enabling their clinical leaders. In general, participants felt that they had been given adequate time and resources to attend the programme. Most felt that their line managers (some of whom had been past participants) had appreciated the value of the programme but that it had been up to them to balance their priorities. Given the intensive nature of DTF many participants asserted that it is only now, on completion, that they are processing and embedding the learning gained.

‘I would like to do it all again to gain even greater understanding ... at the moment I’m just consolidating everything’ (P10)

‘The year that you finish, in many respects, is the year that you consolidate your learning’ (P11)

The statements above illustrate the view that for many DTF was the start of a longer learning process. Almost all participants asserted that completing the programme had

prompted them to embark upon additional self-study. This self-study ranged from re-reading and revisiting programme materials to initiating more formative learning experiences like work shadowing senior managers and civil servants or organising local action-learning sets. On the whole these forms of development had been initiated by participants and it was widely believed that there was a need for greater organisational support and encouragement to help individuals achieve their potential. This was emphasised by P17 when he said:

‘There needs to be more thought about the exit strategy for people on the programme and individual exit strategies ... this was the starting point for me. I’ve come a huge distance, but I still think there’s a distance to go. And it’s what do you do next; how do you progress it; how do you take it further; how do you maintain the momentum? I think the exit strategy from the programme if you like or the follow-on needs to be tailored and specific to the individuals.’ (P17)

The excerpt above is important as it captures the feeling of participants that although DTF provides many benefits and can be a catalyst for long-term change it is not a ‘quick fix’. This relates to the suggestion in the development literature that outcomes of learning occur over time in relation to the context in which it is applied (Hannum *et al.*, 2007; Lester and Costley, 2010). It notes that as individuals start and finish at different levels and have different underpinning motivations and objectives for being on the programme there is a need for personalised organisational support. There was some debate over the role that DTF should play in participants’ future development; for the most part participants believed that annual or biannual ‘revision’ days would be a useful addition to the programme. However, three said that they would find it hard to engage in supplementary elements as they would prefer to progress to new challenges. They also felt that it would be difficult for them to justify these ‘extra’ elements to their colleagues and managers. Nonetheless, over half of those interviewed suggested that the DTF team could work more closely with local organisational development (OD) departments to develop personal strategies to ensure that there is appropriate support for those who want to continue their developmental journey.

In reality, since completing the programme, participants have received mixed levels of developmental support from their organisations. A small number have been offered additional opportunities, for example, two have been approached to participate in and

contribute to in-house leadership programmes while three others have been provided with an executive coach to help them sharpen their skills and deal with ongoing challenges. Such activities were thought to help sustain and consolidate their identity as a leader. The majority; however, said that they had received limited support and would face challenges gaining access to further development within their boards. Two main reasons for this were suggested. Firstly, it was proposed that there was an expectation that those eligible to participate in the programme should have the skills and ability to process and apply learning without support. Secondly, it was observed that it given the current financial climate boards simply do not have the resources to fund follow-up development and participants would find it difficult to justify time away from their work. Notwithstanding financial constraints, both the programme team and participants argued that it was important for the organisation to nurture participants' skills and abilities to achieve the greatest return on their investment.

### **9.3: Learning Transfer and Organisational Impact**

The organisational context also influences how successfully 'off-the-job' learning is transferred and transformed into organisational value. From the interviews it was evident that participants have received varying levels of support and encouragement from their managers to apply, implement, and share learning. The rest of the chapter explores how this has influenced their accounts of leadership impact. As noted in chapter four, value means different things to different people and measuring leadership outcomes can be problematic as effectiveness depends both on the social constructed perspective and the measurement criterion selected (Hiller *et al.*, 2011). Thus, the following sections consider the impact of DTF in relation to its own context-specific aims and objectives including application of learning, succession planning, and engaging others in leadership.

### ***9.3.1: Application of Learning***

Section 8.2.4 (chapter eight) examined participants' accounts of how they have applied techniques, tools, and theory from the DTF programme within their workplaces. It was observed that many believed that participating in the programme had given them the confidence and skills to think innovatively and implement small and large changes within their teams and organisations. Participants explained how their leadership approach and behaviour had changed since completing the programme, for instance, several stated that they now adopt a more engaging leadership style, are more comfortable taking advice from others, and build in time for reflection.

'I'm not running ahead saying follow me, the kind of heroic leader that we heard about as well; I'm much more consultative, collaborative, engaging' (P5)

'I have changed the way I communicate during some of the meetings in giving over a lot more responsibility to the team rather than taking it personally. That gives me more control, actually.' (P10)

'There were real practical applications as to how you could do it ...the biggest skills for me have been about influencing, communicating in different ways, and being subtle.' (P17)

This perception was echoed in the follow-up interviews with selected peers and managers. For example, both P17's colleague and chief executive said that they had observed changes in the way he reacted to and managed difficult situations:

'P17 has very much a can do, will do right now, attitude so it has allowed him to take a more planned approach to his work. I certainly believe that his impact has been greatly enhanced by adopting a pre-planned approach to work, thinking through how others might react and where they are coming from to get a 'win win' out of a situation, and also being able to influence using a range of techniques rather than always reverting to type. That's been the real benefit that I have seen from P17.' (3-CE-p17)

'P17 is much more reflective and he has built credibility and governance into his new role ... he is now more strategic in his contribution because when he engages in the senior management team meetings he is more open to looking at the whole picture and coming to a joint decision' (3-GM-p17)

The quotations above indicate that P17's manager and peer had observed changes in his leadership approach and behaviour which led them to view him as a more effective and

credible leader. This links to the discussion in chapter 8 (section 8.3.5) around the sense of ‘credibility’ that the programme had bestowed on participants. As leadership identity construction is an iterative and reciprocal process (DeRue and Ashford, 2010) it could also be suggested that the endorsement and support of his colleagues has reinforced P17’s view of himself as an effective leader and contributed to his sustained behavioural change. A further idea evident in the above statements is that this behavioural change was thought to have already had an impact on the organisation. It was suggested that adopting a less authoritarian style of leadership has helped P17 engage and motivate his workforce. Likewise, it was proposed that as he has adopted a more strategic and holistic outlook he has been able to find solutions that fit with the organisation’s overall objectives rather than merely focusing on his individual remit. This supports the assertion in the literature that the application of learning and subsequent behaviour changes can have an organisational impact (Crossan, Lane and White, 1999; Easterby-Smith and Lyles, 2011).

### ***9.3.2: Applicability and Time***

A range of individual and organisational factors influence the transfer and application of learning (Cole, 2009; Combs *et al.*, 2009); the following sections discuss the main issues highlighted by the participants. At a basic level it was acknowledged that an important part of the learning process is recognising when it is appropriate to apply specific approaches and tools. Most participants said that while they had applied some elements of learning immediately, other aspects of learning would be applied over time in relation to the social context.

‘In some instances it’s about finding the opportunity to use what you have learnt you don’t always come across those on a regular basis.’ (P20)

‘I wouldn’t say there have been any barriers to implementation, but I think the thing is that you’ve still got to try to be as natural as you can be - you can’t suddenly become this new person’ (P2)

The first statement highlights that the impact of a programme like DTF is likely to occur over long period of time. The second illustrates the view that it is important to remain authentic and reflect on whether a particular approach is suitable for the specific circumstances. This relates to the suggestion that development programmes help



participants begin to see themselves as leaders and act in relation to their view of an effective leader. Participants cautioned that if they had been overzealous in their application their colleagues were likely to have responded with indifference as they would have viewed initiatives as just another idea from the course. This reiterates the perceived importance of building leadership credibility, subtly introducing change, and working with people to overcome potential resistance (see section 8.4.5).

### ***9.3.3: Having the Credibility and Autonomy to Act***

One area of organisational impact that was mentioned by several participants was that having increased credibility and access to a multi-professional, multi-board network had provided them with additional opportunities to apply learning and develop new initiatives. Fourteen participants described initiatives that they have set up across organisational boundaries to share knowledge and resources. For example, P8 and P17 described a joint-project that they had initiated to improve preventative care in remote and rural areas:

‘There are a number of people I’ve worked really close with ... we’ve taken forward projects that, to be honest, I’m not even sure we would have even thought of the concept had we not been together in the programme ... we’ve done a huge project with P8’s Board ...we just got together and conversations became meetings, meetings became proposals, proposals became trials, trials became funding ... and now we’ve got an innovative solution to a real challenge that he was facing’. (P17)

‘One thing that has come from the programme is that we are developing a £150,000 project with P17’s Board which wouldn’t have been initiated if it wasn’t for the programme’ (P8)

It was clear from the interviews with both P17 and P8 that had they not met on the programme and been encouraged to think beyond the confines of their organisation the project would not have been initiated. At the time of the interviews the initiative was trialled; however, it has since been positively evaluated and rolled out in additional locations. P17 himself was involved in three partnership initiatives and these were recognised by his chief executive as key opportunities to develop value for the organisation both locally and nationally. Beyond such collaborative projects, six participants stated that completing DTF had improved their standing within their organisation and given them the opportunity to have their voice heard at a senior level (see section 8.3.5). It was proposed

that this access and had allowed them to make a more strategic contribution to the organisation.

‘I have been invited to the top table; I think DTF must have had some bearing in that’ (P4)

‘I felt empowered to go and push doors and speak to people who, if I hadn’t been on the programme, I would have been in awe of’ (P3)

Although, all six participants spoke of the appreciation that they had felt at having their skills recognised, further investigation suggested that most of those who had been able to contribute at this strategic level were employed in positions that already gave them the autonomy and legitimacy to implement organisational changes. This point was further evidenced by one OD interviewee who suggested that it was very important to choose people with the autonomy to implement learning and lead at a strategic level:

‘When you only have one participant on the programme you are not going to have organisational impact. So I think for us, in board Y, the way that we have transferred that knowledge back has been in a very, very careful selection process. So we have tried our absolute best to ensure that the people that we would send on that national programme are people who do have or will have the absolute key roles in the organisation. So I know that other boards have an open application process for that programme but because we have ran our own strategic leadership programme we have a much smaller pool of people that we would put forward to the national programme ...The people that we have sent on the DTF programme have had a direct impact on the organisation because of who they are and their role - we have made sure that they have the support, the role and the project activity that means they can really make a difference. So P2 is the perfect example, P2 was already lined up with his ‘whole systems’ project to deliver as part of his role...the fact that he got so much support to deliver it I think made his project even more worthwhile and have a higher impact.’ (3-OD-p2)

This above extract makes two key points. Firstly, it shows that P2’s OD Lead was already attuned to the importance of linking leadership learning to the organisation’s strategic objectives. During the interview she spoke of working with individuals on a range to programmes to ensure that their project both stretched them and was of value to the organisation. In the case of P2 she believed that being on the programme had positively influenced the design and implementation of his individual project which has had a clear impact on the organisation’s strategy. Secondly, the passage also alludes to the belief that the impact of DTF on individual Boards is somewhat limited because of the small number

of participants in each Board. Therefore, in P2s board the OD department has developed several local leadership programmes targeted at individuals from multiple levels to support distributed leadership. These local initiatives mean that the Board can carefully recruit and select key individuals who are employed within strategic positions for DTF. She compares this approach with that of other boards with an ‘open application process’ which she implied meant that people are occasionally recruited before they are ready and this can lead to difficulties in learning transfer.

#### ***9.3.4: Appreciation of Expertise***

A further issue, highlighted in the quotation from P6 in section 8.4.6, is that many participants felt that their leadership expertise has not been fully appreciated by their senior managers. This may be in part due to the initial high expectations of participants with regard to the opportunities that the programme would deliver. Nonetheless, there was a strong sense amongst participants that their boards could make better use of their skills and capabilities.

‘Since we started, we have continuously made efforts to try and enable the organisation to get as much out of us as we can possibly offer, because nobody is standing at my door saying now that you’ve done this programme what can we learn from you; they’re not doing that...I would have thought that actually it would have been in their interest to get us around the table and really squeeze us dry, as it were’ (P7)

‘The investment has been made, but now they don’t know what to do with us’ (P9)

‘What I think would be beneficial is if we were used more as part of the wider organisation. The board is not saying to us we’ve invested all this money in you ... there’s a whole group of people in the board who have all these skills and they’re just doing their own individual jobs and using it in their own departments rather than maybe thinking how leadership in the board at quite senior levels taken forward.’ (P1)

The statements above present participants’ experiences within three different boards; however, they reflect the views of more than half of those interviewed. Many participants described how they had made the effort to engage with management and proactively volunteer their services to no avail. Likewise, others noted that although money had been spent on developing their skills they were left feeling abandoned as the organisation had

not nurtured them post-development. There was a real desire to work across the organisation and make a difference – strategically, not just within their own area. This implies that participants had the motivation but not the opportunity and support to use their skills at a strategic level. This is important given the suggestion, in the literature, that for leadership development to be effective organisations must allow and enable leaders to lead (e.g. McCall, 2004). In addition, it relates to perceived importance of organisational support to the sustainability of participants' leadership identities in the longer-term (DeRue and Ashford, 2010).

Moreover, poor organisational capital (an entrenched culture, internal competition and weak support processes) can have a negative impact on the value that an organisation can gain from its leaders' human and social capital (e.g. Kor and Leblebici, 2005). This can also be related to participants' expectations of the programme. In the training literature it has been found that if a programme fails to deliver the expected gains participants may be left deflated (e.g. Tannenbaum *et al.*, 1991). One rationale for limited managerial support was that the managers' had only a limited understanding of the *Delivering the Future* programme and the benefits it provides:

'To be perfectly honest, I've had very little feedback from senior management about having been through the programme ... I don't think it has the recognition yet that it should have. I don't think the exposure is big enough. I think there should be more promotion of it. People need to understand a bit more what it is and what it can do, and the benefits that it has given to the people that have been on it. And I think there is a huge untapped resource in the organisation.' (P13)

The statement above points to a lack of understanding within local boards of DTF, the learning it encourages, and the needs of participants on completion. It was suggested that if managers do not recognise, understand, and appreciate the abilities and knowledge that an individual comes back with the extent to which they can then utilise participants effectively is limited. Thus, several participants advised that there was a need for greater promotion of the programmes objectives and outcomes to ensure that those who are selected occupy roles where they can actively apply learning and are given the encouragement to implement innovative initiatives that contribute to the organisation's long-term strategic objectives.

One of the coaches summed up the main elements and individuals involved in the learning transfer process when he said:

‘There should be a clear emphasis on learning transfer during and after the programme. It starts with the coaches talking on a one-to-one basis with participants about how they plan to transfer elements of the programme to their daily work and challenging them to think differently. However, it is also the participants themselves who are responsible for taking the initiative to apply and transfer learning within the workplace. Finally, it comes back to the issue of organisational support - there is a need for senior managers and colleagues to appreciate what participants can contribute and giving them the opportunity to achieve this ... The disconnect, as I perceive it, is between having a national programme and local application ... there are issues around local OD having the calibre, clout and agenda to take transfer forward. It is a major investment that organisations are making in these clinical leaders, but my perception is that often OD Leads see as just another administrative chore.’ (C2)

The extract above notes that learning transfer should be embedded in the programme from the outset. Successful transfer requires personal drive and creativity as individuals must take the initiative to apply learning within their work. Moreover, it reiterates that limited organisational support can create barriers to learning application. In connection with this two participants suggested that there are discrepancies between what is learnt on DTF and what is expected within their organisations.

‘It might be a bit challenging for the people back at the ranch though ... it may not be a success for some organisations because they may not welcome the level of challenge that we’re encouraged to have around the programme. .’ (P6)

The statement above illustrates that when considering off-the-job development it is important to consider the reaction of those in the organisation including staff, peers and managers (Day, 2011; Dvir *et al.*, 2002; Grint, 2010). It implies that those back in the organisation may feel threatened by change and resist new initiatives which can lead to participants feeling frustrated and defeated. This sense of frustration felt by many participants was summed up well by P17’s colleague when she was asked about the challenges that an individual might face on returning back to their organisation:

‘I think if you have gone away on a development programme and you come back to an organisation which hasn’t changed then that can be very frustrating. So I suppose it is about how effectively do they equip people for coming back to Groundhog Day and taking things forward after that and not getting frustrated ... but I would say it’s

a positive thing as they have the skills to deal with it and are a bit more able to take a step back rather than just react.’ (General Manager, colleague of P17)

This quotation further illustrates the disappointment and dissatisfaction that can result when participants face resistance and cynicism from colleagues. Moreover, it proposes that an important aspect of the development is preparing participants for the reality back at base. The frustrations that arose from not being able to apply knowledge has driven several participants to strive towards promoted posts where they will have the autonomy to implement change; while others have become disillusioned and have taken a step back to reassess their priorities. Those who stepped back went through a further process of identity change, reverting in some ways back to their clinical mind-set.

### ***9.3.5: Succession Planning***

One of the core aims of DTF is succession planning. It seeks to develop clinical leaders who have the skills and competencies to fill senior clinical leadership positions across NHS Scotland. Thus, it is interesting to see that most participants said that completing the programme had motivated them to look towards promoted posts. There were three main rationales provided for this: increased self-belief in their abilities, aspirations for a more challenging and rewarding work environment, and desires to take on more influential posts which would allow them to make a more strategic contribution. This highlights that participants internal logics and goals had changed as result of being on the programme (Gunz and Gunz, 2007).

‘It gave me, I don’t know if itchy feet is the right word, but it made me realise that I could do much more than I ever thought I could, and how my opinion, as a person who works for the NHS, is as valuable as anybody’s else’s.’ (P13)

‘Clearly I’d want to find myself a more senior position, a more influential position in the future’ (P8)

Although promotion is valuable as part of an individual’s personal development (see, section 8.3.4) it can also have a significant impact on their organisations. If participants stay within the Scottish NHS then it is assumed that the organisation will reap the benefits of their enhanced skills and abilities (Carmeli, 2004; Cheng and Hampson, 2008). However, if they leave the organisation and take their abilities elsewhere it could be argued

that the organisation effectively loses its investment. One of the coaches summed this up when he said:

‘I have frequently heard, during the evaluations, that: ‘the organisations’ don't know what to do with us’. For some this leads them to promoted posts, but not all will achieve promotion. So for others, the organisation effectively loses the not insignificant investment that it has made. One particular case that I am thinking about was a nurse on cohort three who was so frustrated with her organisation that she is moving to a two-year secondment in the Scottish Government and that comes down to the fact that she could see no way forward with her current organisation’ (C2)

The excerpt above notes that participants from previous cohorts have also received mixed support from their organisations which has led some to explore alternative avenues such as secondments and promotions outside of their organisation. In addition, it suggests that not all participants will be ready for promotion or have the opportunity to progress their career within their immediate boards. This was reiterated by a five participants who stated that while they would feel comfortable moving into another role in the future now was not the right time as they needed to process the learning. One participant who had applied for a promotion but had been rejected said that being on the programme had helped him overcome his disappointment allowing him to focus on improving his current position and working towards new opportunities in the future.

It was felt that the programme had given participants a clearer understanding of the strategic direction of NHS Scotland. This had led many participants to consider a future beyond their profession and board. Several said that they were keen to develop their skills further so that they could occupy a more strategic role within their board while others spoke of the potential to take on national roles (see section 8.3.3).

### ***9.3.6: Confidence and Identity Construction***

As mentioned earlier, an individual's self-belief and confidence in their leadership abilities is an important component of an individual's leadership identity construction at an individual level (Lord and Brown, 2001; Carroll and Levy, 2010; DeRue and Ashford, 2010). This section considers the concept of confidence in relation to participants' career choices.

‘I think going through the programme has probably given me the confidence in myself to perhaps, and I am not saying it will happen any time soon, but perhaps look outwith the board, outwith my profession as an option and I certainly wouldn’t have considered that before.’ (P20)

‘In my position I only have responsibility... I don’t have the level of authority, and that’s not a problem for me because I work outside of my authority almost all the time ... but I need a board level position to be able to have more influence ... for my own personal development I need to move to that next level to be able to work outside my current role and to be honest, there isn’t the willingness here to change things fairly radically ... I want to work somewhere which is a bit more ambitious I think, probably; a bit more risk taking; a bit more challenging.’ (P6)

The first quotation is illustrative of the view of several participants who said that the programme had given them the confidence to look towards promoted posts in future, not necessarily within their current organisation. The second statement demonstrates the desire, mentioned earlier, to be used more strategically and gain greater autonomy to implement change. At the time of the interviews two participants had already taken on national secondments while four others had been promoted during or shortly after the programme.

‘The other thing that seems to have happened in the cohort is that people who came onto the course have moved jobs and I am one of those. I took on this national secondment nine months ago and I thought long and hard about it ... I’m one of two doctors, both GPs, who are working on this ... coincidentally she was in cohort one of the leadership programme ... DTF’s given me confidence and the practical skills to take on a significant role.’ (P3)

The statement above illustrates that P3 believed that the programme had provided him with the confidence and skills to feel comfortable commencing a national secondment within the Scottish Government. This could be perceived as a loss to his organisations as implied in the previous quotation from C2; however if managed effectively secondments can provide benefits for all involved. Firstly, the secondee is exposed to new on-the-job development opportunities, a different organisational culture and a new community of practice. Secondly, the secondee’s organisation can benefit from the relations built with the host organisation, the transfer of skills from the returning secondee, and their increased motivation and engagement. Thirdly, the host organisation gains additional expertise to achieve its objectives, new skills that can be passed onto existing staff, and constructive



relations with the secondees' organisation (IES, 2004). For those who had already achieved promoted posts there was a sense that the programme had widened their horizons and helped them evolve beyond their previous job.

'If you're thinking about the next job, it's about how you position yourself ... I applied for this [promoted] position within this organisation and I think I had already started to position myself for that job ... I was interviewed and they offered me the job. So, I think the Leadership course on top of my experience and personal was probably something that aided me in that direction.' (P14)

The statement above shows that she believed that being mentally prepared for promotion and portraying to her managers that she had the skills and confidence to be effective in the new position had helped her to achieve success. The notion that participants have to prove themselves through their behaviours relates back to the social construction of leader identity and the reciprocal roles of leaders and followers (DeRue and Ashford, 2010). Although most participants were motivated to promotion as a form of career progression and as an opportunity to gain strategic influence it was evident that personal circumstances also play a part in career planning. This was particularly evident in the case of P19 who had chosen to move away from Scotland to take up a new opportunity which better suited his family life.

'An opportunity came up ... it was a bit of promotion and also it was a move back home and we made the decision because our children are at the age, my eldest was about to go to secondary school and we said if we didn't move now, we wouldn't. So I suppose that it has been a combination of professional and personal reasons as to why we have moved back ... it is probably been very helpful in getting me to where I am, helping with my promotion as well. Going for this position, there was a number of challenges and I'd probably been on the course for about a year, or maybe 14 months, so I had the benefits already, I think that helped me with going forward for the position that I'm in.' (P19)

The excerpt illustrates that in the case of P19 the real benefit of the programme has been on his own personal development. DTF has assisted him to acquire a new promoted post outside of the Scottish NHS and given him the skills to perform that role more effectively. This highlights the potential for loss of investment if participants ultimately leave the organisation. However, it also notes that a range of personal and professional factors influence an individual's career progression decisions. P19 is an avid supporter of the

programme and has maintained links with both the programme team and participants so perhaps the organisation can gain some value through the contacts his new position brings.

### ***9.3.7: Taking a Step Back***

One potentially negative outcome for the organisation is that a small number of participants have stepped away from all or some of their leadership responsibilities. Six participants described ways in which they have prioritised their responsibilities and discarded unproductive aspects of their work to achieve a better work-life balance.

‘What this has been good for is focussing on my priorities and being quite clear about how much I’ll not let carryover.’ (P1)

‘I think that oddly enough I’ve got a greater appreciation for the need to have a better work life balance ... I’m not saying that I’ve got this right yet, but trying to not do everything and be selective about what the most productive things are that I need to do ... Its impacted how I cope with the whole thing in general’ (P7)

These participants argued that prioritising their work had improved their productivity and helped them stay motivated in the face of challenges. However, two others had resigned completely from their leadership role. Both spoke of various challenges that they had faced within their roles and the sense of frustration that they had felt at having the responsibility but not the authority to implement change.

‘The forum that I had to clarify my thinking led directly to me deciding to leave, as a positive thing. Not as an ‘I’m fed up, this isn’t working’ but as a positive weighing up of where can I make the most difference and where can I use my skills most ... ‘I’ve resigned from the [senior clinical leadership position]. There were two main motivators. One was a new HEAT target ... which impacts directly on my clinical service and is very challenging ... I thought I might as well do that full time ... Secondly, the job didn’t end up being what I thought it was going to be ... it’s not an autonomous unit ... it kind of crystallised into being lots of responsibility and no power which is just the worst place to be ... so I had the opportunity to go back into something with lots of responsibility and challenging targets but I have considerably more autonomy and clout ... more patient-focused ... more rewarding and more meaningful ... it’s allowing me to broaden my horizons in a different way ... I’m not retreating into a box.’ (P5)

‘It has actually helped my self-confidence a lot ... I’ve been able to set outer boundaries about what I am and not able to do, what I could do with assistance, but also what is not possible ... I stood down from my [leadership] role in December last

year because there were further changes being made here that I agreed with and thought were sensible but they were going to make the role more difficult and more hard pressed than it was ... so I stepped down at the end of last year and I now have the opportunity to concentrate on other clinical things that interest me and that are major pieces of work. So at a practical level it is useful.' (P9)

The extracts above show that both participants felt that the support and learning that they had received on the programme had opened their eyes to the challenges within their own organisations. Both said that they had struggled with the bureaucracy surrounding their roles; there was a sense that although they were in challenging positions they had limited autonomy and support which had led them to feel isolated and lost in the system. Both had been in their positions for over a year before commencing DTF; however, the programme had illuminated these issues leading them to resign from their posts. This is problematic as the transformation of knowledge into action is crucial to organisational value creation (Pfeffer and Sutton, 2000). Moreover, it relates to the suggestion, in the training literature, that if an organisation develops people but does not give them the opportunity to make use of their skills the development is likely to be a de-motivating rather than inspiring experience (Burke and Hutchins, 2007). Common to both experiences was a sense of relief at no longer being constrained by a deficient role. Both spoke of taking on new challenges and revisiting their clinical roots but also stressed that it was not the end for them in terms leadership – they would just be leading in different ways through, for example, focusing on key projects, participating in working groups and mentoring junior staff. In addition, they said that while they were happy focusing on their current positions for the next few years if a leadership position with the autonomy to implement change was to come up in the future they would hope to be ready for a new challenge.

### ***9.3.8: Engaging Others in Leadership***

Another important organisational outcome is the development of intellectual capital (collective knowledge resources) through the transfer and sharing of knowledge learnt on the programme (e.g. Nahapiet and Ghoshal, 1998; Youndt *et al.*, 2004). During the interviews participants spoke of how they have engaged others in leadership and organisational change since completing the programme. There was a belief that the programme had helped participants to understand themselves which, subsequently, had helped them to get the best out of others. Participants were involved both formally and

informally in the sharing and transfer of knowledge and skills from DTF within their boards. Five participants were involved directly in the development of formal programmes or courses to cascade 'leadership' throughout their organisations. The statements below provide a taste of this involvement:

'Interestingly the Deputy Head of HRD is developing a local executive leadership programme, and the idea would be that we would develop eight key people in the organisation ... and then have them cascade some of that knowledge, and I have been asked to be one of the initial eight ... I'm just a bit part player in that big house so obviously something about the leadership programme has rubbed off in some of the things I have said' (P4)

'We're are setting up an internal clinical leadership programme; myself and the head of leadership got together to develop some clinical leadership modules ... we also got them all in a room and talked about the future and how we would plan it, what are their needs and skills ... we're building it around the [*Delivering the Future*] learning' (P17)

Participants involved in the formal cascading of leadership expressed feelings of gratitude and honour at being given the opportunity to share what they had learnt and contribute to the organisation's distributed leadership objectives (see chapter 4, section 4.3.4). Although some initiatives were more established than others it was apparent that within these boards there was a real desire to embed leadership development within the organisation's culture. The boards had attempted to coordinate their programmes with the national programme. For example, both P2's and P17's boards had designed local development programmes based on the DTF model, which incorporated classroom based learning, on-the-job projects, mentoring, coaching, and action learning. Contributing to such holistic programmes was considered to be a privilege; however it was acknowledged that it was also time consuming. An alternative method of transfer used by participants was to introduce initiatives within their teams including, for example the Myers Briggs personality exercise, leadership coaching, and mentoring relationships.

'I recently worked with our local organisational development department to take a whole set of my team through the Myers Briggs process which we found incredibly useful and helpful ... now we are looking at how we can use everybody's skills and abilities to develop an [X] strategy' (P20)

'Knowing how useful some of the coaching has been for me I'm also suggesting some of the clinical leads might benefit from it ... I've also got one clinical lead

who's very keen on managerial aspects, and I'm really encouraging her to go and do the [DTF] course' (P10)

'I am supervising one of the principal clinicians and I am just trying to help her through her leadership journey relating to my own experience' (P4)

It was suggested that introducing specific elements within their own teams was a cost effective way of engendering a culture of development and increasing the groups' cohesiveness. This is interesting as the greater the sense of social community within a team or organisation, the more likely it is that knowledge will be created and transferred (Huiyan and Run-Tian, 2006; Lin and Haung, 2005). Although some participants are engaged in transferring learning formally and encouraging others to complete formal development programmes like DTF most are sharing knowledge more informally within their teams and working groups when and as it is necessary.

'Mainly, I've shared the little practical nuggets.' (P5)

'I share things with my peers ... I've also got a resource file that everybody knows they can come and access ... I've not said, right girls, get together, I'm going to tell you what I've learnt about having difficult conversations. I've just used opportune moments, really, to cascade any learning.' (P11)

'I've certainly shared a lot of learning with my managers ... I'll say I was away at my few days and there was this great tool and we had a great presentation and we did this, this and this. I'll send them out things like that, which I'm hoping will help them as part of their learning and development.' (P1)

Almost all participants said that they had shared aspects of the learning, in particular the practical aspects that can be used on a day-to-day basis such as how to target communications to get the best results and the benefits of reflecting on the views of other stakeholders. Some had forwarded tools and materials on an ad hoc basis when relevant, while others like P11 had developed a resource file for colleagues and staff to access when they wanted. In addition, three participants said that they had shared learning while applying it, when they had implemented tools and knowledge from the programme they had explained the reasoning to staff and colleagues in a bid to engage them in the process. In most cases, it was argued that learning and sharing was implicit rather than explicit within the organisation and imparting knowledge was a responsibility that comes with any leadership position.

‘It’s off my own back, if there were systems in place I probably wouldn’t welcome them, because I don’t really like formal structured teaching sessions or feedback sessions. I prefer doing things opportunistically’ (P21)

‘I have that forum with my own staff, but I wouldn’t say there’s any firm set up to encourage the sharing of learning from this type of programme ...there’s just so much on the agenda ... It might be quite good to have some way of sharing best practice ... So it would be quite useful, but I wouldn’t have the time to commit to something.’ (P16)

The first statement emphasises the view that formal structures to encourage the sharing and transfer of knowledge would not necessarily be welcomed as many participants preferred the more informal approach which they suggested resulted in greater employee engagement and enhanced collaborative learning. This relates to the proposition that if there is a culture of trust and collaboration within the organisation knowledge sharing through informal interactions can play an important role in the creation of collective knowledge resources (Abrams *et al.*, 2003; Burt, 2001; Wenger, 1998). Others were more open to the introduction of formal systems in principle but on reflection said that they would not have the time to properly engage in such mechanisms.

#### **9.4: Conclusion**

This chapter considered participants’ perceptions of the organisational and leadership context within the Scottish NHS. It then examined the role of this context on participants’ accounts of how they had applied and transferred learning from the programme into their working environment. It was observed that historical reforms, hierarchical bureaucracy, and current financial constraints mean that clinical leaders in the Scottish NHS operate within a challenging and demanding environment. Moreover, clinical leaders can face resistance from both fellow clinicians who think that they have joined the bureaucrats and managers who perceive them to be threatening their authority. Nonetheless, the impression was that leadership and specifically clinical leadership was a strong theme within the NHS which had gained momentum over the last few years.

The results showed that participants had had mixed levels of support from their organisations to hone their skills and apply and share knowledge within their workplaces. Within more supportive organisations participants were being given the opportunity to

enhance their skills, apply learning and cascade leadership within their teams and boards. This helped participants to develop a strong leadership identity which had allowed them to take up new challenges and contribute more strategically. However, within less supportive organisations participants had become frustrated. The programme had helped them to see the challenges within their work but they had faced barriers in applying learning to overcome these. This had led many participants to positively strive towards promoted posts where they would have the autonomy to make a more strategic contribution. However, others had effectively given up and taken a step back to focus on their clinical role. Both these scenarios have an impact on the value capture for the organisation. If participants stay within leadership positions then it was anticipated that they would gain from their increase skills and strategic capability; however if they decide to leave the organisation or revert back to their clinical role the organisation effectively loses its investment. The past four chapters have presented the results of the case study analysis chapter ten now discusses the theoretical and practical implications of these results.

## Chapter 10: Discussion

### 10.1: Introduction

By combining an extensive literature review with a phenomenological case-study design this thesis has explored leadership development, transfer, and application within the context of the Scottish NHS. There has been a particular focus on clinical leadership and how a leader's identity is socially constructed at an individual, relational and collective level. This penultimate chapter returns to the original research questions in light of the theoretical and empirical developments within the thesis. It reflects on the key issues that emerge from the findings and the contribution that the thesis makes to current research and approaches to leadership development. To conclude, it discusses the implications of the research for theory and for policy and practice in NHS Scotland and the Scottish Government. Reflecting on my professional learning, chapter eleven then summarises the thesis, considers the strengths and limitations of the study, and examines the future directions for research, practice and policy making.

### 10.2: Research Purpose

To set this chapter in context the research aim and questions are revisited. The research began with the broad aim of exploring the role of human capital development on public sector reform within the Scottish NHS. After reviewing the literature and completing the first phase of data collection the focus was narrowed to clinical leadership development and a conceptual framework setting out the key elements of the study was produced. This led to the formation of the focal research question:

*In a healthcare context, how do clinicians who participate in a leadership programme account for its impact on their identity, through their human and social capital, and what organisational factors influence their accounts?*

The above question provided focus for the research and emerged from the literature on leadership development, social identity and intellectual capital. Despite the recent growth in leadership development theory there remains uncertainty as to how leadership identities



are co-constructed at an individual, relational and collective level (Carroll and Levy, 2010; Day, 2011). This research explored the complexities involved in the process, in particular, the perceived role of individual factors (such as: participants professional logics and identities) and organisational factors (such as: culture and hierarchical structures) on development effectiveness. As the research evolved two subsidiary questions were developed relating firstly, to the conceptualisation of development programmes as identity workspaces and secondly, to the special case of clinical leadership, namely:

- (a) What role can leadership development programmes play in shaping participants' leadership identities at an individual, relational and collective level?
- (b) What do we mean by clinical leadership and how do clinical leaders construct this concept in action?

To address the primary and subsidiary questions case study research was completed with participants and stakeholders from NHS Scotland's *Delivering the Future* clinical leadership development programme. Data were gathered through semi-structured interviews, observations and documents. The main findings from the research were reported in chapters 7, 8, and 9. The following sections discuss the key findings in relation to the existing literature.

### **10.3: Key Findings and Contribution**

#### ***10.3.1: Revisiting the Conceptual Framework***

In the introduction chapter it was noted that the conceptual framework was developed by synthesising two relatively discrete bodies of literature related to leadership development and intellectual capital. Figure 10.1 provides an overview of the focus and scope of the thesis and has been adapted to include 'psychological capital' (Luthans *et al.*, 2007) to reflect the empirical findings. During the empirical study qualitative semi-structured interviews were completed primarily with participants of the DTF development programme, but also with the programme team and selected organisational stakeholders. The interviews explored accounts of the impact of the programme on participants' human and social capital and the role of the organisational context on these accounts. The



organisations, like the NHS, as it allows pre-existing power relations and individual accountability to be incorporated, both of which have been found to be barriers to distributed leadership if not acknowledged at the outset (Currie *et al.*, 2009; Gordon, 2010).

A primary objective of this study was to explore the relationships in the centre of conceptual framework relating to the perceived impact of development on an individual's human and social capital and the role of the organisational context on how learning is transferred and applied. Past studies on leadership development have theorised that a well-designed, multifaceted leadership development programme will build and enhance participants' human capital - personal capabilities, knowledge, skills, and attitudes - and social capital - positive relationships and networks with other individuals and organisations (Day, 2011; DeRue and Ashford, 2010; Grint, 2007; Iles and Preece, 2006). However, intellectual capital theory argues that the organisational context (including the social environment, culture, support systems, existing networks, and forums for applying and sharing knowledge) will influence the extent to which new skills and relationships are utilised which in turn influences learning transfer and the generation of intellectual capital and organisational outcomes (Kong, 2008; Kulvisaechana, 2006).

The DTF programme placed particular emphasis on developing the skills and abilities of the individual leaders. Nonetheless, there was a recognition amongst both the programme team and participants that effective leadership is co-constructed through leaders social interactions with followers and important others (Grint, 2000; Shamir 2007). It was anticipated that elements like the work-based project, coaches and action learning sets would enhance participants' social capital (Day, 2011; Iles and Preece, 2006) and encourage them to apply and reflect on learning within their team and organisation (Garnett, 2001; Hurd, 2009; McCauley *et al.*, 1995; Raelin, 2006). Underpinning these individual and relational goals were two further organisational objectives on engaging staff in change and providing succession planning for future leadership positions (Berke, 2005; Day, 2000; Scottish Government, 2009; Turnbull and Edwards, 2005).

### *10.3.2b: Human Capital – Self-Management, Reflection, Communication and Innovation*

Chapter 7 considered participants experiences of DTF, specifically its role as an identity workspace and the synergy between its component parts. For the most part, DTF was viewed as a reward and participants expressed a sense of appreciation at being chosen for development. However, it was noted that changing one's identity is not easy as involves destructive as well as reconstructive processes. Moreover, as in previous studies (e.g. Day *et al.*, 2009), the case highlighted the individualised nature of development: participants perceived that they had different learning styles and preferences and these accounted for their reactions to different elements of the programme. Nevertheless, there was general agreement that the combination of traditional and practice-based elements had provided a holistic learning journey. Chapter 8 identified four aspects of human capital which were thought to be enhanced by participating in DTF. These compared with three individual capacities proposed by McCauley and Van Velsor (2004): self-management capabilities, work facilitation capabilities and social capabilities. However, in this case, a fourth dimension - innovative capabilities - was also explored to reflect changes in participants' abilities to implement learning and initiate change.

Self-management capabilities referred to participants having greater awareness of their own strengths and weaknesses as well as how their actions impact on others. It was proposed that the development programme acted as an identity workspace (Petriglieri, 2011) where participants were able to step back and take time to reflect. This had helped them to recognise their limitations and had given them the confidence to draw on the strengths of others without feeling like a failure. This is relevant as both the critical and higher purpose perspectives of leadership (see chapter 2, section 2.3) argue that effective leadership is dependent on leaders recognising the skills of others and distributing ownership for complex problems to those people in the organisation who are most knowledgeable about the issues involved (Currie *et al.*, 2009; Grint, 2005a,b; 2008). In line with the existing learning literature three elements of the programme were considered to be crucial to encouraging self-reflection and facilitating change. These included the 360 degree feedback process, Myers Briggs master class, and one-to-one coaching (Begley and White, 2003; DeRue and Wellman, 2009; Drew 2009). Participants proposed that having greater self-awareness had also played a part in improving their work facilitation skills.

They suggested that being given the space to work on their leadership identity had shown them that it was important to build in time to plan and reflect before acting. This, in turn, was believed to have helped some participants overcome tensions with their staff and facilitated effective prioritisation, delegation, and collaboration. These activities highlight two-way nature of leadership and the relational aspects of leadership identities.

The third HC theme, social capabilities, relates to the literature on closed networks and communities of practice, which assert that shared group membership and the creation of trust encourage the transfer of tacit knowledge and behaviours across group members (Adler and Kwon 2002; van Knippenberg and Hogg, 2003; Wenger, 1998). This sense of community contributes to identity formation at both the individual and relational level as participants learn from each other, gain confidence and engage in collective identity change (Carroll and Levy, 2010). In this study participants explained how observing how others communicate, in particular members of their learning set and the invited speakers, had taught them to subtly target their message, be more concise and ordered in their approach, and to adopt an inspiring and motivating style. Although these represented only small changes in participants' behaviour they were also remarked upon during the follow-up interviews with selected colleagues. Finally, innovative capabilities referred to the participants' ability to introduce change within their team and organisation. Participants' accounts emphasised a variety of ways in which they had implemented tools and learning from the programme to their daily work. However, they stressed that for substantial change to be achieved in complex organisations like the NHS, leaders must work with a range of individuals and organisations. This relates to the proposition in the literature that leadership and intellectual capital emerge through social interaction and are dependent on leaders' actively coordinating and managing network relations (Balkundi and Kilduff, 2005; McCallum and O'Connell, 2009; Nahapiet and Ghoshal, 1998).

#### *10.3.2c: Social Capital – Bonding, Bridging, Brokering and Legitimising*

This study explored how leadership development programmes can provide a forum for social capital creation through group-based learning and the establishment and maintenance of networks. Interviewees asserted that DTF had given them access to a supportive peer group and had opened up new opportunities for networking across the

Scottish NHS. Action learning and coaching had played an important role in creating a supportive and trusting learning environment for them, which they believed had facilitated the sharing of new and valuable knowledge, produced supportive dialogue, and enhanced collective learning (Edmondson, 1999; Gubbins and MacCurtain, 2008; Iles and Preece, 2006). The development of trust and strong bonding network ties had also led to groups of participants working across organisational and professional boundaries on collaborative projects and initiatives. Participants proposed that having greater credibility and access to extended networks through each other had produced more efficient cross-organisational interactions. These social relationships and perceived credibility had also contributed to the relational construction of participants' leader identities. Past studies have shown a delay between learning leadership skills and translating these into leadership behaviour (e.g. Hirst *et al.*, 2004); thus further collaborative value may be generated in the future.

The diversity within the cohort was also viewed as an important feature of the programme by participants. For the majority, the multi-board, multi-professional component had enhanced their appreciation of the contribution of different professions and the strategic environment within NHS Scotland. This new knowledge, they argued, had prompted them to reflect on their own practice and find new ways of working. In contrast with the previous discussion on trust within closed networks this relates to theory on loose networks. Loose network theory proposes that network ties which span 'structural holes' (bridging disparate groups) can deliver more productive and innovative results as they provide a source of new information which can challenge existing assumptions and views (Adler and Kwon 2002; Bartol and Zhang, 2007; Burt, 1992; 2001; Iles and Preece, 2006). Yet, in this study it was also noted that too much diversity can be counterproductive because it can lead to a lack of understanding and confusion among parties (Burt, 2001; Mayo *et al.* 1996). Nonetheless, several participants suggested that the knowledge they had brokered through both bonding and bridging activities had helped them nurture relations in their own teams and organisations through both dyadic interactions and the establishment of local action learning or working groups. This supports the proposition that an individual's social capital can enhance their human capital (Subramaniam and Youndt, 2005). The dynamics and productivity of these groups and interactions were influenced by the organisational context and members' human and psychological capital (Brookes and Grint, 2010; Schyns and Day, 2010).

### 10.3.2d: Psychological Capital – Self-Efficacy, Hope, Optimism and Resilience

As illustrated in figure 10.1, participants also believed that aspects of their psychological capital (Luthans *et al.*, 2007) had been enhanced by participating in DTF. In the literature review psychological capital was discussed in relation to a leader's emotional intelligence, self-identity and motivation to learn from experience (Combs *et al.*, 2009). Luthans and colleagues (2007; 2009) have conceptualised it as comprising of four interrelated elements: confidence, hope, optimism and resilience. This study suggested that development programmes can positively affect participants' levels of 'confidence' and 'hope'. Prior to the programme, participants had received only limited leadership training, to which they attributed feelings of insecurity and uncertainty over their abilities as a leader. However, their accounts suggest that both the traditional and social aspects of the programme had increased their confidence, helped them to develop positive goals and assert control over their career.

Participants' optimism appeared to be influenced by the organisational context. Those who perceived high levels of support from their organisation were more likely to express optimism about the future than those who did not. This links to the literature on engagement which has found that perceived organisational support is a key influence on both job and organisational engagement (e.g. Saks, 2006). Those who were more optimistic also tended to see themselves as more resilient individuals. This is relevant as Luthans *et al.* (2007) assert that optimistic and resilient leaders can help followers see threats as opportunities and engage them in change. In this case, individuals who were optimistic about the future claimed they had been able to cope with different situations and overcome challenges to achieve their goals. In contrast, two participants who expressed a less optimistic outlook said that the programme had shown them that they were 'fighting a losing battle', which had led them to refocus their priorities towards clinical rather than leadership careers. This is important as it suggests that completing the programme had impacted the participants' leadership identities at an individual level, in most instances positively but occasionally negatively. It should also be noted that to avoid the risks associated with narcissistic leadership optimism must be balanced with effective self-management (*ibid*).

The study also suggests that psychological capital could also be a valuable addition to the intellectual capital literature. The participants' accounts implied that strong psychological capital enhanced an individual's human capital and social capital. For example, participants who saw themselves as more self-confident claimed to be better able to apply their skills and abilities. Likewise, their confidence, optimism and hope had also influenced the social capital that participants were able to leverage from constructive relationships and networks.

#### *10.3.2e: Transfer of Learning*

DTF incorporated various practice-oriented elements including: 360 degree feedback, policy consultation workshops, a work-based project, local mentoring which together aimed to help participants embed learning within their ongoing work and organisations (Day, 2000; McCauley, 2006; Raelin, 2006). Thus, a key consideration for the study was how participants had applied learning, the support that they had received, and the resultant organisational outcomes. Chapters 8 and 9 discussed the various ways in which learning had been applied within participants' organisations through, for example, changing the way they interacted with others, employing specific tools and knowledge, implementing cross-organisational initiatives, and making more effective decisions. This is particularly important as participants' interactions with others, in particular followers, back in the organisation are crucial to the construction and maintenance of a leader's identity at a relational and collect level. Followers must view them as leaders and respond reciprocally (DeRue and Ashford, 2010). However, it was noted that the full impact of development would only be evident in the future as the application of learning is an ongoing process. Past studies and reviews have suggested that learning transfer is improved when learners have the autonomy to trial different approaches and implement change (e.g. Brennan and Little, 2006; Day, 2000; 2011; Hartley and Hinksman, 2003; McCall, 2004; Sung and Ashton, 2005). This study reaffirmed this as most of those who believed that the programme had enabled them to frame policy and contribute at a more strategic level were already employed in relatively high-level positions. In contrast, participants with less autonomy were more likely to express feelings of frustration because they had not been used more strategically and to see themselves as struggling to have their voice heard.



In chapter 2, it was proposed that the work-based project and local mentoring components aim to help participants integrate off-the-job learning into their workplace (Garnett, 2001; Scandura and Williams, 2004). Participants spoke enthusiastically of their projects and the benefits of seeing how what they were learning in the master classes could be applied in practice. Moreover, they noted that designing and completing the projects had been challenging and had provided a source of further learning. However, participants spoke less enthusiastically about writing the project reports stating that they had been unsure of what was expected and felt pressured by the time involved. This can be explained by the dual objectives of organisational implementation and personal reflection within work-based learning (Costley, 2011). Both the coaches and the participants themselves acknowledged that the reports that had been submitted varied in quality, which raises questions about how well participants were able to reflect on the experience. Work in this area argues that for work-based assignments to provide optimum results three elements must be present: assessment, challenge, and support (DeRue and Wellman, 2009). In this study, projects appeared to have been challenging, requiring participants to dynamically adapt to the changing environment. Yet, although participants had received support from their managers, team members, and coach to complete the project, they had received limited formative feedback, which had led them to express a sense of ambiguity and dissatisfaction.

The prescriptive focus of mentoring is on support rather than challenge or assessment (Iles and Preece, 2006). In this study participants saw themselves as experiencing varying levels of support from their local mentors for different reasons. For most participants the relationship with their nominated mentor was limited and ambiguous with P15 stating: 'I just didn't get access when I needed it' while P17 exclaimed: 'how do you identify a mentor? ...guidance about where to look would have been useful'. Some expressed disappointment that their mentor did not view the role as a priority, while others acknowledged that within complex organisations like the NHS it can be difficult to find people who have the time and skills to mentor others. Thus, on the whole, the mentoring element was not felt to match the level of personal and organisational gains proposed in the literature (e.g. Baranik *et al.*, 2010; Scandura and Williams, 2004). However, a few participants had more positive experiences and the data provide some limited support for

the value of informal mentoring relationships, which are built up over time, over those which are formally imposed (Ragins *et al.*, 2000). Thus, the effectiveness of both the work-based projects and mentoring relationships were found to be dependent on the context. Projects developed in collaboration with the participants' managers and/or OD lead were perceived to have provided greater organisational benefit as they had focused on a priority area for the organisation which resulted in greater organisational support (Costley, 2011). Likewise, participants' accounts reinforced the view that it is important to take account of existing relations (e.g. structural and social relationships between the mentor and mentee), and the time and social skills required when selecting a mentor (Ragins *et al.*, 2000).

Succession planning was a key focus of DTF and the expectation that completing the programme would enhance their career prospects had become part of the group's socially constructed world. Six participants had already commenced promoted posts or secondments and in most cases this had had a positive impact on the organisation as the enhanced skills had been kept in house. However, one participant had moved to an external post which meant that the organisation had effectively lost its investment. Likewise, it was also noted by interviewees in each of the respondent groups that not all participants were ready for promotion. Several participants described how they had taken a step back to evaluate their options and process what they had learnt. For some, this was a positive process resulting in them developing more effective ways of working within their current roles. Yet, for others it was a more destructive process resulting in two participants removing themselves from their leadership roles because the structure of the organisation meant that they had responsibility but no authority to implement change. This point further highlights the view that if people are developed but are not given the opportunity to use new knowledge then learning can be a de-motivating experience (Combs *et al.*, 2009; Day, 2011; McCall, 2004). Alternatively, it could be argued that these individuals were in difficult leadership roles and wanted to use their new leadership skills but not in the role allocated by the organisation.

### ***10.3.3: Developing a Leadership Identity***

As discussed in chapter 2 leadership development theory and practice is increasingly turning its focus to identity construction as a central goal of development efforts (Carroll and Levy, 2010; Day and Harrison, 2007; Day, Harrison and Halpin, 2009; Petriglieri, 2011). Social constructionist theorists emphasise that an individual's identity is multifaceted and fluid. It is a product of their experiences and interactions and therefore shifts in relation to both the social and temporal context (Beech, 2008; Carroll and Levy, 2008; 2010; Cunliffe and Eriksen, 2011; Tourish and Barge, 2010). Some authors have recommended taking a long lens approach to leadership identity development conceptualising it either within an adult development framework (Day *et al.*, 2009; Komives *et al.*, 2005; Mumford and Manley, 2003) or over an individual's entire life span (Day, 2011b; Murphy and Johnson 2011). Likewise, others have highlighted that developing a leadership identity at an individual, relational and collective level is dependent on context-based social and relational processes (DeRue and Ashford, 2010). Both approaches raise questions about the value of formal leadership programmes whereby learning is effectively removed from the organisational context (Ardichvili, 2003; Burgoyne, Hirsh and Williams, 2004; Vicere and Flumer 1998).

Despite these concerns, several theorists still advocate the use of off-the-job development programmes proposing that they can provide participants with the opportunity to step back from the rush and familiarity of their daily contexts to reflect on their experiences and explore how their inner and social worlds affect the ways they that make sense of and act on those experiences (Carroll and Levy, 2008; Day, 2010; Ibarra, 2003; Petriglieri 2011). Moreover, social learning theory proposes that as participants come together on a development programme they share knowledge and experiences and to some extent define themselves in relation to the group (Wenger, 1998; Siebert *et al.*, 2009) Drawing on this view, Petriglieri has conceptualised leadership development programmes as 'identity workspaces', which can promote not only the attainment of knowledge and skills but also facilitate the revision and consolidation of individual, relational and collective identities. Programmes that incorporate learning about the activities and identities associated with leading, provide opportunities for practice-based learning, and encourage individual and group-based reflection are believed to personalise and contextualise participants' learning and work on their leadership identity (*ibid*). However, there is still a lack of clarity over how training and development initiatives contribute to participants identity construction

and how such practices interact with experiences gained within the ‘real world’ to foster relational and collective identities (DeRue, Sitkin and Podolny, 2011; Watkins, Lsyø and deMarrais, 2011).

This thesis has examined the processes, practices and tensions underpinning leader and leadership identity development. A number of themes pertinent to identity were discussed in the results chapters. Over half of those interviewed used the metaphor of a being on a journey to explain their experiences on the *Delivering the Future* programme. This is significant as Petriglieri (2011) proposes that the journey metaphor is apt for development programmes that aim to act as ‘identity workspaces’ as it suggests that the programme is engaging participants cognitively, emotionally, and practically. In line with the extant literature on leadership identity development (e.g. Lord and Hall, 2005; Day and Harrison, 2007) participants regarded DTF as an intensive, iterative and transformational journey which had helped many move from being a novice who was ‘play-acting’ at leadership to having individual and relational credibility in their leadership role. Schyns *et al.* (2011) assert that an important element of both leader and leadership development is helping participants to recognise their own implicit leadership theories and how they relate to the wider social context in which they operate. DTF had provided participants with the time and space to reflect, which they believed had enhanced their self-awareness (understanding their leadership approach and its strengths and weaknesses), social awareness (understanding how their actions impacted others), and self-management capabilities (having the ability to modify their leadership approach to the situation) (see sections 7.1.2; 8.2.1).

Participants within this study felt that learning alongside a group of peers had helped them to appreciate the value of different leadership approaches and had enhanced their own self-efficacy. In chapter 8 I proposed that increased skills and self-confidence had facilitated participants in taking on an individual leader identity as they had been able to see a link between leadership theories and their own self-concept (DeRue and Ashford, 2010). Thus, my data suggested that they gradually began to see themselves as leaders and acted accordingly. Yet, this is not always an easy process, an important theme to emerge during the analysis was that participants had had to effectively deconstruct their previous identity as a clinician before they could begin to work on and reconstruct their leadership identity.

This is interesting as the existing literature has focused on how to develop, regulate and maintain leader identities (Carroll and Levy, 2010; DeRue and Ashford, 2010a,b). Two elements of the programme, individual coaching and group action learning, were considered by participants to be crucial in prompting this transformational activity. Consistent with social identity theory, this suggests that both identity deconstruction and construction in this context were stimulated and shaped by interactions with others (*ibid*).

This process of deconstruction had affected people differently: some spoke of the exhilaration that had come with being awakened to new ideas while others referred to the emotional tensions and struggles that they had experienced including feeling exhausted by the process and a sense of loss at having to tear down their previous theories of leadership and sense of selves. This is an area where this thesis makes a significant theoretical contribution as although briefly explored within the critical pedagogy literature (e.g. Gruenewald, 2003) identity deconstruction has received little attention in the leadership development literature. One notable exception is recent PhD research completed by Helen Nicolson at the University of Auckland. Drawing on feminist sociological theory her thesis explores the process of what she terms ‘undoing’, she proposes that participants ideas of who they are as leaders (their identity) is undone within development programmes. As in this study Nicholson (2011) found that this ‘undoing’ process can be both energising and debilitating. This also links to the literature on ‘unlearning’ and the suggestion that emotional and distressing impacts can arise when individuals and organisations are challenged to unlearn ingrained cognitions and behaviours (Rushmer and Davies, 2004; Wijnhoven, 2001). Moreover, Beech (2011) has recently explored the state of liminality or in-between-ness that can occur during identity reconstruction.

In chapter 2 it was proposed that in addition to helping a leader work on their identity at personal level leadership development programmes can also impact the construction of a leader’s identity at a relational and collective level (Carroll and Levy, 2010). Four related themes transpired in the analysis of the empirical study. These were: socialisation and collective learning; wider networks and organisational strategy; the programme’s identity; and organisational support. Socialisation and collective learning concerned the proposition that learning alongside a group of peers had facilitated peer identification and knowledge exchange which had encouraged the construction of shared views and collective identity

change (Lord and Brown, 2001; Carroll and Levy, 2010; Weick, 1995). These interactions were found to have further enhanced individuals' views of themselves as leaders, giving them the confidence to utilise their skills which had in turn enhanced their credibility with others within the organisation. Wider networks and organisational strategy encompassed two subthemes. Firstly, it included the credibility and networks that participants had gained through each other, evidenced through both the establishment of collaborative projects and invitations to contribute more strategically within their own organisations. Secondly, it concerned the proposal from participants that the programme had enhanced their understanding of the strategic environment within the NHS. This had helped them to understand how they fit within the wider system enhancing both their individual identity but also their relationships with others in the organisation. Furthermore, this knowledge helped them to appreciate the complexity of the organisation and realise that within hierarchical organisations leader-follower identities are often in flux (Gronn, 2009).

The programme's identity had also impacted participants' leadership identities at a relational and collective level. The title of *Delivering the Future* aligns the programme with NHS Scotland's wider leadership strategy (Scottish Government, 2009) and emphasises the focus on succession planning and developing future senior leaders. However, from a social constructionist perspective it also raises questions as to who defines what the future is. In some ways it is impossible to 'deliver' the future as although individuals can strive towards idealistic notions of what they think the future should hold their assumptions may be flawed and the context in which they operate will change over time. There was also a sense of mystery and exclusivity surrounding the programme with one participant comparing it to a secret society. It was suggested that this had both positive and negative implications for participants' leader identities and their relations with colleagues and senior managers.

Participants expressed a sense of appreciation for the opportunity with many referring to the credibility that they had gained due to the DTF's reputation with senior managers and policy makers. However, some participants felt that the programme was not fully understood or appreciated within their board which had had a detrimental effect on their ability to apply learning. Participants had received mixed reactions from their team members and colleagues. Some had experienced support and interest while others spoke

about having to negotiate time and manage colleagues' resistance to change. In addition, in both the participant and the follow-up interviews it was implied that in some cases there may have been some resentment from peers over why one particular group had been given the opportunity to 'deliver the future' while others had received only limited training. The impact of not being selected could be explored further in future studies, especially the impact it has on peer motivation within organisations that promote more distributed forms of leadership.

In the literature chapters it was noted that acceptance of someone as a leader is only possible if there is a match between the implicit leadership theories of potential followers and their perception of that person as a leader (Giessner *et al.* 2009; Schyns and Schilling, 2011). One interpretation of the data in this study is that relational and collective levels of identity were better facilitated when the organisation had promoted socially shared views of leadership by providing leadership training (underpinned by common theory) at multiple levels (De Rue and Ashford, 2010; Haslam, Reicher, and Platow, 2011). Central to this shared view was the notion that within the NHS people must take on both leader and follower roles depending on the situation. Likewise, it was noted that development programmes are only one part of participants' wider leadership journeys. DTF was not a quick fix; rather it was the start of a longer learning journey for participants. Participants had received mixed levels of organisational support and encouragement since completing the programme and this had influenced how well they were able to enact their leadership roles.

To recap, this study has shown that the 'learning' participants gain within their workplace and the social interactions that they have with followers, peers and managers dynamically influence the construction of their leadership identity. However, off-the-job leadership development programmes can play an important role in leader and leadership identity formation. They provide a space for participants to reflect on the leadership issues they have faced which can help them to uncover the implicit leadership theories that they and others hold. This helps them to work on their leadership identities; however identity change takes time and is influenced by changes in the environment. The special case of clinical leadership is now discussed.

#### ***10.3.4: The Special Case of Clinical Leadership***

The previous section discussed the importance of identity within leadership development. This section now turns to the special dual-identity of clinical leadership. As was noted in chapters 1 and 4, over the last fifteen years ‘leaderism’ discourse (O’Reilly and Reed, 2010; 2011) has become a key feature of public service reform within the UK and beyond. One way in which this has transpired within healthcare services is through the promotion of clinical leadership as a means of transforming healthcare and improving patient care (Ham, 2003; Spurgeon, 2001; Woodward and Weller, 2011). The application of ‘soft power’ through incorporating powerful clinical professional groups, in particular doctors, into the decision-making process is believed to be a crucial means of bridging the clinical and managerial worlds and engaging clinicians in change (Baker and Denis, 2011; Sheaff *et al.*, 2003). In spite of this support, there remains limited understanding of how the concept operates in practice and there is no accepted definition within either the policy or academic literature (Martin and Bushfield, 2011; Garrubba, Harris and Melder, 2011; Howieson and Thiagarajah, 2011; Woodward and Weller, 2011). Addressing the second subsidiary research question this section considers how the participants’ accounts inform our understanding of clinical leadership in practice. In particular, it explores how clinical leadership differs from other forms of management and leadership in healthcare and the unique challenges involved in occupying such a dual-role.

Clinical leadership practice is strongly rooted in the psychological traditions of leadership focusing on the delineation of leader qualities, behaviours and competences (Clark; Spurgeon, and Hamilton, 2008; Cook and Leathard, 2004; Scottish Government, 2005; 2009). However, there has been a gradual move within the academic literature towards wider perspectives that emphasise the importance of context and social relationships (Bolden and Gosling, 2006; Milward and Bryan, 2005; Edmonstone, 2009; Howieson and Thiagarajah, 2011; Woodward and Weller, 2011). In addition, emphasis has recently been placed upon the distribution of leadership responsibilities (Gronn, 2002) to clinicians at all levels and the need to encourage all clinicians to play a role in the leadership of their organisations (Scottish Government, 2005; 2009; The King’s Fund, 2011). Nonetheless, much of the focus within the existing literature remains on either doctors (e.g. Baker and Denis, 2011; Dickinson and Ham, 2008; Ham *et al.*, 2011) or nurses (e.g. Alleyne and



Jumaa, 2007; Carryer *et al.*, 2007; Cook and Leathard, 2004; Cook, 2008) who hold a hybrid clinical- leadership position.

This study drew attention to the diversity that is encapsulated within the term ‘clinical leadership’. Although the DTF participants were all senior clinical leaders they varied with regard to their clinical background and service area. The cohort comprised of not only doctors and nurses but also a range of allied health professionals who worked across acute, primary, community and national services. Equally participants’ leadership roles took several forms and had been enacted in different ways. Participants were positioned at different levels within their local hierarchy and as such their autonomy to implement change varied. This was significant as, consistent with previous studies on development, a participant’s perceived autonomy to implement change was found to influence both the transfer of learning and leadership effectiveness (Awoniyi *et al.*, 2002; Axtell *et al.*, 1997; Sung and Ashton, 2005; Brennan and Little, 2006; Huczynski, and Lewis, 1980). Likewise, studies in clinical leadership have revealed that the issues faced by clinical leaders differ according to their seniority in the hierarchy, their experience, and spans of control (Howieson and Thiagarajah, 2011). Those who have no managerial responsibilities can find themselves isolated within the organisation and struggle to implement change (Stevenson, Ryan, and Masterson, 2011)

A further important way in which participants could be differentiated was the extent to which they had retained clinical responsibilities. Approximately half of the participants spent at least fifty percent of their work time on clinical duties, while the other half were primarily leaders with no or limited clinical duties. This is interesting given the promotion of clinical leaders as bridges between managerial and clinical worlds (Ham *et al.* 2011; Llewellyn 2001; Witman *et al.* 2011). There is debate within the literature over how activities should be balanced. Some authors have suggested that constantly having to negotiate between two distinct roles can result in tensions for the individual and their colleagues, and can lead to neither role being completed to optimum effectiveness (Kippist and Fitzgerald, 2009). Yet, others have advised that maintaining clinical duties is important for retaining credibility among clinical colleagues (Ham *et al.*, 2011). For example, Witman *et al.* (2011) argue that for the benefits of clinical leadership to be achieved clinical leaders have to ‘stay active in clinical practice and should avoid being considered

as managers who ‘coincidentally’ happen to be doctors’ (p.491). Furthermore, they caution that to avoid being seen as a defector to the management world by their medical colleagues clinical leaders should maintain their professional identity and use tools and instruments of the management world selectively (*ibid*).

In this study, individuals who balanced dual-roles reiterated these views as they regarded the clinical dimension as crucial to: (1) their personal motivation, (2) remaining at the forefront of their field, and (3) preserving their credibility with other clinicians. Alternatively, those who had moved into full-time ‘leadership’ roles stated that they had worked their way up through several levels of hierarchy and had got to a stage in their career where they felt it was no longer viable for them to balance clinical activities with their leadership responsibilities. Nonetheless, they believed that having a clinical background still gave them a good understanding of the health system which enhanced their credibility with others. The analysis also highlighted that the educational level, financial rewards, historical autonomy and prestige of different professions may influence an individual’s leadership route.

In chapter 4, it was suggested that clinicians are often seen as ‘reluctant leaders’ (Davies and Harrison, 2003; Gleeson and Knights, 2008). Yet, the group of clinical leaders in this study appeared to be relatively engaged. They had a variety of motivations for going into leadership including both positive personal and organisational outcomes. There was a strong belief that having a clinical background gave them insight into the complex systems within the NHS which meant that they could make more informed decisions than their non-clinical counterparts. This supports the view that some clinicians regard health service managers as under-qualified and lacking the skills to provide direction to clinicians (Dickinson and Ham, 2008). Nonetheless, in general, leadership as a discourse in the NHS was viewed as more acceptable to clinicians than the previous management discourse. Though most admitted that their role comprised of both management and leadership tasks there appeared to be a wariness to call themselves managers. There was a suggestion that management encompasses more mundane tasks while leadership holds more prestige and influence. In other words, people want to be associated with inspiring and motivating. This relates to the legacy of ‘management’ as a bad word within the NHS and links back to theory around the concepts of charismatic and transformational leadership (Bass, 1997;

Kotter, 1999). Moreover, the data is in line with Martin and Learmonth's (2012) proposition that the discourse of leadership can help clinicians construct a self-identity that reflects supremacy, prestige and authority as it does not hold the same negative connotations as the former discourse of management.

Alternatively, others argued that leadership was simply the current theme within the organisation. Participants referred to the plethora of rhetoric and policy around leadership but, at the same time, suggested that this was not always put into practice and supported. Similar points have been raised within the critical leadership literature which has suggested that the promotion of shared and distributed leadership can mask more coercive forms of power as it encourages people to buy into existing managerial logics (Martin and Learmonth, 2012). In line with previous studies which have explored the perceived power disconnect between clinicians and managers within the NHS (MacIntosh *et al.*, 2011), the clinical leaders in the study frequently stated that power remained with managers which they found frustrating. This psychological attribution of power to the other (in this case, managers) became a key element of their socially constructed world which potentially hindered the construction of their leadership identity at a collective level. Alternatively, others argued that the role of clinical leaders was to influence the power holders, engage staff in leadership, mentor staff through difficult situations, and help staff appreciate the reasons behind change. Yet, they acknowledged that balancing these different roles of influencer and motivator can be challenging.

The clinical leadership literature emphasises the importance of clinical leaders working closely with both managers and other clinical professionals (O'Reilly and Reed, 2011) so that they can contribute to healthcare reform, regulation, patient safety, and patient care (Howieson and Thiagarajah, 2011). As noted previously, this study highlighted the dynamic nature of leadership and the various roles as leaders and followers that individuals have over time within hierarchical organisations like the NHS. Participants believed that completing the programme had helped them to appreciate others' views and build productive relationships across the organisation (see section 8.4). Like the medical chief executives in Ham *et al.*'s (2011) study, they also spoke of the importance of recognising gaps in their own competence and knowing when to delegate and bring others in. In addition, participants described ways in which they were formally and informally sharing

and ‘cascading’ the knowledge and skills that they had gained. However, they cited that limited organisational support and training together with a lack of time were the main barriers to advancing more distributed forms of leadership.

The findings of this study lend support to other research into the fragile nature of clinical leadership roles in the NHS and the challenges facing clinicians and other professionals (such as lawyers, teachers and academics) occupying hybrid positions (Ham *et al.*, 2011; Llewellyn, 2001; Osborne, 2011; Robertson, 2011). Participants spoke of the ‘culture shock’ they had experienced in moving over to a management or leadership role and the residual tensions that existed between clinicians and managers. It was proposed that there is a need for greater training across the organisation that helps both managers and clinicians to understand each other’s roles and how they interconnect. Nonetheless, there appeared to be less animosity towards management than has been found in previous studies (e.g. MacIntosh *et al.*, 2011). This may be due in part to the general support for clinical leadership within the group who as volunteers are perhaps more sympathetic to the need for effective management. In addition, the focus placed upon understanding the strategic context of the NHS and the contribution of different professions (including managers) within the DTF programme may have contributed to this positive view.

A further area which has received attention within the literature is how clinical leaders balance their clinical and managerial priorities. Research has suggested that balancing activities is not trouble free as sometimes a clinical leader will have to make decisions that are in conflict with their clinical habitus, which can strain relations with their colleagues (Kippist and Fitzgerald, 2009; Witman *et al.*, 2011). In addition, Kippist and Fitzgerald’s (2009) case study of a clinical leadership development indicated that organisational tensions can also arise as the organisation may suffer if the managerial role is abandoned in favour of the clinical role. Within this study participants found the process of balancing clinical and leadership priorities challenging but also rewarding. Five participants also alluded to the difficulties in managing and leading other professions due to historical power relations (e.g. Currie and Lockett, 2011; Fitzgerald and Ferlie, 2000; Fitzgerald *et al.*, 2006). Additionally, participants mentioned that they had occasionally met resistance from colleagues who thought that they had gone over to the dark side (e.g. Llewellyn, 2001). Interestingly, participants stated that the current economic pressures and austerity

measures within the NHS had created uncertainty which although in some ways had made it more difficult to motivate and engage staff it had also created a common acceptance of change which has made it easier for them to implement some reforms.

The final theme worthy of discussion relates to the ambiguity surrounding the role and the need for clinical leaders to take on a coherent professional identity. Past research has suggested that hybrid clinical leaders do not yet have a coherent work identity or common knowledge base (Fitzgerald *et al.*, 2006; Montgomery, 1990). This study has reiterated this view; participants often spoke of the ambiguity surrounding their leadership role. Initially many participants had found it difficult to place boundaries around the role and eight of those interviewed felt that important others within their organisation did not fully understand what their job encompasses. Ham *et al.* (2011) propose that clinicians who take on leadership roles experience a shift in their professional identities, moving from a keen amateur to skilled professionals during their careers. As mentioned above the participants in this study could be split into two groups the first encompassing those hold a hybrid role and the second including those who had taken on full time leadership positions. The first tended to identify primarily with their clinical profession while the second group had begun to identify themselves as leaders, but were keen to stress the importance of their clinical background.

This study highlighted that the process of moving from a purely clinical to a dual clinical-leader identity is important to success. Moreover, it illustrated the role that leadership development can play in this identity change process. It was suggested that DTF had provided participants with an improved knowledge of the strategic context within the NHS, helped them understand the role of different professions, and given them the opportunity to identify with a peer group of clinical leaders. This socialisation is important as feeling part of a group who faced similar challenges and insecurities was thought to encourage collective learning and enhance participants' self-efficacy. This relates to Montgomery's (1990) proposition that development can play an important role in 'discovering colleagueship' and 'establishing legitimacy' which are requirements for the conception of clinical leadership as a speciality in its own right (p. 183). Many participants felt that their identity had been enhanced because they were now able to bridge the clinical and managerial worlds. However, others stressed that changing their professional identity had

not been an easy process; some described feeling a sense of loss at giving up part of their professional identity, while others described the organisational barriers they had faced in maintaining this ‘new’ identity at a relational and collective level.

## **10.4: Implications of the research**

### ***10.4.1: The Theoretical Contribution***

This research contributes to the existing body of knowledge on leadership development by adding a new understanding of how leadership development programmes can impact participants and their organisations. The research takes a holistic approach informed by multiple strands of literature that have thus far remained in parallel. It addresses past calls in the leadership and leadership development literature for more integrative studies that draw on micro and macro perspectives of leadership (e.g. Day *et al.*, 2009; Day, 2011; Hiller *et al.*, 2011). This approach also provided scope for the thesis to contribute to three bodies of literature relating to: clinical leadership, leadership development, and intellectual capital. The phenomenological research design adds to earlier, predominantly positivistic, research into leadership and leadership development by exploring in-depth the perceptions of those involved in the development process (Alvesson, 1996; Hiller *et al.*, 2011). The qualitative mode of inquiry allowed participants to convey the context, attitudes and feelings behind their experiences and helped to clarify the different nuances of clinical leadership that exist in the Scottish NHS.

As the DTF programme recruited participants from across multiple health boards and from a range of clinical professions the study was able to clarify the nature and role of clinical leadership in different contexts and explore the variety that comes under the broad band of ‘clinical leadership’. Moreover, the findings were prevented from being skewed by any dominance of one single profession. The empirical chapters compared participants’ accounts of the programme, how they had approached and performed their leadership role, the guidance and support that they have received, and how they had transferred learning back into their organisations through (a) sharing learning with others, (b) applying learning and changing processes, and (c) contributing to the organisations strategic objectives. This discussion confirmed that there are many forms of clinical leadership and that an

individual's background and past experiences will influence how they make sense of, react to and manage different situations (Weick, 1995). Unpicking the variety that exists within clinical leadership is important as the past literature is predominantly from the perspective of doctors (e.g. Baker and Denis, 2011; Dickinson and Ham, 2008; Ham *et al.*, 2011) and nurses (e.g. Alleyne and Jumaa, 2007; Carryer *et al.*, 2007; Cook, 2008). Yet, regardless of an individual's professional background, a central argument that ran through this thesis is that for a dual-role to be effective leadership must become a central part of the clinician's identity.

In this study clinical leaders often associated themselves with their professional group, their clinical role was an integral part of their personal identity, and they were confident in their clinical abilities. In contrast, although many viewed the leadership role as an exciting new opportunity, they also spoke of the ambiguity surrounding the role (using words and phrases like 'uncertain', 'big change' and 'vague idea'), and reported varying levels of confidence in their leadership abilities. Individuals acknowledged that taking on a leadership role had been challenging as it had taken them away from their clinical comfort zone and exposed them to the political tensions that exist within the organisation. This resonates with past research which has found that key barriers to engaging clinicians in management and leadership include: concerns over leaving their comfort zone and their preparedness for the role, cynical perceptions and tensions surrounding healthcare management, and worries over the impact that reducing their professional practice may have on their autonomy and professional credibility (MacIntosh *et al.*, 2011; Marnoch, McKee, and Dinnie, 2000; NHS North West Leadership Academy, 2008). Nonetheless, the extent to which these issues were emphasised during the interviews varied according to the participants' profession and whether they worked in acute, primary or community services.

It was proposed that organisations can support clinical leaders to overcome these challenges by providing them with the opportunities to develop the leadership part of their dual-identity. Through the lens of social identity theory the study showed how off-the-job development programmes can play an important role in this leadership identity construction process. It contributes to research on leadership development as it provided clarity over how participating in a multidimensional development programme, like DTF,

can enhance an individual's human, psychological, and social capital. Moreover, it explored how these elements interact and combine, bringing about an identity changing process from novice to a leader at an individual and then relational level. It was confirmed that identity change is complex and occurs over time in relation to the wider social context. Leadership programmes provide participants with the space to reflect and work on their identity; however collective identity is only achieved if followers, peers and managers accept the participant as a leader and give them the opportunity to implement learning.

Prior to commencing the programme participants spoke of having to learn through making mistakes on the job. They described feeling almost like they were fakes, 'play acting' at leadership and worried that someone would catch them out. The analogy to 'play acting' has important connotations; it suggests that participants had little confidence in their skills and that they felt like they had to perform to an imagined ideal of leadership to cover up their deficiencies. Participating in *Delivering the Future* was described as being on an intensive learning journey that broke down their preconceptions and enhanced their leadership knowledge, skills, and abilities. Importantly, it was proposed that participating in the programme and learning from others had given them not only the ability but also the confidence to utilise their skills. This relates to the first stages of the identity change process as enhanced confidence had led to them to see themselves as leaders and as such form an identity as a leader at an individual level. The relational aspects of identity were also emphasised during the follow-up interviews. In the case of P2, his colleague and manager had always seen him as a leader and were pleased that participating in the programme had increased his confidence. Alternatively, in P17's case his colleague and manager said that since being on the programme they had observed changes in his behaviour which had enhanced their view of him as a leader.

The group-based learning element of the programme was also crucial in developing participants' social capital and helping them to identify with a peer group of clinical leaders. This relates to the notion that participants of a development programme can form a new 'community of practice' that encourages collective identity change and the construction of shared logics and practices (Wenger, 1998). It allowed them to observe that others often had similar worries and concerns. Moreover, it gave them a sounding board to explore issues and find solutions for managing different situations. This peer



support, together with the credibility and extended networks that the programme afforded, prompted several participants to make changes to their behaviour and commence new initiatives. The follow-up interviews with selected colleagues suggested that these changes had been observed by participants' colleagues whom in turn began to think of them as effective leaders. It was argued that these views helped participants to form an identity as a leader at a relational level and reinforced their individual identity.

Despite the positive role that leadership development can have on a leader's identity construction it was noted that participating in a development programmes is not the end of the story. The organisational context, including for example, the support they gained from their managers and the systems in place that encourage or hinder innovation, plays an important role in sustaining and 'cementing' an individual's identity as a leader over time. The transfer of learning into intellectual capital and the development of a collective leadership identity are dependent on a supportive organisational context which allows individuals to implement and practice what they have learnt. This reinforces past learning, training, and development literature which proposes that for training to be a positive and motivational experience participants' must be given the autonomy to apply learning (Cheng and Hampson, 2008). In general, it was those who had professional and managerial responsibilities who were best able to re-contextualise learning and implement strategic changes in their organisation. Moreover, initiatives were thought to be better received when leadership was embedded within the culture of the organisation. Thus, it was suggested that in a hierarchical organisation like the NHS which promotes distributed forms of leadership it is important for off-the-job (national) programmes are supported by more localised initiatives that promote leadership at different levels in the organisation and prepare individuals for the various roles they will hold as leaders and followers.

Finally, the study also adds to the intellectual capital literature as it suggested that an additional factor, psychological capital, may play an important role in the generation of intellectual capital. A key finding to emerge from the study was that developing an individual's human and social capital is not enough as individuals must also have the determination and confidence to apply their knowledge and skills and pursue productive networks. Thus, it was proposed that nurturing positive psychological capital compliments

and enhances investments in an individual's human and social capital. Together these three elements interact with organisational capital to generate intellectual capital.

#### ***10.4.2: Contribution to the Policy Context***

As the research was co-funded by the Scottish Government and Economic and Social Research Council there was a strong emphasis from the outset on the study's potential relevance to policy and practice. Throughout the PhD I attended a number of policy meetings and events which provided useful contextual information. Presentations and reports summarising relevant findings were given to NHS Scotland and Scottish Government stakeholders. These represented a direct and immediate contribution and meant that feedback and discussions could be focused from the policy and practitioner perspective and not just from academic colleagues and conferences. In addition, five months were taken out from PhD work to take part in three Scottish Government placements. During these placements I worked in both the Care Team (Health Analytical Services Directorate) and in the Professional Development Team (Office of the Chief Researcher). These experiences provided insight into the patient-focused objectives of the National Health Service and the issues policy makers face in balancing quality with efficiency.

Since the election of the Scottish National Party in 2007 all work within the Government has been consistently focused on the National Performance Framework. This framework is guided by the overall purpose: 'to focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth' (Scottish Government, 2007). The themes discussed within this thesis relate to this purpose as they explore how effective management and leadership within public services can contribute to the provision of more effective and efficient service provision.

Given the focus of this research the findings have particular implications for current policy relating to clinical leadership and leadership development within NHS Scotland. In chapter 4 it was observed that 'leaderism', a development of managerialism, has been promoted within the recent policy discourse of public service reform (O'Reilly and Reed,

2010; 2011). ‘Leaderism’ prioritises the role of leaders as inspiring others in collaborative endeavours (*ibid*). Linked to this clinical leadership has been posited as a means of engaging clinicians, particularly doctors, into the overall management of the NHS rather than for them to use their powers to oppose reforms (Buchanan *et al.* 1997; Department of Health, 2007; Scottish Government 2005, 2009). Thus, governments have placed particular emphasis upon the development of hybrid clinical leaders who can drive forward and engage others in change (Ham and Dickinson, 2008; Swanwick and McKimm 2011).

Enticing significant numbers of motivated and qualified clinicians into clinical leadership roles has not been easy. The managerial and market reforms of the 1980s and 1990s have left residual negative associations with management positions within the NHS. As a result, clinicians can be reluctant to adopt a leadership identity as they may be perceived by peers as abandoning their professional principles (Kirkpatrick *et al.*, 2009). This research highlighted that often clinicians recruited into leadership struggle to manage conflicting demands and to establish a strong identity as a leader. Yet, within the development programme there was evidence of interest and involvement in clinical leadership from a range of professions including general practitioners, hospital medics, nurses, psychologists, physiotherapists and other professions allied to medicine. There was a sense that leadership was perceived to be more appealing to clinicians than previous notions of administration and management. However, most participants accepted that their roles encompassed elements of both leadership and management. Others have also cautioned that this ‘romance with leadership’ could collapse if initiatives fail or make little difference (Brookes and Grint, 2010; Grint, 2009; The King’s Fund, 2011).

In terms of developing clinical leaders, this study stressed the importance of providing opportunities for clinicians to develop their leadership knowledge and skills and to reflect on the applicability of learning. Moreover, it was suggested that through interaction and collaboration with other clinical leaders and managerial leaders’ clinicians gain an understanding of the organisation’s strategic objectives. In particular, multi-professional programmes were purported to help individuals overcome their profession focused mindset and move from silo-based working to more collaborative forms. Having an overview of the organisation and an understanding of other professions helps them to see where they fit within the process and enhances their leadership identity. A key finding from the study

relevant to policy makers is that development programmes are only the first step in leadership identity construction. Sustainable success in the form of leadership identity construction and positive results requires organisational support to be in place e.g. in the form of OD development plans, a supportive learning culture, and cross-organisational development that embeds a common worldview and encourages distributed leadership. Ultimately, it is important for clinical leaders to have the autonomy to implement learning on their return.

The importance of preparing clinicians for a dual-role and the length of the identity change process involved has implications for the proposed health reforms in England outlined in the recent Health and Social Care Bill (2011). This bill proposes that clinical commissioning groups (with GPs at their heart) will take over from managers in Primary Care Trusts as the people who buy health services for patients. This will place GPs at the centre of a complex web of relationships spanning primary and secondary care and health and social care (Giordano, 2011). This ‘sharing of leadership’ with GPs may prove a difficult burden for them to carry, especially if they lack the will, skill and opportunity to lead in such complex networks. It may also lead to resistance and scepticism amongst other healthcare professional who feel disenfranchised by this focus on GPs. In addition, even if GPs are given opportunities to develop, identity change is not immediate but rather occurs over extended time periods in relation to the social context. Thus, these temporal rhythms of identity development may not be compatible with the expectations of organisational and policy stakeholders.

#### ***10.4.3: Contribution to Practice***

This research adds an understanding of how individuals develop a dual clinical-leadership identity and the variety that exists within such dual-roles. This is important as clinical leaders are thought to provide an important role in how clinical services are delivered to NHS patients across Scotland. Leaderism as a discourse in the NHS appears to be more appealing to clinicians than past focuses on management. Nonetheless, there is debate over whether it really is substantially different or merely ‘lip service’ and rebranding of the management function. Individuals within dual-roles still struggle with the role’s complexity and conflicting demands. In addition, the move into such a complex and

ambiguous role seems to suit some more than others. An individual's prior logics, orientations and experiences will influence how they enact the role and their successfulness in the role (Day *et al.*, 2000; Robertson, 2011). Thus, choosing a clinician to participate in a strategic role requires sensitivity and respect to be developed between senior manager and the clinician. Participating in a development programme can enhance a clinician's leadership skills self-awareness and self-efficacy and can add to their credibility as a leader amongst followers, peers, and superiors. An important theme within the study was how credibility influenced leadership identity construction at four levels including being credible to themselves, credible to those under them and to peers, credible to 'the organisation', and credible to society. To achieve organisational benefits senior managers must nurture a supportive organisational culture and ensure that participants have the autonomy to implement learning.

The research also considered the leadership theories that inform leadership development within the Scottish National Health Service. Despite a clear rhetoric within the literature supporting distributed leadership across the NHS it was evident from both the policy and programme documents that there remains a strong focus within current initiatives on developing individual leaders with desirable leadership qualities and behaviours. This has the potential to be problematic as although effective leadership requires leaders with the necessary skills to communicate, influence, manage and inspire followers it emerges through social interaction and is dependent on effective followers (DeRue and Ashford, 2010; Shamir 2007; Tourish and Pinnington, 2002). In addition, this research has emphasised that there is no one best approach to leadership and solutions are often context specific and socially constructed by the individuals involved. The boards that appeared to gain the most from sending participants on the programme worked with individuals from the outset on the applicability of the programme to their role and how it fitted within their context. There was also a focus on leadership throughout these boards; supplementary localised initiatives promoted leadership across different organisational levels and professions. This helped to create credibility and respect for leadership and its aspirations but also prepared individuals for the reality that within a hierarchical organisation, like the NHS, individuals will at times be both followers and leaders. Thus, this study highlighted the importance of integrating leader development with more aggregate leadership development to encourage collaboration and nurture effective followers as well as leaders.

A further implication for leadership development practice is the suggestion that identity development is an integral aspect of leadership. Although not a new notion this research has illustrated how development programmes (and their component parts) can be used to assist in the identity construction process. Identity development occurs through experiences and through an individual's social interactions. Thus, programmes designed to enhance participants' self-management skills, confidence and resilience can help them to develop a confident and consistent personal leadership identity. Similarly, programmes that promote group-based learning and relationship building through, for example, action learning sets and collaborative activities can provide participants with a peer group that they can identify with and learn from. The credibility and mutual respect that can arise amongst participants and those in their wider networks are crucial to the development of a participant's leadership identity at a relational level as colleagues begin to believe in an individual's identity as a leader and work to support them. The study also showed that it is important for those coordinating development to collaborate with organisational development departments and senior managers to ensure that there are individualised development plans in place that ensure participants are supported through further on-the-job learning. It was proposed that such support plays a crucial role in sustaining and strengthening an individual's leadership identity by encouraging learning transfer and collective endorsement of the leader.

## **Chapter 11: Summary and Conclusions**

### **11.1: Introduction**

The purpose of this final chapter is twofold: (a) to summarise and evaluate what has been achieved throughout the process of this research; and (b) to propose areas of future research. Section 11.2 provides a brief summary of the thesis. Section 11.3 sets out the main findings and the contributions of this research. To conclude, section 11.4 discusses the limitations of the research, and from the issues raised, section 11.5 suggests areas for further research.

### **11.2: Thesis Overview**

The research began with the broad aim of exploring the role of human capital investment within health service reform in Scotland. A review of the human capital and public value literature revealed that while past research had established measurement tools and suggested causal connections between the different dimensions of intellectual capital and various performance outcomes (e.g. Bontis and Fitz-enz, 2002) there remained terminological confusion and uncertainty over how human, social, and organisational capital components interrelate and dynamically combine to create intellectual capital (e.g. Bowman and Swart, 2007). It was decided that a qualitative case study design would provide the best means of gaining insight into the interrelationships of these components within a health care context. Exploratory interviews were completed with NHS HR Directors to gain insight into the organisation's current human resource challenges and priorities. The results of these interviews were presented in chapter 6. It was noted that the recent economic downturn and subsequent 'austerity' measures had led to a move in focus from recruitment to retention and from stability to change. A key priority for the HR directors was developing the organisation's clinical leadership capabilities as it was believed that effective leadership would improve employee engagement and encourage collaborative working which they hoped would in turn increase the efficiency and effectiveness of the service. These results informed the study design and led to the development of the focal research question:

*In a healthcare context, how do clinicians who participate in a leadership programme account for its impact on their identity, through their human and social capital, and what organisational factors influence their accounts?*

As the study progressed, two further research questions relating to the role of development programmes as identity workspaces and to the special case of clinical leadership emerged as the study progressed:

- (a) What role can leadership development programmes play in shaping participants' leadership identities at an individual, relational and collective level?
- (b) What do we mean by clinical leadership and how do clinical leaders construct it in action?

An important objective for the study was to critically review and evaluate the literature on leadership, clinical leadership, and leadership development (see chapters 2 and 4). This review revealed that leadership is an inherently complex and contested topic that has been conceptualised in a multitude of ways (Grint, 2005a). Traditionally, leadership research and practice has been dominated by an interest in leaders and their traits, styles and behaviours (Yukl, 1999; Bass, 1997; 1999). However, contemporary research has suggested that leadership is co-constructed by leaders and followers and that the organisational context plays an important role in the formation of leadership outcomes (e.g. Fairhurst, 2009; Grint, 2010; Kellerman, 2008; Shamir, 2007; Schyns and Shilling, 2011). In addition, there has been a growth in critical approaches which advocate more collective, distributed, and ethical forms of leadership (e.g. Gardner *et al.*, 2011; Gronn, 2002; 2009; Grint, 2011). In particular, distributed and hybrid forms of leadership which promote leadership at multiple levels of the organisation have been advocated as an alternative to previous 'heroic' theories focused the skills and abilities of the select few (Gronn, 2002; 2009). This change in focus has been echoed in the clinical leadership literature with recent approaches advocating the need for more inclusive and collective forms of leadership as means of engaging staff in change and achieving effective healthcare (Bolden and Gosling, 2006; Buchanan *et al.*, 2007). Yet, there is uncertainty over how the practice of clinical leadership differs from other forms of management leadership and the challenges involved



in occupying such a dual-role (Currie and Locket, 2011; Howieson and Thiagarajah, 2011; Mackintosh *et al.*, 2011).

Leadership development theory and practice has also evolved over the years and there is evidence to suggest that it is gradually moving beyond ‘best practice’ leader-centred approaches to incorporate wider social constructionist and critical perspectives (Carroll and Levy, 2010; Day, 2011; Dvir *et al.*, 2002; DeRue and Wellman, 2009; Petriglieri, 2011). However, questions remain as to how leadership development initiatives are informed by the plethora of leadership theories available. Moreover, there is debate over how leaders are developed, the relationship between leaders and leadership, and the individual and organisational effects of off-the-job development (Day, 2011; Grint, 2010; Lord and Shondrick, 2011).

The research question and the results of the literature review led to an in-depth case analysis of *Delivering the Future*, a leadership development programme for senior clinical leaders from across the Scottish NHS. The case study was guided by five broad objectives:

- To explore participants’ accounts of the leadership development programme in terms of learning content, applicability and human capital development.
- To examine how leadership development programmes can provide a forum for social capital creation through group-based learning and the establishment and maintenance of networks.
- To investigate the perceived role of policy and organisational context on accounts of learning effectiveness, transfer, and intellectual capital development.
- To evaluate how leadership development programmes can act as identity workspaces, connected to, yet removed from, participants’ organisational contexts and daily routines, which facilitate the revision and consolidation of individual and collective identities.
- To assess the special case of clinical leadership: what makes it different from other forms of management and leadership in healthcare and what are the unique challenges involved in occupying such a dual-role.

Chapters 7, 8 and 9 reported the empirical findings from the study. The analysis provided an in-depth account of the perceptions of clinicians who have completed the programme. The frameworks used to guide the interviews provided individuals with the opportunity to give a detailed account of their experiences of the programme, how they had applied and transferred learning, the challenges they had faced, and the organisational factors that they believed had influenced learning transfer and impact. Chapter 10 then discussed the empirical findings in relation to the existing literature and set out the main contributions of study. These contributions are briefly summarised in the following section.

### **11.3: Research Strengths and Implications**

#### ***11.3.1: An Integrative Approach***

This thesis has taken an integrative approach to leadership development theory and practice. It has explored the concepts relating to clinical leadership, leadership development and intellectual capital that have been published thus far and extended these through empirical analysis. The empirical findings of this research are based on an in-depth study of a multidimensional leadership development programme that recruits senior clinical leaders from across NHS Scotland. The phenomenological approach allowed the complexity surrounding leadership in a healthcare setting to be explored. In particular, the semi-structured qualitative interviews provided a useful means of obtaining data as they allowed participants to convey the context, attitudes and feelings behind their experiences on the programme. In addition, the multi-professional nature of the programme meant that I was able to explore how different professions had enacted their dual-role. Similarly, as it recruited from across the 24 Scottish health boards and incorporated different services areas (e.g. acute, primary, community, and special services) I was able to study the perceived influence of organisational context and professional specialism on learning transfer and effectiveness.

#### ***11.3.2: Diversity within Clinical Leadership***

Much of the existing literature on clinical leadership has been concerned with defining the competences and qualities of effective clinical leaders and has largely focused on doctors

and nurses in formal leadership positions. This study drew attention to the diversity that is encapsulated within the term ‘clinical leadership’. Participants of the case programme were all senior clinical leaders; however they varied with regard to their clinical profession, health service area, hierarchical level, degree of autonomy, and the extent to which they balanced clinical and managerial duties. In the literature clinicians are often described as ‘reluctant leaders’; in contrast the group in this study were relatively engaged and had a range of personal and organisational motivations for moving into leadership positions. There also appeared to be less animosity amongst the group towards those working in general management roles than has been suggested in previous studies.

### ***11.3.3: Power Disconnects and the Importance of Autonomy***

In general, the clinicians on the programme viewed leadership as a more desirable notion than management. It was acknowledged that most leadership roles encompass elements of management, but it was suggested that leadership provides greater opportunities to engage with the organisation strategically and has a better reputation with clinicians. Nonetheless, power disconnects were still thought to exist within participants organisations. There was a sense that much of the power remained with general managers who controlled the budgets and strategy. In contrast, the HR managers stressed that within a healthcare setting it was almost impossible to implement change without the support of clinicians. Some non-medical clinical leaders also noted difficulties that they had experienced in leading other historically more powerful professions. The challenges presented by these power disconnects appeared to affect some participants more than others; some were in senior positions and had the autonomy to introduce change, others were semi-autonomous and viewed themselves as influencers and negotiators, but a small minority who had no or limited managerial responsibilities struggled to implement change and grew frustrated with the system. Thus, the study illustrated the importance of participants’ local autonomy on development and leadership effectiveness. Moreover, it drew attention to the ‘fantasies of power’ that can exist within organisations when professionals attribute power to managers, while managers attribute power to professionals.

The findings from the study also lend support to past research into the fragile nature of clinical leadership roles in the NHS (e.g. Kippist and Fitzgerald, 2009). It was noted that

there is ambiguity surrounding the role and the clinical leaders in the study faced both internal tensions and external challenges. Internally, they had had to balance staying active clinicians in the forefront of their field with establishing themselves as competent clinical leaders within their organisation. Externally, they had faced challenges leading in the face of adversity; having to make unpopular decisions, and overcome resistance from colleagues. This study highlighted that it is important for clinical leaders to assume a dual professional identity that allows them to move from a keen amateur to skilled professional during their careers. It was suggested that establishing a coherent professional identity for clinical leaders would also help to provide clarity for both clinical leaders and others in the wider organisation.

#### ***11.3.4: Leadership Development and Identity Workspaces***

This study makes a contribution to the leadership development literature on identity workspaces. It has explored how off-the-job development programmes can act as ‘identity workspaces’ where participants can step back from the rush and familiarity of their daily work to self-reflect and work on their identity (Petriglieri, 2011). It suggested that multi-disciplinary development programmes can provide an opportunity for back-stage dialogue which helps to overcome power disconnects in the organisation and promote shared logics and practices. The one-to-one coaching and action learning sets were both considered to be important facilitators in the identity change process. Together they provided a source of social interaction and promoted trust amongst group members. Participants were encouraged to reflect on their leadership challenges and question their implicit leadership theories. This process was said to have enhanced participants’ self-efficacy and sense of power as it had given them the opportunity to identify with a peer group of clinical leaders which had shown them that there was no magic formula underpinning leadership. Yet, it was observed that shifting ones’ professional identity is not an easy process with many participants describing the internal struggles they had faced around creating a sense of self (Sveningsson and Alvesson, 2003). This was particularly apparent given the focus on clinical leaders who must balance multiple competing identities. The case participants spoke of how they had had to first deconstruct their self-identity and unlearn their previous beliefs and behaviours before they could reconstruct a new sense of selves. The process of deconstruction had affected participants in different ways. Some had found it an

energising experience, which resulted in them feeling empowered and more confident in their leadership role. In contrast, others had found the process overwhelming and struggled to let go of their previous professional identity as a clinician. The importance placed upon deconstruction and unlearning past notions of leadership differentiates the study from others which have focused predominantly on the construction, maintenance, and regulation of specific leadership identities.

### ***11.3.5: A Forum for Social Capital Creation***

Both identity work and social identity theory emphasise that the identities are formed within social and discursive contexts and that there are relational and social processes involved in coming to see one's self and being seen by others as a leader or follower (Beech, 2008; DeRue and Ashford, 2010; Sveningsson and Alvesson, 2003). The study demonstrated that multi-faceted leadership development programmes can play a role in the co-construction of a leader's identity at an individual, relational and collective level. It was proposed that DTF had initiated bonding, brokering, bridging and legitimising activities that had enhanced both individual participants' and the group's social capital. The programme had promoted bonding ties by establishing a supportive peer group and a sense of group identity across the cohort. It had brokered social capital by facilitating communication between different actors, encouraging collective learning, supporting collaborative activities, providing access to wider networks, and creating and disseminating knowledge. In addition, as discussed above, it bridged different forms of clinical leadership through identity work and encouraging the social interactions that help to create, reinforce, diminish, and maintain an individual's self-concept as a leader. Specifically, the participants formed a community of practice with shared meanings, practices and aspirations. Finally, in most cases, participating in DTF had increased participants' legitimacy in the eyes of important others. Peer support together with enhanced credibility had helped to establish participants' leadership identities at a relational and collective level. Moreover, increased legitimacy and credibility had assisted them in achieving both organisational objectives and exploiting new networks to further their careers. Thus, they had reinforced their leader identity through action.

### ***11.3.6: Collective Identity Construction***

Although development programmes can act as spaces where leaders can work on and co-construct their identity they are only one part of participants' wider leadership journeys. An individual's identity evolves and changes throughout their life in relation to the wider social context. In the current case, participants past knowledge and experience together with their daily interactions with followers, peers and managers had influenced their leadership approach and others views of them. In the literature it was proposed that acceptance of someone as a leader is only possible if there is a match between the implicit leadership theories of potential followers and their perception of that person (Giessner *et al.* 2009; Schyns and Schilling, 2011). This study showed that it is more difficult for development programmes to influence these wider bonding ties. Participants alluded to the challenges that they had faced within their organisations in maintaining their 'new' identity at a relational and collective level. However, it was asserted that having greater credibility combined with improved communication and self-management skills had and would continue to improve participants' relations with their managers, peers and staff. This was believed to be most successful in cases where the organisation had combined top-level development with leadership training across the organisation, which promoted collaboration and recognised the dynamic nature of leadership within the NHS.

### ***11.3.7: The Role of Psychological Capital***

In agreement with Gronn (2009), participants suggested that complex organisations like NHS Scotland require both top-down and distributed leadership. Linked to this, the study showed that leadership development programmes can also impact participants' psychological capital, in particular their level of self-efficacy (confidence) and hope (aspirations and goals for the future). Moreover, it was proposed that psychological capital could provide a valuable addition to intellectual capital frameworks as strong psychological capital was shown to enhance participants' human capital and social capital. Individuals who were more self-confident had been better able to apply their skills and abilities, while those who claimed to have high resilience had overcome challenges and found alternative solutions. Likewise, the strength of participants' professed self-efficacy, together with optimism and hope, had influenced the amount of social capital that they had

leveraged from constructive relationships and networks. In a similar manner, social capital enhanced participants' human and psychological capital as it encouraged collective learning and enhanced participants self-efficacy and motivation to succeed. Thus, the study substantiated the interdependent relationships that exist between human, psychological, social and organisational capital. To conclude, intellectual capital theory provided a useful theoretical framework for the research, but it was also observed that in practice the components of intellectual capital are not always definitive.

#### **11.4: Limitations**

As in any research project, this thesis is subject to a number of limitations. Chapter 2 has already critically discussed the limitations of the theoretical approach, whilst chapter 5 weighed up the pros and cons of the methods used to collect and analyse data. However, there were three further important limitations which may have affected the data produced.

Firstly, the purposive sample of participants, encompassing 44 interviews spread over three phases, together with the fact that participants in the second phase were recruited from one cohort of a single programme may be seen as a limitation as it reduces the generalisability of the results. However, the premise behind the research question was a desire to access the accounts of clinicians participating in a leadership development programme and examine how their experiences on the programme had influenced the enactment of their clinical leadership role. The level of meaning required from individuals led to the need to limit the size of the sample and focus on depth rather than breadth. Focusing on one cohort of DTF could cause the findings to be influenced by idiosyncrasies within the group but allowed for an in-depth analysis that drew on the accounts of multiple stakeholders. Moreover, it provided analytically generalisable findings which inform wider theory. This study showed that leadership development and subsequent identity change is a complex and ongoing process underpinned by a range of individual, relational and organisational factors. These findings are congruent with similar research (e.g. Carrol and Levy, 2010; Day, Harrison, and Halpin 2009; and DeRue and Wellman, 2009), thus it is unlikely that focusing on a single case has limited the credibility of the process and findings. The limited sample size was also balanced with the benefits of a design that included multiple views (12 HR managers, 5 members of programme team, 21 participants, and 6

organisational stakeholders) and collected additional data through observation and document analysis.

Secondly, although a range of stakeholders were interviewed, a further possible limitation of the embedded case study was the use of narrow participant pools at each level. The organisational interviews focused on the views of Human Resource Directors as part of their role is to design and shape human resource development strategy. However, this perhaps assigns too much power to HR managers, since those who apply strategies on the ground such as OD leads and line managers will also influence the organisation's development approach. Similarly, the analysis of *Delivering the Future* focused on the views of programme participants and providers. Critical theorists may argue that focusing on these accounts fails to acknowledge the social and ideological forces underpinning leadership and identity construction (Alvesson and Spicer, 2012). The observations and selected follow-up interviews completed with peers and managers of three 'special' case participants hoped to lessen the impact of this by introducing an alternative perspective on participants development and leadership approach within their organisation. Nonetheless, expanding this phase to incorporate greater stakeholder views, in particular those of participants' staff and followers would have enhanced the study as it would have allowed further analysis of the power dynamics and the two-way relationships between leaders and followers. Also, it would be interesting to see if the dynamics and outcomes have differed across cohorts.

Thirdly, despite the longitudinal nature of the study, the interviews were conducted over a relatively short period of time and are a snapshot of the interviewees' experiences and meanings. The study provided insight into the role of development programmes as identity workspaces and the dual destructive and constructive nature of identity change. However, as the research was carried out in the early stages of the learning transfer process further empirical research is needed to confirm the longer-term impacts of development programmes.



### 11.5: Future research and practice

In light of the implications and limitations of this project, the thesis closes by identifying opportunities for future research arising from this study. The study highlighted that development programmes can provide an important space where individuals can work on their professional identity and identify with a peer group. However, it was also noted that a leader's identity evolves over time and is co-constructed through their interactions with followers, peers, and supervisors within their organisations. Thus, research that explores how these different interactions impact leadership development effectiveness and contribute to the adoption of distributed forms of leadership would be a useful addition to the development literature.

Both development and leadership itself have different effects over time from immediate to significantly delayed effects (Day, 2011; Yukl, 2010). Thus, it would be useful for future research to examine how and when different processes and outcomes occur (Day *et al.*, 2009; Grint, 2005a,b). Specifically, studies that incorporate mixed methods, multiple measurement perspectives, or a longitudinal component would provide additional insight. It would be helpful to explore the broader outcomes surrounding leadership. For example, due to the socially constructed nature of leadership greater attention is needed in terms of the impact of leaders and leadership has on emotional constructs (Bono and Isles, 2006), on motivational states and social identification (Dvir *et al.*, 2002; Shamir *et al.*, 1998), and on cognitive constructions of meaning (Marks *et al.*, 2000). This study suggested that leadership occurs through a pattern of relational and dialogic activities embedded within the organisational context and that impacts are dependent on existing notions of power, autonomy and responsibility. Comparing the perspectives of followers, peers and superiors would enhance our understanding of these complex relations.

This study was particularly interested in how clinical leaders enact their dual-identity. It was observed that while development programmes can provide the space for clinicians to reflect and work on their leadership identity many struggle with the process of 'unlearning' their previous professional identity. Moreover, some faced resistance from peers who thought that they had abandoned their professional principles and from managerial colleagues who felt threatened by the dual-role. This may also be generalisable outside of

the health care sector. Future research may benefit from exploring the challenges faced by other professionals in similar dual-roles, for example, academics who lead in a similar public setting or perhaps other professionals, such as accountants or lawyers in private contexts. This study noted that clinical leadership is a complex phenomenon which takes a multitude of forms and clinical leaders face a number of barriers in implementing the learning they gained on the programme. Thus, further research on how to maximise the contribution that clinicians and other professionals can make to the leadership of their organisations would be valuable. Finding a balance between real involvement with responsibility and authority, and a more influencing role remains a challenge.

The participants in this study enacted their leadership role in multiple NHS organisations and the contextual differences noted in the thesis might be worthy of further exploration. This includes that leadership was held in higher regard in some boards more than others, receptivity to change varied across boards, the developmental support available also differed, and cross-organisational training to encourage distributed leadership was mixed. Thus, this study also suggested some important things for practitioners to consider. Firstly, it highlighted the need for a place or forum where clinicians have the time and space to work on their leadership identities. Secondly, it suggested that it is important for senior managers to understand organisational and personal barriers to dual clinical-leadership roles and the need to encourage receptive contexts for change. Thirdly, future training and development must seek to embed distinct professional groups within each other's worldview from the outset to help overcome disconnected dialogues and encourage distributed leadership across the NHS.

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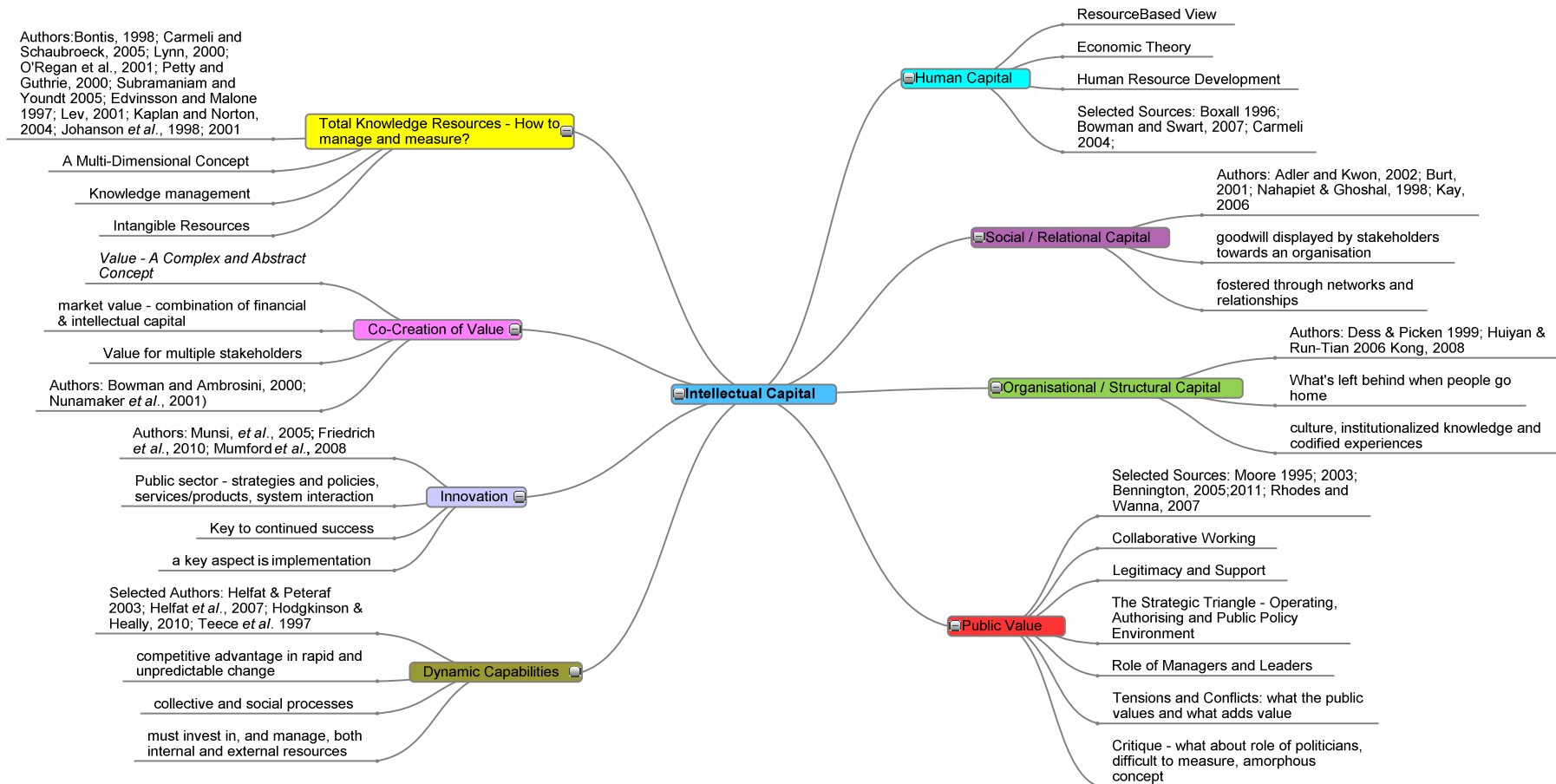
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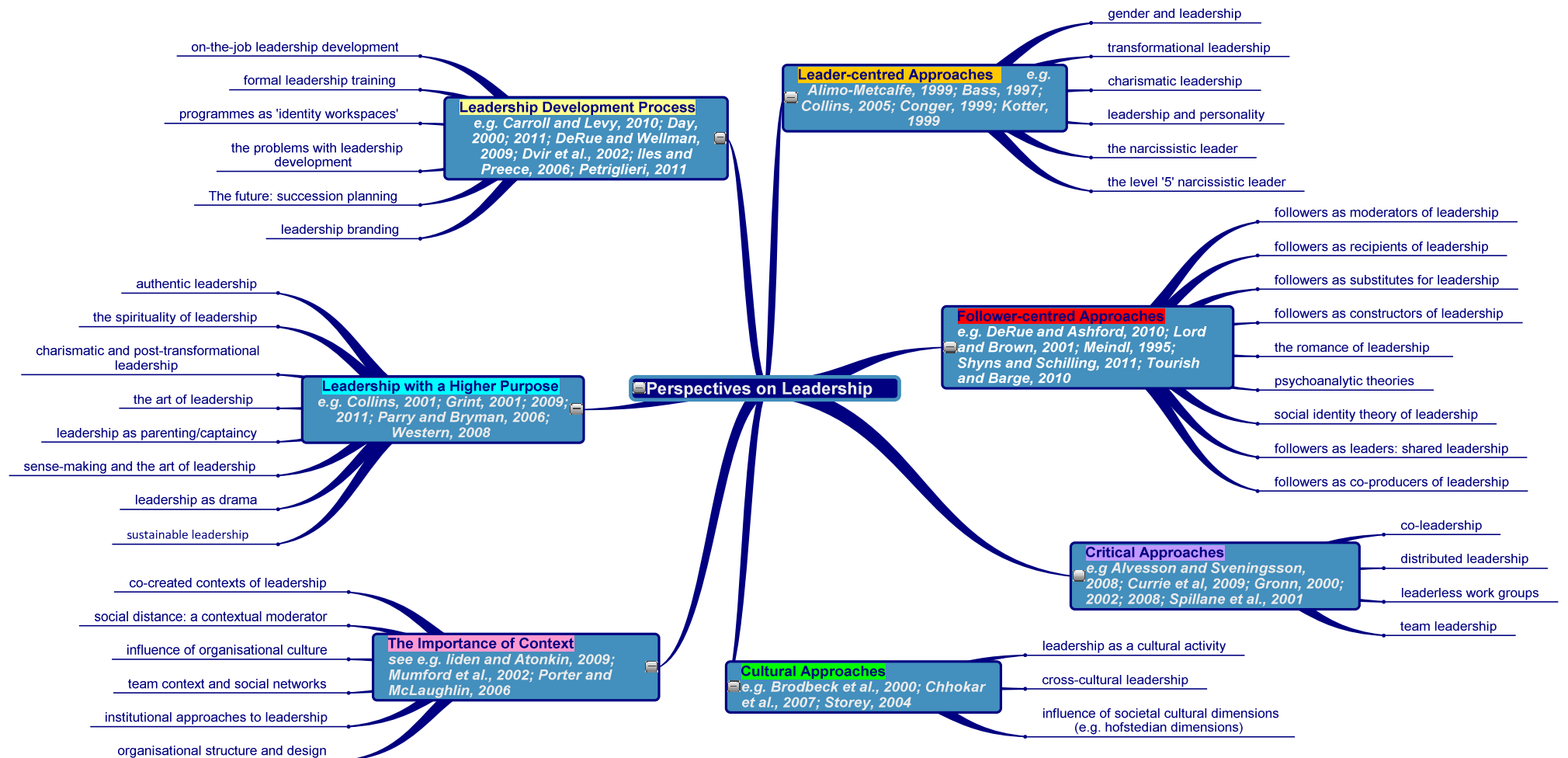
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## Appendix A - Intellectual Capital and Public Value Literature Scoping Study



## Appendix B - Leadership Literature Scoping Study Mind Map



## Appendix C: Summary of Selected Methods in Leadership Development

<i>Method</i>	<i>Description</i>	<i>Aim</i>	<i>Strengths</i>	<i>Weaknesses</i>
360-Degree Feedback	A method for systematically collecting perceptions of an individual's performance from various perspectives including: e.g. peers, subordinates, and supervisors.	Develop human capital in the form of enhanced self-awareness.	Comprehensive picture Broad participation	Overwhelming amount of data; no guidance on how to change. Time and effort required
Mentoring	Advising / developmental relationship, usually with a more senior manager	Build supportive relationships (SC) and enhance leader skills (HC)	Strong personal bond	Peer jealousy; over dependence
Coaching	Practical, goal-focused form of one-to-one learning	Improve self-awareness and social skills	Personalised; intensive	Perceived stigma (remedial); expensive
Action Learning	Project-based learning directed at important business problems	Learn from each other and benefit from experiential learning	Tied to business imperatives; action-oriented	Time intensive; leadership lessons not always clear; over-emphasis on results
Job Assignments	Providing 'stretch' assignments in terms of role, function, or geography	Build team building, strategic thinking, persuasion and influence skills.	Job relevant: accelerates learning	Conflict between performance and development; no structure for learning
Networking	Connecting to others in different functions and areas	Enhance Social Capital and encourage knowledge exchange	Builds organisational support Better problem solving	Ad hoc, unstructured, connections often blurred and takes time.
Taught Seminars	A class based verbal lecture or workshop on a particular leadership topic.	Enhance human capital (specific knowledge, skills)	Topic can be targeted, cost-effective training methods	Involves one-way communication Relies on participant memory Can be dry and less effective than other approaches
Secondments	A temporary transfer to another position or organisation (often involves a geographical move).	Enhance both human capital (knowledge, skills) and social capital (networks)	Focused on the leadership function, provides 'on-the-job' learning for secondees, and a source of new knowledge and contacts for the team / organisation	Complex and costly
Outward Bound Activities	Takes people away from the office to complete structured (challenging) activities in an outdoor environment	Improve self-awareness and the awareness of others	Opportunity for valuable 'experiential' learning.	People's preconceived notions May be incompatible with an individual's learning preferences Lack of empirical evidence

Sources: Day, 2000; Kur and Bunning 2002; Badger, Sadler-Smith, and Michie, 1997

## Appendix D: Selected Definitions of Intellectual Capital

Author(s)	Date	Definitions
Gratton and Ghoshal	2003	Human Capital consists of the Intellectual, Social and Emotional Capitals of Individuals and Organisations. <i>Intellectual capital</i> refers to fundamental individual attributes such as cognitive complexity and the capacity to learn, together with the tacit and explicit knowledge, skills and expertise an individual builds over time.
Johnson	2002	A firms intellectual assets encompassing human, structural and relational capital. As all innovation comes from the intellect or knowledge set of human beings it is apparent that all intellectual capital originates first from human capital
OECD	2000	Economic value generated by two categories of intangible assets of a company: organisational capital and human capital
Nonaka <i>et al.</i>	2000	Firm specific resources that are indispensable to create value for the firm
Stewart	1998	The intellectual material – knowledge, information, intellectual property, experience – that can be put to use to create wealth
Lev	2001	Intangible assets are non-physical sources of value (claims for future benefits) generated by innovation (discovery), unique organisational designs, or human resource practices
Kaplan and Norton	2004	Intangible assets consist of human capital, i.e. skills, talent, and knowledge; information capital, i.e. databases, information systems, and technology infrastructure; and organisational capital, i.e. culture, leadership style, ability to share knowledge
Bontis	1998	Collective Knowledge Resources of the Firm - three prominent factors human, structural and relational capital but does not include intellectual property
Subramaniam and Youndt	2005	The sum of all knowledge firms use for competitive advantage – three prominent factors human, organisational and social capital.
Marr and Schiuma	2001	The group of knowledge assets that are attributed to an organisation and most significantly contribute to an improved competitive position of this organisation by adding value to the defined key stakeholders. It includes human assets, relationship assets, culture assets, practices and routines, intellectual property assets, and physical assets



## Appendix E - Participant Pseudonyms and Descriptions

### *HR / Organisational Context Participants*

Participant Pseudonym	Specific Role
HRD1	Human Resource Director
HRD2	Human Resource Manager
HRD3	Human Resource Director
HRD4	Workforce Director
HRD5	Workforce Director
HRD6	Human Resource Director
HRD7	Head of Human Resources
HRD8	Associated Human Resource Director
HRD9	Head of Staff Governance
HRD10	Head of Organisational Development
HRD11	Human Resource Director
HRD12	Human Resource Director

### *Programme Providers*

Participant Pseudonym	Specific Role
C1	Coach
C2	Coach
C3	Coach
C4	Coach
C5	Programme Coordinator

### *Programme Participants*

Participant Pseudonym	Responsibility Split	Clinical Profession
P1	Predominantly Leadership /Managerial	Allied Health Professional
P2	50/50 split between clinical and leadership	Medic (General Practitioner)
P3	60/40 split between clinical and leadership	Medic (General Practitioner)
P4	1/3 of time spent on leadership duties, remainder on clinical	Medic (Consultant)
P5	20/80 split between clinical and leadership	Allied Health Professional
P6	Completely Leadership /Managerial	Allied Health Professional
P7	Predominantly Leadership /Managerial	Allied Health Professional (Consultant)
P8	Completely Leadership /Managerial	Nurse

P9	50/50 time split between clinical and leadership	Allied Health Professional (Consultant)
P10	70/30 time split between clinical and leadership	Medic (Consultant)
P11	Completely Leadership /Managerial	Nurse
P12	40/60 split between clinical and leadership	Allied Health Professional (Consultant)
P13	Completely Leadership /Managerial	Allied Health Professional
P14	Completely Leadership /Managerial	Nurse
P15	40/60 split between clinical and leadership	Medic (General Practitioner)
P16	Completely Leadership /Managerial	Nurse
P17	40/60 split between clinical and leadership	Allied Health Professional
P18	Completely Leadership /Managerial	Nurse
P19	Predominantly Leadership /Managerial	Allied Health Professional (Consultant)
P20	Predominantly Leadership /Managerial	Allied Health Professional
P21	1/3 of time spent on leadership duties, remainder on clinical	Medic (General Practitioner)

*Additional Participants*

Participant Pseudonym	Specific Role / Relationship to Programme
3-CE-p17	Chief Executive - P17's Manager
3-GM-p17	General Manager – P17's Colleague
3-OD-p2	OD Lead – P2's Manager
3-CL-p2	Clinical Lead – P2's Colleague
3-SM-p10	Senior Manager, P10's Manager
3-GM-p10	General Manager – P10's Colleague

## Appendix F - Flexible Interview Guides

### Interview Guide - HR Directors

#### **Introduction to Project**

- ESRC SG funded PhD – human capital and public value
- Current interviews: gain an understanding of current approaches to and thoughts on people management and measurement.
- Ethics / Paperwork

#### **Key Themes**

- Understanding of human capital, is it a term that is used in practice?
- Current approaches to measuring investment in people management
  - What do you measure
  - How do you do it?
- Current approaches to assessing management and leadership capability
  - Capability to measure
  - ROI approaches to measuring
  - Examples?
- Views on measuring what are often seen to be intangible issues
  - Public sector deeper issues
    - Perceptions toward measurement differ to private sector
    - Targets flawed
    - Validity over range
    - What is important cant be measured
- Perceptions on the value and relationship between different levels of measurement:
  - What do you measure at the different levels?
    1. Basic employee data;
    2. Operational measures;
    3. Outcome measures; &
    4. Performance measures.
- Views on the link between people metrics and organisational performance
  - Perceived importance of making the link
  - Public sector and the intangibility of performance
  - Difficulties involved
- Thoughts on how wider organizational issues impact people management
  - understanding of social and organisational capital
  - utilise / leverage internal & external networks
  - what is left when employees go home at night
  - Does HR have a role here?
  - How to measure impact?
- Measuring in practice?
  - Views towards measurement ... why measure?
  - AOM – why people measure
  - Ability (Skill) - government strategy; Opportunity - time to measure / lack of resources & Motivation to measure

Thank you for your time, this has been very useful. Before we finish off is there anything that you think I have missed or that you would like to discuss in more detail.

## Delivering the Future Interview Guide (Participants)

### **Introduction to Research**

- ESRC SG funded PhD examining the links between human capital investment and public value creation in the Scottish NHS.
- Looking at the Delivering the Future programme as a specific case in which to explore these links by focusing how knowledge is applied and exchanged following training.
- Ethical consent, permission to digitally record, material will be stored and analysed confidentially; no names or identifying features will be used in any publications or reports.

### **Key Themes:**

- **Background details and expectations of the DTF programme:**
  - Role within organisation and NHS Board.
  - How did come to be completing the programme?
  - What were your motivations / expectations for the programme?
- **Your experience of the DTF programme:**
  - Did you find the programme enjoyable?
  - How did you find the learning process?
  - Do you think the programme was effective? How would you rate success?
    - o What worked, what didn't?
    - o Examples of useful learning opportunities?
  - Practicalities:
    - o Did the training fit easily with your work schedule?
    - o How did you balance the programme with your other commitments?
- **Thoughts on the knowledge application :**
  - Have you been able to apply the knowledge and skills gained within your workplace?
    - o Examples of how you have applied / implemented what you learnt?
  - Have you received support from your line managers to use skills and knowledge from the programme?
  - Have you received support from colleagues / co-workers to use skills and knowledge from the programme?
  - Have you experienced any difficulties in implementing what you learnt on the programme?
    - o Organisational culture,
    - o Time constraints,
    - o Policy focus / targets
- **Views on knowledge transfer and exchange:**
  - Opportunities to share knowledge with co-workers / colleagues
    - o Are there systems within your organisation that encourage you to share knowledge?
    - o How has the DTF complimented other forms of learning within your organisation?
  - Usefulness of being part of a multidisciplinary cohort?
    - o What worked / what didn't
    - o Friendship, Support
    - o Collective learning
- **Perceptions on the impact of the programme:**
  - Personal changes or benefits that you have experienced as a result of completing the programme?
  - Do you feel that completing the programme will help you in the future
    - o If yes, in what ways?
  - Has completing the programme led to you to implement changes within your team, organization or department?
    - o Examples of changes
- **Questions / suggestions:**
  - Thank you for your time, it has been very useful. Before we finish is there anything that you think I have missed or that you would like to discuss in more detail.

## Appendix G - Initial Coding Frame Example

### A: Motivations for Participation

Theme	Description
Recommendation	Comments relating to friends or colleagues advocating or recommending the programme.
Previous Training	Comments acknowledging a lack of or limited leadership training in the past and a perceived need to enhance those skills
Timing	Comments relating to how programme fits with their current role, family life, having the time to complete it as well as previous applications to the programme.
Manager	Comments suggesting that the individual's manager had driven the application process or to the support participants received from their managers
Self-Development	Comments about the individual's drive to self-develop, enhance their skills and continue their education in General

### B: Overall Impressions

Theme	Description
Protected Time	Comments relating to importance of having time away from work to focus on their own development, take a step back from demands of their job and plan etc.
Reflection	Comments suggesting that being on the programme has encouraged them to reflect on what they do and why.
Confidence	Comments suggesting that being on the programme has increased participants confidence in their skills.
Sum of Parts	Statements and examples that illustrate that the different components of the programme combine to produce optimum individual and organisational outcomes.
Reward	Comments alluding to the programme being seen as a bit of a luxury, a reward, recognition of their hard work, or investment in their talent.

### C: Relationships

Theme	Description
Networks	Comments describing the strategic networks that have been created amongst participants on the programme as well as less direct networks that have occurred.
Friendship	Comments describing friendships and emotional relationships arising between participants - the softer benefits of the programme.
Collective Learning	Statements and examples suggesting that group learning was enhanced as participants bounced ideas off each other and shared experiences.
Collaboration	Comments describing collective projects or collaborative working between participants within but also beyond the programme setting.
Diversity of Group	Comments (positive and negative) about benefits/issues of being part of a programme with a diverse range of participants – multilevel, multidisciplinary, multi board.
Action Learning	Specific comments about the action learning process and the dynamics of their particular AL set.

## D: Re-contextualising Learning

Theme	Description
Application	Statements and Examples describing how participants have applied knowledge, skills and learning from the programme in their day-to-day work.
Sharing	Comments and Examples relating to how participants have shared knowledge, skills and learning from the programme both formally and informally with their colleagues, superiors and subordinates.
Issues	Comments relating to the issues / problems / political barriers individuals face in transferring learning from the programme within their own organisation / board.

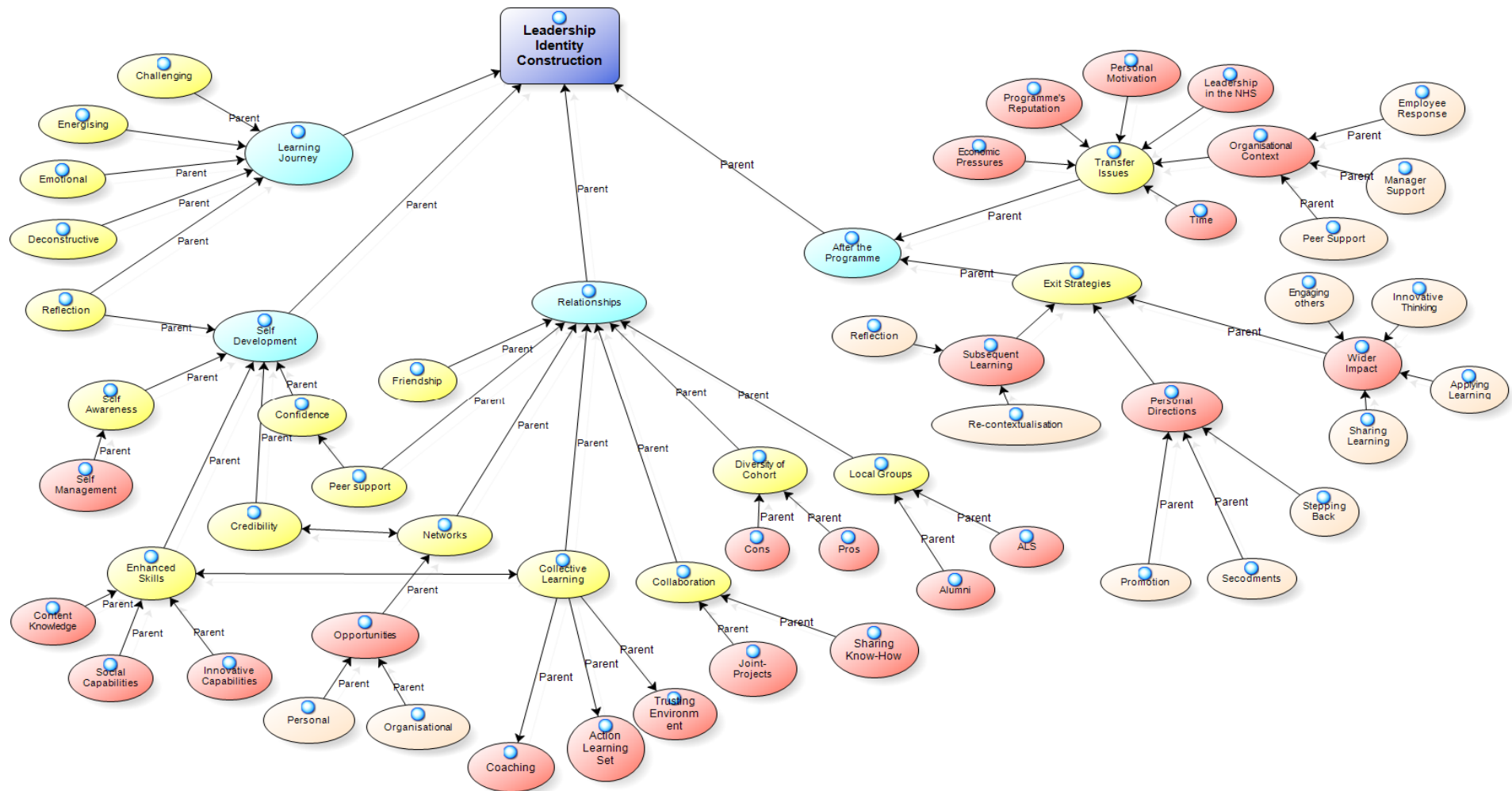
## E: Perceived Impact

Theme	Description
Promotion	Comments describing promotions that have already been achieved and personal aims for the future
Secondments	Statements relating to opportunities in the form of secondments / consultancy etc.
Skills	Comments relating to the skills developed by the Participant
Innovation	Comments describing innovative ways of doing things they have incorporated into their work.
Organisational	Perceptions of impact for organisation both in the short and long term.

## F: The Future Life after the Programme

Theme	Description
DTF- Where to next?	Future direction plans for the DTF programme
Exit Strategies: Subsequent learning;	Statements relating to future development plans
External Support	Comments relating to organisational / managerial / colleague support to apply and share learning and to continue development
Taking a step back	Statements relating to work-life balance and getting back to their clinical roots

## Appendix H - Identity Development Coding Tree Example



## Appendix I - University of Glasgow's Principles of Ethical Research

1. In all forms of research conducted in the Department we will operate with as full a consideration as possible of the consequences of our work for society at large and groups within it.
2. We will handle all confidential information with appropriate levels of discretion and compliance with the law and with due diligence as to the security of that data.
3. We will normally prevent the publication or use of data in any way that could compromise the subject's confidentiality or identity.
4. Any material being prepared for publication both inside and outside of examination purposes will be produced in such a way as to reduce the possibility of breaches of confidentiality and / or identification. If necessary, this process will be subject to a written statement as to agreed process between any sponsors of research, research subjects and the Department.
5. We will try to avoid overburdening subjects, causing them inconvenience and intruding into their private and personal domains.  
Subjects will be informed as to the purpose and nature of any inquiry in which they are being asked to participate.
6. We will avoid misleading subjects or withholding material facts about the research of which they should be aware.
7. Where the research methodology allows for it, a research subject will be expected to be provided with a copy of these Statements of Principles along with a consent form which will also indicate a subject's right of referral and appeal to a higher authority in the Department and through Faculty to the University Ethics Committee.
8. Where the research methodology suggests that a different kind of consent is the only one possible this will be made clear in the ethical approval form but subjects will be referred to departmental web pages or made aware of these principles by the researcher in order to understand the issues as at paragraph 7 above.
9. All staff, researchers and their supervisors are required, before the project begins, to submit to the chair of the departmental ethics committee, either a short-form or a long form ethical approval form. Only on formal approval by the ethics committee will the project be permitted to begin.
10. In the situations listed in the following subsections, staff, researchers and their supervisors must produce a justified case using a standard Application Form for Ethical Approval.
  - a. When the research methods employed might be regarded by the lay public to have delicate or controversial elements or when the research might be considered to give rise to adverse publicity for the University.
  - b. When the research involves the use of individual medical records
  - c. Where there might be difficulties in obtaining the subject's informed consent. This to include but not be limited to the following examples: with vulnerable people, including children; and those with learning difficulties; when proposing to use covert observation; or when employing a methodology in which the practicalities of obtaining signed consent forms are infeasible.

*Only if and when the Departmental or subsequently the Faculty Ethics Committee has approved the research can it commence.*
11. All members of staff and all student at all levels are required to read and agree to comply with these statements and to operate them in the full spirit in which they are written. Failure to comply with these statements will be regarded as a disciplinary offence.
12. All researchers and all supervisory staff at all levels must sign an agreement on an annual basis, indicating their acceptance of these Principles.



## Appendix J – Informed Consent Form Example



### CONSENT TO THE USE OF DATA

I understand that **Stacey Bushfield** is collecting data in the form of digitally recorded interviews for use in an academic research project at the University of Glasgow.

The project is funded through the Scottish Government, and Economic and Social Research Council (ESRC) PhD scheme. The objective of the research is to gain an understanding of human capital management and its effects on innovation and improved public service delivery. It aims to explore how social interaction and work engagement influence organisational learning and innovation within the Scottish National Health Service. The anticipated outcomes for the Scottish public sector are: (i) better prediction of what is likely to result from particular types of human capital investments, (ii) greater understanding of the relationship among human capital and other types of capital investment, including social and organizational capital, and (iii) more effective allocation of future resources.

A key element of the research is an in-depth case analysis of the *Delivering the Future* leadership programme. This involves conducting semi-structured interviews with key stakeholders to explore their experiences of the programme, views on knowledge application, perceptions on supplementary benefits, and thoughts on how the policy and practice environments have impacted knowledge transfer and implementation. The research will contribute to Stacey's final PhD thesis.

I give my consent to the use of data for this purpose on the understanding that:

- (1) all names and other material likely to identify individuals will be anonymised.
- (2) the material will be treated as confidential and kept secure at all times.

Signed by the contributor: \_\_\_\_\_ date: \_\_\_\_\_

Contributor details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Researcher's Name** \_\_\_\_\_

**Researcher's Tel:** \_\_\_\_\_

**Supervisor's Name:** \_\_\_\_\_

**Department Address:** \_\_\_\_\_  
 \_\_\_\_\_

**If you require further information about the research please contact the researcher or supervisor in the first instance.**

*If there are any unresolved problems please call the Department on 0141 330 XXXX and ask for the Chair of the Research Ethics Committee.*