Rosemary Linda Gomes BSc Hons

A Grounded Theory Investigation to Build a Preliminary Model of the Transformational Process of How Clinical Psychologists May Evolve Into Compassionate Leaders

Section A: A Literature Review of Empirical Studies of Leadership Development in Healthcare Settings: What Do These Approaches Contribute to Understanding Leadership Development in the UK National Health Service?

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Section B: Building a Preliminary Model of the Transformational Process of How Clinical Psychologists May Evolve Into Compassionate Leaders: A Grounded Theory Investigation

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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology
June 2015

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CANTERBURY CHRIST CHURCH UNIVERSITY
Doctorate in Clinical Psychology (D.Clin.Psychol.)

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Summary of the MRP

Section A provides a literature review of empirical studies of leadership development in healthcare settings. Recent calls and rationales for improved leadership in the UK National Health Service (NHS) are outlined and a brief history of leadership conceptualisations and implementation in the NHS is given. Relevant theoretical and conceptual issues for NHS leadership development are discussed. Thirty-two studies and their contributions to understanding leadership development in the NHS are reviewed. The review highlighted the limited replicability, problematic evaluation and lack of processes and longitudinal approaches in the studies reviewed. The review concludes with future research recommendations to address gaps in the evidence base.

Section B presents a grounded theory investigation into how clinical psychologists may evolve into compassionate leaders. A brief rationale for the study is given, outlining recent considerations of the need for compassionate leadership in the NHS. Qualitative interviews with twelve clinical psychologists were conducted and data from this were analysed using a grounded theory approach. A preliminary model of how participants developed as leaders and the main categories of this model are discussed in terms of their meanings, theoretical and clinical implications and relation to the extant literature and research. The model indicated that compassionate leadership is enabled by reflection, supervision and being treated with compassion. Leadership development appeared to be facilitated through personalities, sense of mission, professional relationships and leading by experiential practice. A brief methodological critique is given and conclusions are drawn.

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Rosemary Linda Gomes BSc Hons

Section A: Literature Review

A Literature Review of Empirical Studies of Leadership Development in Healthcare Settings: What Do These Approaches Contribute to Understanding Leadership Development in the UK National Health Service?

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Abstract

A brief history of leadership in the NHS is given, including past rationales and current focus. Thirty-two studies and their contributions to understanding leadership development in the NHS are reviewed. These included diverse case studies, overview studies, mixed methods, qualitative and quantitative studies. The need to explore the realities of leading was highlighted, with several studies illuminating contextual factors. The review found that several studies usefully distinguished between individual and organisational concerns in leadership development interventions. Multiple studies illuminated the situational context for leadership development including power dynamics, resourcing, ethics and ethical dilemmas. The review found that, generally, suitable evaluation methods for leadership development were problematic to operationalise due to the difficulties inherent in capturing and measuring direct impact and effectiveness of interventions, including how to evidence their influence on patient outcomes. The review highlighted the dearth of studies employing methodological approaches encompassing longitudinal processes; lack of process paradigms contributed to the issues the review found around replicability of studies. The review found that certain professions such as clinical psychologists are under-represented in research populations. A paucity of NHS-based studies in the review meant only tentative suggestions for applications in NHS settings were made. Future research directions implicated are more longitudinally orientated methodologies and inclusion of other healthcare professionals such as psychologists.

Keywords: leadership development; healthcare; interventions; empirical

Introduction

Recent Calls for Improved Leadership in the UK National Health Service (NHS)

Numerous scandals of care failure have resulted in urgent considerations of leadership in NHS systems. The Francis Report (2013), investigating care failings at the Mid Staffordshire NHS Foundation Trust, cited disengagement from managerial and leadership duties as the cause of the negative work culture where unacceptable care standards were delivered. Francis (2013) recommended that leadership required shared training and ethical codes amongst staff, to be partly achieved through a leadership framework. Berwick's (2013) review for improving quality and safety of NHS care advocated for NHS leaders to be present and visible, with first-hand knowledge of and connection to front line followers and their realities. Berwick (2013) stated that leadership mobilised others towards the continual reduction of patient harm through culture change and continuous improvement, modelling compassion and appropriate behaviours. Keogh's (2013) review of quality of care in hospitals with consistently high mortality rates reported that lack of leadership meant that quality improvement was not effectively driven.

Hartley, Martin, and Benington (2008) cited several contemporary challenges that require good quality in NHS leadership: targeting of chronic illnesses and lifestyle choices becoming growing clinical priorities; new need for forecasting and preventative care approaches; changing expectations of multiple stakeholders; changed workplace structures, cultures and ways of working. Clinicians within the mental health workforce are expected to lead change to accomplish parity between mental and physical health treatments (Department of Health [DoH], 2013), though the operationalisation of this leadership has not been clearly delineated.

Working Definitions of Leadership and Management

Within healthcare organisations in both theory and practice, leadership and management are often not distinctly nor separately conceptualised. For example, Kotter (1990) differentiated leadership as being contextual, directional and visionary and management as the means of achieving those leadership concerns. In contrast, Mintzberg (1973) viewed leadership as a crucial managerial role.

Leadership is considered to be multi-faceted (Grint, 2000). There remains a lack of consensus on what is desirable or effective leadership in UK healthcare as is illustrated by the implementation of different, sometimes overlapping models in NHS organisations over time. In parallel, within the literature the terms leadership and management with regards to the NHS are frequently used interchangeably, with ambiguity about which definition authors may have intended. Therefore, in briefly discussing the historical context, the terms used in the literature will be reproduced here, and where possible some indication given of what is meant by them. Theoretical concepts of leadership will be described before reviewing empirical studies on interventions for leadership development.

A Brief History of Leadership in the NHS: Past Rationales and Current Focus

Leadership in the NHS has received increasing interest from policymakers, British governments, researchers and academics. This has been particularly with a view to developing clinical leaders (Kumar, 2013). Various publications have provided the impetus to improve the quality of healthcare delivery through clinical leadership. Lord Darzi's Next Stage Review (DoH, 2008) highlighted the need for clinical leadership programmes in order to develop clinicians who manage organisational budgets and policies. The White Paper 'Equity and Excellence: Liberating the NHS' (DoH, 2010) further pursued this in wholesale restructuring of the English NHS, with

commissioning and budget responsibilities devolved to general practitioner consortia to empower professionals, an NHS board to adopt many functions previously undertaken by the Department of Health, and decision-making to be shared by clinicians, carers and patients, with clinical outcomes being powerfully and financially incentivised. Martin, Beech, MacIntosh, and Bushfield (2015) reported investment in clinical leadership research and reports from the Academy of Medical Royal Colleges and the Kings Fund (2011, 2012), showing recent academic and research initiatives undergirding NHS leadership. Here leadership is defined as engaging with others to achieve objectives of improving client care and health outcomes.

From the inception of the NHS in 1948 to present day, the importance of clinical leadership has waxed and waned, although it remains uncertain whether it was leadership or management being emphasised due to lack of definition clarity. Martin and Learmouth (2012) noted how over this time period, leadership in NHS discourse was termed “administration”, then termed “management”, then “leadership”. In the 1960s, different policies were introduced to promote clinician leadership. Porritt (1962) recommended services be joined under area boards led by medical doctor chief officers while the Salmon Report (Ministry of Health and Scottish Home and Health Departments, 1966) recommended a hospital departmental structure led by a chief nursing officer (King’s Fund, 2011). Such changes in management structures shifted the focus away from administration, though it was management rather than leadership that was advocated in policy (Hewison & Morrell, 2014).

The 1974 NHS reorganisation, locating clinical services within health authorities (Department of Health and Social Security [DHSS], 1974) promoted ‘consensus management’ via multi-disciplinary teams, where each individual could vote against each decision, sometimes resulting in minimal decision-making (King’s Fund, 2011).

The Griffiths Report (1983) challenged this with endorsements for management budgets, the involvement of doctors managerially, and stronger management through new appointments of general managers at unit and hospital level. Consequently, acute and primary care trusts directed by executive boards were established, with tiers of management throughout, functioning autonomously yet accountable to the board (Kumar, 2013).

Throughout the 1990s, reforms presented by the Conservative administration which separated purchasers and providers of health care services were implemented, inaugurating internal market mechanisms and competition in the NHS (Propper, Burgess, & Gossage, 2008). This was seen as strengthening managerialism since hospitals became NHS Trusts, each steered by a chief executive and board, while health authorities and primary care providers became purchasers (Goodwin, 2000). Management and control remained centralised (Goodwin, 2000). There was, however, a power shift towards primary care providers which was seen as advantageous for patients though the desired efficiency through competition was questioned, citing variability across the NHS and possible weak management (Lacey, 1997).

The Labour administration of 1997 proposed a third way (DoH, 1997) where collaboration instead of internal market and command-and-control mechanisms could gain prominence (Clarence & Painter, 1998), the latter seen as unhelpfully bureaucratic (Exworthy, Powell, & Mohan, 1999). Health authorities and trusts were to have more relational types of contracts, with trusts co-operatively determining strategy and design and health authorities offering leadership and co-working with community and voluntary organisations (Exworthy et al., 1999). Importantly,

clinician-led primary care groups were created to procure health services for local populations of approximately 100,000 people (Goodwin, 2000).

The early 2000's saw a new discourse of leadership emerge within the NHS as stylistically and ontologically distinct from management (Martin & Learmouth, 2012). Leadership began to be seen as pluralised (Martin & Learmouth, 2012), a quality that could be spread across the system from the most senior to frontline professionals (Hartley & Allison, 2009). Additional shifting of clinical professionals into strategy and management roles occurred as health systems continued to be restructured (Veronesi, Kirkpatrick, & Vallascas, 2012). GPs and primary care staff were involved in care commissioning due to the 1999 Health Act (King's Fund, 2011). The National Institute for Health and Clinical Excellence (NICE) was founded, authenticating a system of evidence based appraisal and treatment review (Statutory Instrument, 2005), advancing a clinical focus in service-level decision-making. Policy changes began to advocate for practitioners to lead and shape services, supported with relevant training, and this decentralisation of leadership was extended to patients and the public (DoH, 2000; 2006; 2010; 2012). Various leadership training initiatives emerged to meet these new agendas, which has contributed to current debate around the most effective approaches to leadership development in the NHS, including the need to draw from a thoroughly researched evidence base (Storey & Holti, 2013).

Theoretical Considerations in NHS Healthcare Leadership

Challengingly for examining leadership in healthcare is that relevant leadership theories were commonly developed in a business context and extrapolated to healthcare (Dawes & Handscomb, 2005). Moreover, published health care and business leadership literature has been found to be mainly theoretical or descriptive,

with limited evidence of improved patient care or enhanced organisational performance (Vance & Larson, 2002).

From the 1960s, the NHS began investing in training managers though these programmes were not rigorously evaluated (Edmonstone, 2005). This management approach leaned towards trait theories which held that leadership consisted of personal, innate qualities generalisable across professions which were to be discovered and isolated to recruit individuals into leadership positions (Alimo-Metcalfe, 2013; Bolden, 2004; Heifitz, 1994). Trait theories, the 'great man' approach (Carlyle, 1907) or the heroic approach to leadership have been countered by several reviews (Stogdill, 1948; Mann, 1959; Gibb, 1947) which indicated that a definitive set of traits could not be identified as being linked to leader effectiveness.

Transactional leadership, with its emphasis on budgeting and planning (Edmonstone, 2005), was particularly appropriate to the internal market being strengthened within the NHS. Bass (1985) conceptualised transactional leadership as achieving expected outcomes between leaders and subordinates through an exchange relationship involving contingent rewards. However, such controlled transactions were not as straightforward in practice in the NHS. Transformational leadership, where leaders and followers interact to mutually encourage motivation and morality (Burns, 1978), became increasingly associated with more patient-centred care which grew as a concern in policy as NHS structures became less orientated around command-and-control mechanisms. Transformational leadership theory included a moral dimension in leadership (Bolden, 2004) which seems better aligned to a values-based organisation. However, it has been argued that transformational leadership is not conceptually distinct from other theories of leader influence and is a model developed from research samples reflective of a dominant

group of existing leaders, which limits generalisability (Alimo-Metcalfe, 2013). Effective leaders may employ a combination of both transactional and transformational leadership (Yukl, 2002), since different styles may be suited to specific contexts (Hartley et al., 2008), especially in complex healthcare environments.

Charismatic, charismatic-inspirational and heroic models of leadership stressed the charisma, personal characteristics and vision for organisational objectives of an individual leader which were theorised to develop trust, obedience and confidence in their followers (Conger & Kanungo, 1998; House, 1977; Sashkin, 1988). These approaches have been criticised for being derived from a mainly American literature base yet having been assumed to be applicable in British public sector situations (Alimo-Metcalfe & Lawler, 2001). Shamir (1995) distinguished between the personalities of distant charismatic leaders such as chief executives compared with those of nearby charismatic leaders such as line managers. The former were considered to have the characteristics contained in the charismatic-inspirational model such as being non-conformist, rhetorically skilled and ideologically grounded whereas, in contrast, the latter were more often considered field experts, sociable and thoughtful (Shamir, 2005). Alimo-Metcalfe and Alban-Metcalfe (2005) asserted the significance of distinguishing between distant and nearby leadership when examining the research literature since leadership development applications of such research have erroneously conflated the two. Moreover, the concept of toxic leadership, where charismatic individuals can have a destructive impact on employees and organisations (Lipman-Blumen, 2004) has challenged the value of heroic models. Mintzberg (1999) warned of the mercenary and antisocial culture cultivated by valuing one top level individual over all other employees.

Most recently and particularly in light of policy imperatives to decentralise power in the NHS, ideas of shared, engaging, collective or distributed leadership and followership are coming to the fore. The relative simplicity of the linear model of exchange relationship between leader and follower has been questioned (Avolio, Walumba, & Weber, 2009). Distributed leadership overlaps with shared leadership in that it is a model emphasising social processes. Distributed leadership values inclusivity and collaboration (Oborn, Barrett, & Dawson, 2013). Similarly, collective leadership in the NHS, prioritising collaboration across organisational and professional silos, is seen as creating a work culture where high quality care can be delivered (West, Eckert, Steward, & Pasmore, 2014). This more relationship-oriented perspective of leadership has highlighted the importance of considering followership in the NHS. Followership, considering those who are following and engaging with leaders, has been associated with enhanced patient experience, stronger financial management, lower mortality rates and improved staff morale (Ham, 2012). Shared, or engaged leadership is less about extraordinary individuals and more about teamwork, connectedness, openness and accessibility (Alimo-Metcalfe & Alban-Metcalfe, 2009). Engaging people across levels of NHS hierarchies is seen as encouraging more wholesale ownership for how an organisation runs and achieves. Moreover, Ham (2012) suggests changing commissioning structures due to NHS reforms and the growing acknowledgement for care to be integrated across systems requires leadership that both engages over the organisation and extends beyond the NHS.

Conceptual Issues in Leadership Development

There is no universally agreed upon definition of leadership, no shared understanding of effective methods for leadership development or training and a

minimal evidence base for the effect on service performance (Bolden, 2004), such as on patient outcomes. This has implications for leadership development, which can be problematic to examine if the model of leadership underpinning development is not clear. Alimo-Metcalfe and Lawler (2001) highlighted poorly defined concepts of leadership in thirty organisations they studied, which made it difficult to match leadership development in employees with a suitable approach and leadership practices that match organisational needs.

Models of leadership development are not as prolific as those of leadership. The difficulty in locating tangible accounts of the leadership development process is recognised (Roberts & Coghlan, 2011). Few theoretical frameworks of leadership development have been empirically tested (Day & Antonakis, 2013).

According to Dinh, Lord, Gardner, Meuser, Liden, and Hu (2014), evaluation measures of leadership development may be insufficient due to being event non-specific, conceptualising leadership behaviours as stable and global and overlooking the influence of events which generate ambiguity and variability affecting leadership phenomena. Additionally, 360-degree feedback has been critiqued as not always translating into behavioural change (Day, 2001). Uhl-Bien, Riggio, Lowe, and Carsten (2014) spotlighted the relational interactions and co-creation between multiple participants in leadership processes which require new evaluation methods as constructionist approaches to leadership development become more common, such as the shared leadership currently advocated in NHS settings.

Aims of the Review

This review covers a range of empirical studies which each include a leadership development intervention implemented in a healthcare setting. The purpose was to

review what empirical studies of leadership development in healthcare settings have to offer our understanding of leadership development in the NHS.

Methodology

Studies pertaining to the literature review were located initially through systematically searching three electronic databases several times in December 2014: PsycINFO; Medline; Cochrane Library. To increase the relevance of the studies being accessed, three leadership e-journals were also searched: 'Leadership',' The Leadership Quarterly' and 'Leadership in Health Services'. Searches were limited to publications from the last fifteen years i.e. January 1999-December 2014. For all searches four search terms were used in combination:

- Leadership.
- Development.
- Mental health OR healthcare OR health OR healthcare service.
- Stud* OR investigation OR research OR project OR intervention.

To be included in the literature review, studies needed to be published in English, be an empirical study of a leadership development intervention, be based in a healthcare organisation with healthcare organisation staff participants, and to have some form of findings. Conceptual studies and commentaries were excluded. The search strategy utilised to identify these studies is summarised diagrammatically in Figure 1.

To assess methodologies of case studies for inclusion in this review, Yin's (1994) quality criteria were applied (Table 2). Greenhalgh's (2014) guidelines were used to critique methodological quality of quantitative and mixed methods studies. For example, Greenhalgh's (2014) checklists raised questions such as 'have assumptions been made about the nature and direction of causality?' and 'what

outcome(s) were measured, and how?' Elliott, Fischer, and Rennie's (1999) quality criteria for qualitative research guided methodological critique of mixed methods studies and qualitative studies (Table 3).

Figure 1: Diagrammatic Summary of Search Strategy Used for the Literature Review

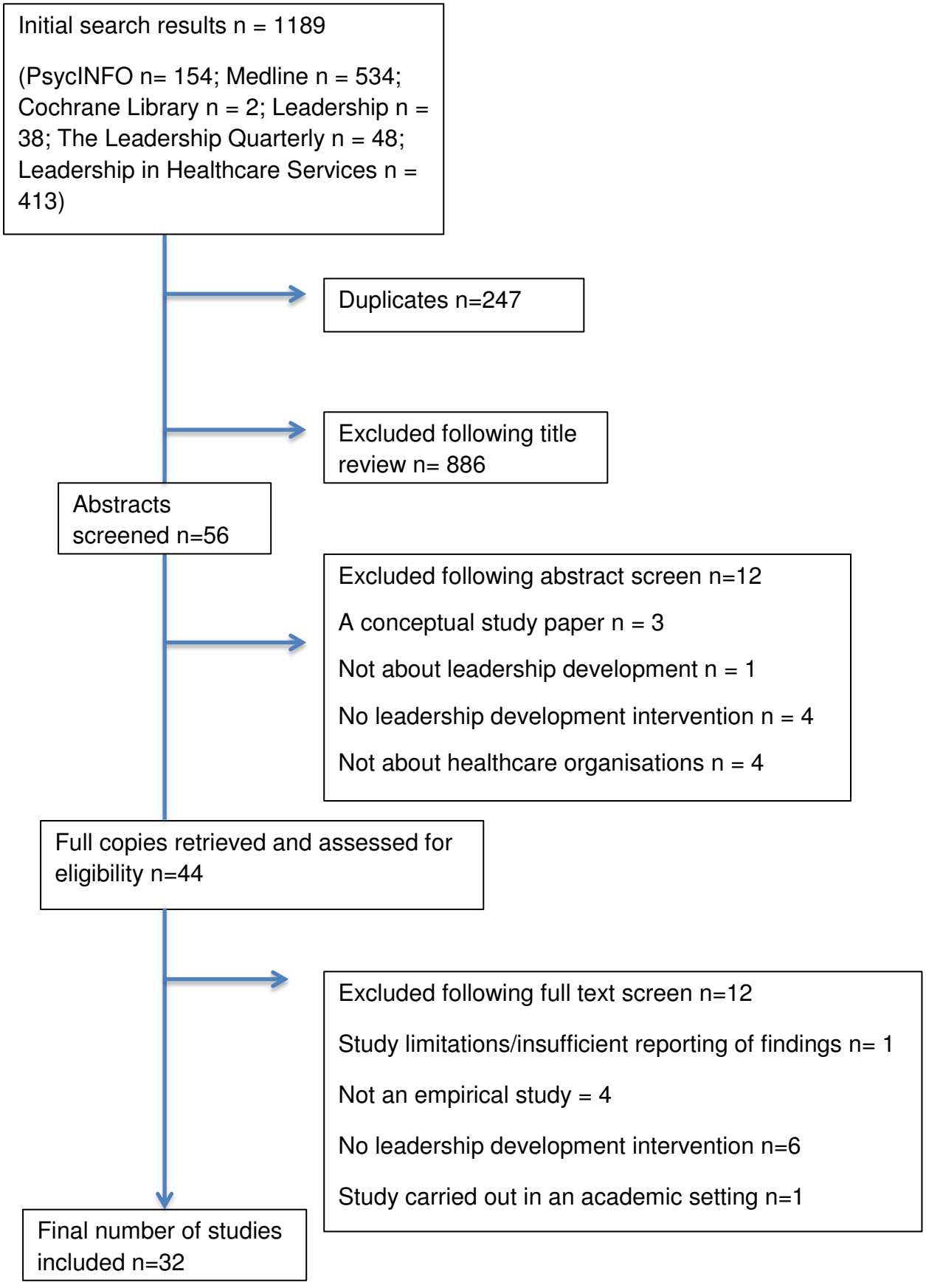

Table 1: Summary Table of Studies in Section A Literature Review

Study (authors)	Country	Study Design	Sample	N	Intervention	Theory	Quantitative Data	Qualitative data	Methods of analysis	Outcome measures
Block, L. A., & Manning, L. J. (2007).	Canada	Mixed methods.	Professionals working in acute and community settings (61% nurses)	92	8 day certificate program that combined classroom instruction, practical skill development, and applied projects.	Systemically driven leadership development; leadership life cycle.	Follow up survey.	Applied projects and focus groups. Generally positive results.	Unclear how the focus groups were analysed. Some sort of statistical analysis of participant evaluations and follow-up surveys.	The data collected in the study.
Borkowski, N., Deckard, G., Weber, M., Padron, L. A., & Luongo, S. (2011).	America	Qualitative study via structured interviews.	35% of participants completed MM program, 55% completed LM program, 26% completed the executive coaching program.	31	Memorial Healthcare System's Pillars of Leadership Academy's leadership development programs.	Transformational leadership.	None.	Interviews. Major themes in data included mentoring and "Just" culture.	Unclear.	None.
Chappell, K. K., & Willis, L. (2013).	America	Mixed methods.	Online respondents who had completed the program.	42	The AVC Fellowship. A year-long programme.	Emotional and social intelligences.	Online survey. Three yes/no questions.	Online survey. Questions on impressions. Themes of four areas of impact of the program.	Content analysis and basic percentages.	None.
Cikaliuk, M. (2011).	Canada.	Case study.	Members of large healthcare organisations.	37	Cross sector alliances.	Making and utilising a leadership capability framework.	None.	37 interviews, participant observation, documentary sources. Both benefits and challenges. .	Unclear.	None.
Cleary, M.,	Australia	Quantitative	Mental health	12	Clinical	Transformational	Ratings on the	Each	Pre and post	(NSCQ).

Freeman, A., & Sharrock, L. (2005).		outcomes.	nurses in a metropolitan service.		leadership programme.	and transactional leadership.	Nurses' Self-Concept Questionnaire (NSCQ). Of 36 items, 15 increased by up to one Likert point, 2 items had decreased; others stayed the same.	participant's portfolio of work showed that they had achieved their learning aims.	statistics.	
Conroy, M. (2009).	UK.	Qualitative study.	Managers from the NHS, social services and voluntary sector.	50	Six session programme titled "Leading Change in the Public Sectors – Informing Learning and Change".	MacIntyre's virtue ethics schema. Virtue conflict meaning antagonism or a clash derived from opposing social and moral traditions and standpoints.	None.	Six themed expressions of needs from the managers. The programme exceeded expectations.	None.	None.
Crethar, M., Phillips, J., & Brown, P. (2011).	Australia	Descriptive case study.	Participants on the program to date.	>10,000	Organisation-wide suite of leadership development programs	Experiential learning. Executive coaching. Action learning principles.	Online survey asking participants to rate the programme; generally positive feedback.	Qualitative survey comments. Recurring themes included how the programme enhanced understanding of MDT relationships.	Unclear.	Kirkpatrick's evaluation model. Workplace culture survey results and 360-degree feedback data have been used to evaluate program outcomes at the organisation-wide level.
Dahinten, V. S., MacPhee, M., Hejazi, S., Laschinger, H., Kazanjian, M., McCutcheon	Canada.	Quantitative. A quasi-experimental, pre-test–post-test design.	Staff nurses of nurse leaders who attended the intervention group and staff nurses of the leaders of a comparison group of nurse leaders.	129	A leadership development programme based on an empowerment framework.	Relational leadership. Workplace empowerment theory.	Leaders' programme participation was directly associated with greater staff organisational commitment 1 year after the programme.	None.	Pre-test–post-test statistics.	None.

, A., ... & O'Brien-Pallas, L. (2014).										
Edmonstone, J. (2011).	Scotland	Descriptive paper.	Applications were encouraged from leaders from all clinical professions who were currently in senior posts.	Unclear.	A national strategic and multi-professional clinical leadership programme	Transformational and facilitative approach.	All elements of the programme were positively rated by participants with ratings becoming more positive as the programme progressed.	Generally positive evaluations.	Unclear.	Questionnaires seeking participant views on the masterclasses and action learning sets; comparison of 360 assessment results before and after programme; Q-Sort technique; stakeholder reports and qualitative material based upon a summary of participant reflective reports.
Endrissat, N., & von Arx, W. (2013).	Switzerland.	A longitudinal, context-sensitive analysis of a change initiative.	Staff from a large public hospital.	Unclear.	None. Examination of change initiative.	A recursive relationship between leadership and its consequences and context.	None.	Observations of everyday leadership practices during the change initiative, which were shown to be context-shaped and also context-shaping.	Narrative strategy. A 'change story' was written from the raw data, then diverse literature was used to help make sense of this data.	None.
Graham, I. W., & Wallace, S. (2005).	UK.	Qualitative design.	Nurse consultants.	15	Programme involving reading and action learning	Interactive learning process.	None.	The main themes were asymmetry, contest,	Unclear.	Evaluative focus groups.

					sets.			authenticity and polarities.		
Law, H. & Aquilina, R. (2013).	Malta.	Mixed methods study.	Randomly chosen Nurse Ward Managers.	12	Programme including coaching methods and a systems approach.	Transformational and ethical forms of leadership; Executive and Leadership coaching. Action research learning cycle.	None.	27 idealised leadership attributes identified. Group and individual coaching sessions were found to be effective in helping participants identify areas of development and goals.	Unclear.	None.
Lee, H., Spiers, J. A., Yurtseven, O., Cummings, G. G., Sharlow, J., Bhatti, A., & Germann, P. (2010).	Canada.	Quasi-experimental and mixed methods.	Healthcare managers	N=86 for quantitative data. Three focus group (n=18); 13 individual interviews;	Leadership Development Initiative (LDI).	Transformational leadership.	An increasing trend was observed in self-assessed leadership practices after the LDI with a significant increase in "inspiring a shared vision" ($P < 0.01$). Before the LDI, participants' self-assessment of their practice to "enable others to act" was negatively related to emotional exhaustion ($P < 0.01$). Post-LDI, "inspiring a shared vision" was negatively ($P < 0.01$) and	LDI as a mechanism to share organisational vision; Rapid organisational expansion and deteriorating workplace conditions; Scepticisms grows as individuals cannot implement learning; No win situation.	Regression analyses on pre and post data. Focused ethnography using grounded theory and Nvivo software for the qualitative analysis.	Study was the evaluation of outcomes.

							"enabling others to act" was positively (P < 0.05) related to cynicism.			
Leigh, J. A., Wild, J., Hynes, C., Wells, S., Kurien, A., Rutherford, J., ... & Hartley, V. (2014).	UK.	Qualitative design.	Community healthcare leaders	25	The Multidimensional Model of Clinical Leadership	Organisational leadership development.	None.	Three key themes: personal leadership development; organisational leadership; the importance of multi-professional action learning/reflective groups.	Inductive content analysis.	The first two stages of Kirkpatrick's Four/Five Levels of Evaluation.
MacNeill, F., & Vanzetta, J. (2014).	UK.	Mixed methods design.	Lancashire Care NHS Foundation Trust employees.	497 delegates and their associated 423 line managers.	A bespoke Appreciative Leadership Programme.	Appreciative inquiry: interdependencies, conversation, novel and creative ideas, and engagement that fosters a true desire to co-create the future.	A statistically significant link between the programme design and delivery and the subsequent sustainability of the learning and levels of engagement within the organisation.	Evaluation of the action research project-variable write-ups. Feedback forms-generally positive responses.	Content analysis and thematic analysis. The research collects data pre, during, end and post-programme.	Pre, end and post-programme questionnaires.
MacPhee, M., Skelton-Green, J., Bouthillette, F., & Suryaprakash, N. (2012).	Canada.	Qualitative study.	Front-line and mid-level nurse leaders.	27	LD programme for front-line nurse leaders	Theoretical empowerment framework.	None.	Increased self-confidence with respect to carrying out their roles and responsibilities; positive changes in their leadership styles; and perceptions of	Content analysis.	Study was evaluation.

								staff recognition of positive stylistic changes.		
MacPhee, M., Dahinten, V. S., Hejazi, S., Laschinger, H., Kazanjian, A., McCutcheon, A., ... & O'Brien-Pallas, L. (2014).	Canada.	Quantitative. A quasi-experimental, pre-test–post-test design.	Nurse leaders.	110 intervention group. 27 comparison.	A yearlong leadership programme.	Workplace empowerment; leader empowering behaviours.	(i) Participation in the NLI was associated with increases in leaders' self-reported use of empowering behaviours 1 year after workshop attendance (ii) the work- place empowerment process significantly influenced leaders' self-reports of using more empowering behaviours.	None.	Multiple regression analyses.	Data used in statistical analysis.
MacPhee, M., Chang, L. L., Havaei, F., & Chou, W. S. (2014).	Taiwan.	Qualitative design.	Members of healthcare teams in one large, urban cancer care centre.	50 individuals from 5 teams.	Workshop.	Individual team members' self-development, then collaborative team development, then collaborative leadership development within teams, then connecting teams in networks across the organization.	None.	They recognized the need for a culture change within their organization—a shift to a more egalitarian, collaborative team approach.	Some content analysis.	Kirkpatrick four-level training evaluation model.
Marinelli-Poole, A., McGilvray, A., & Lynes, D. (2011).	New Zealand.	Qualitative evaluation; overview paper.	Clinician participants.	Sample size of 32.6%.	"The Leading Excellence in Health Care programme."	Engaged leadership; Organizational performance.	None.	Unanimous enthusiasm for leadership development in general and strong endorsement	Unclear.	This study.

								of the programme.		
Martin, J. S., McCormack, B., Fitzsimons, D., & Spirig, R. (2014).	Switzerland.	Qualitative study.	Nurse leaders purposefully selected from 14 programme participants.	6	Ward leaders were challenged to develop a shared vision together with their teams.	Transformational leadership - 'visioning', 'futuring' and 'imagineering'.	None.	Findings showed the different approaches used in the process of vision formation.	Qualitative content analysis.	This study.
Martin, G. P., & Waring, J. (2013).	UK.	Qualitative, interview-based study.	Nurses and operating department practitioners.	23	Being redesignated as leaders.	Empowering frontline staff.	None.	The rhetoric of leadership; (un)doing leadership; managing to lead.	Data analysis combined inductive and deductive approaches. Incorporated Nvivo software.	Study was evaluation method.
McAlearney, A. S. (2006).	USA.	Qualitative study.	Experts who were participants had a variety of current and former affiliations.	160 interviews.	Varied.	Varied but generally transformational.	None.	Six themes including industry lag and lack of representativeness of community and patient population.	Rigorous ethnographic interview techniques. Comparative method of qualitative data analysis, grounded theory approach.	Study was evaluation method.
McAlearney, A. S. (2007).	USA.	Qualitative design.	Hospital and health system managers and executives, academic experts, consultants, individuals representing associations, vendors of leadership development programs, program participants.	>200 interviews.	Varied interventions.	Leadership training is necessary.	None.	Leadership development programs were found to provide four main opportunities to improve quality and efficiency in healthcare.	Grounded theory; constant comparative method.	Study was evaluation method.

McAlearney, A. S. (2009).	USA.	Mixed methods.35 item survey plus qualitative interviews.	Results of a national survey of health system CEOs, supplemented by interviews with multiple health system key informants.	104 survey; 25 interviews.	Varied interventions.	Varied.	ELD programs are believed to help further healthcare systems' strategic goals and have other benefits.	Four main topics of discussion including rationale for program development.	Basic statistical analysis. Not sure or they are not explicit about what method of qualitative analysis was used.	Study was evaluation method.
McNally, K., & Lukens, R. (2006).	USA.	Survey evaluation.	Leaders were selected to participate in the coaching program.	64	An external and an internal coach who joined to provide coaching programme.	Professional coaching as a leadership development strategy.	None.	Most leaders stated that their coaching experience met and frequently exceeded their expectations.	Unclear/not stated.	Survey reported in this study.
Micallef, J., & Straw, B. L. (2014).	Australia.	Case study.	Junior doctors. Unclear how many of them.	?	Medical Service Improvement Program for junior doctors.	Lean improvement and "Six Sigma".	A table provides examples of initial project outcomes, reported soon after completion of the service improvement rotation.	Participants identified the positive impact of the program on their understanding and their career prospects.	Unclear; the paper cites the need for "a more rigorous evaluation".	None.
Miskelly, P., & Duncan, L. (2014).	New Zealand.	Mixed methods design.	Purposefully sampled nurses and midwives.	N = 38 for questionnaire. N = 7 for interviews. N = 11 for focus groups.	Pebbles was an in-house nursing and midwifery leadership programme aimed at improving leadership capacity in clinical environments.	Transformational leadership. Benner's (1984) novice to expert stages.	Evidence indicated participants' self-confidence improved. Not clearly distinguished from qualitative results.	The main themes included expectations and confidence. An emerging theory of the relationship between leadership development, maturity and professional identity.	SPSS. Thematic analysis involving triangulated data.	Study was evaluation method.
Nilsson, K., & Furåker,	Sweden.	Qualitative study.	Swedish healthcare	22	No intervention;	Learning leadership through practice.	None.	Leadership learning	Qualitative content analysis	None.

C. (2012).			managers.		the study examined practical situations that contributed to leadership learning.			occurred in relation to reorganisation, developmental work and conflicts.	including a phase of inductive analysis.	
Ouellette, P. M., Lazear, K., & Chambers, K. (1999).	USA.	Case study.	Grassroots community leaders plus varied allied professionals.	?	Phase 1: Engagement. Phase 2: Setting priorities. Phase 3: Change acceleration. Phase 4: Feedback.	Action-research, experiential learning and social constructionist theory.	None.	Resiliency, natural supports, and leadership teams were articulated as part of the vision.	Description of their meetings.	None.
Phillips, N., & Byrne, G. (2013).	UK.	Qualitative design.	Ward sisters.	24	Tailored programme for ward managers to develop their portfolio of skills.	Engaging leadership.	Postal questionnaires. All respondents evaluated the experience positively; course objectives were met.	Postal questionnaires. All respondents evaluated the experience positively; course objectives were met.	Unstated.	None.
Ponte, P. R., Gross, A. H., Galante, A., & Glazer, G. (2006).	USA.	Qualitative design.	Coaches and nurse leaders.	4 of each.	Coaching intervention.	Coaching to improve effectiveness.	None.	Idea of 'deliverables' such as advice.	Some sort of thematic analysis.	Study was the evaluation method.
Stoddart, K., Bugge, C., Shepherd, A., & Farquharson, B. (2014).	Scotland.	Mixed methods design.	Senior charge nurses in hospitals carrying out national clinical leadership policy.	N=9 interviews. N=50 survey.	'Leading Better Care' programme.	(Some) transformational leadership.	SCN respondents generally perceived positive change.	Interview themes included process and structure.	SPSS and thematic analysis.	Study was the evaluation method.

Table 2: Yin's (1994) Quality Criteria for Case Studies

Criteria
A theoretical basis including research questions is described
Triangulation is ensured by using multiple sources of evidence (data collection and Interpretation
A chain of evidence is designed with traceable reasons and arguments
The case-study research is fully documented
The case-study report is compiled through an iterative review and rewriting process

Table 3: Abridged Evolving Guidelines for Publication of Qualitative Research Studies in Psychology and Related Fields from Elliott et al. (1999)

Publishability guidelines especially pertinent to qualitative research
Owning one's perspective
Situating the sample
Grounding in examples
Providing credibility checks
Coherence
Accomplishing general vs. specific research tasks
Resonating with readers

Review

Thirty-two relevant studies were identified (Table 1). This review categorised the studies according to type and methodology in order to aid comparisons and learning from each. Studies exploring new theoretical conceptualisations of leadership development intervention were deemed to warrant a separate category, since they

were all case studies which tended to employ different means to the more obviously quantitative, mixed methods and qualitative studies. These case studies exploring new theoretical conceptualisations in turn were categorised as either exploratory case studies or national and strategic programmes so as to allow meaningful comparison between similar studies. Three overview studies were also identified which due to their scale and aims were grouped separately and reviewed together. The remaining studies were broadly clustered as being either quantitative, mixed methods, or qualitative in methodology and reviewed within these categories. Due to the diversity of qualitative studies, these were further sub-categorised as competency based studies, coaching interventions, studies without interventions and interventions for strategic outcomes.

New Theoretical Conceptualisations

Ten diverse case studies gave varied theoretical conceptualisations of healthcare leadership development.

Exploratory case studies. Five of these case studies (Cikaliuk, 2011; Conroy, 2009; Ouellette, Lazear, & Chambers, 1999; Endrissat & von Arx, 2013; Law & Aquilina, 2013) offered novel approaches to the mechanisms explicating leadership development. Cikaliuk (2011) presented two Canadian case studies of cross-sector alliances to improve health leadership capacity in response to perceived need for system-wide reforms. Such alliances, it is argued, create value that is difficult to generate by a solo organisation. Case One described fourteen organisations joining to produce the province's first leadership capability framework, the foundation for a suite of leadership development services and products. Case Two described how a nationwide cross-sector alliance used the leadership capability framework of Case One and adapted it for the country, creating assets such as the first Canadian

inventory of leadership programmes. Cikaliuk (2011) cited numerous benefits including enabling dialogue between decision-makers across organisational boundaries and making management more relational. Challenges included issues around the governance of complex collaborative relationships. Cikaliuk (2011) usefully offers a radically different approach to dealing with resource deficits which has not been trialled in many healthcare systems to date. However, Cikaliuk (2011) acknowledged that the specific context of Canadian healthcare may not be generalisable. Competency discourse itself has been critiqued as falsely linear and erroneously used as a leadership fix-all (Bolden & Gosling, 2006).

Conroy (2009), Endrissat, and von Arx (2013) and Ouellette et al. (1999) took more social constructionist stances in their qualitative case studies. Conroy (2009) and Endrissat and von Arx (2013) employed narrative strategies. Conroy (2009) used MacIntyre's virtue ethics schema (MacIntyre, 1981) as the theoretical framework to analyse stories of mental health service managers when implementing improvements which highlighted ethical conflicts in participant narratives of contradictory change initiatives. Conroy (2009) concluded that stronger appreciation of ethical dilemmas was necessary as these may hinder intended objectives of reform programmes. However, Conroy (2009) reported a pilot study, with narratives taken soon after changes. Perspectives may be different after initial adjustment has passed. It remains to be seen if replication logic (Yin, 1994) will occur and Conroy's (2009) findings will similarly emerge in other situations. Endrissat and von Arx (2013) examined change stories during a strategic process to introduce more management thinking in a hospital. The paper asserted that leadership is both influenced by and produces context, together recursively shaping the change

dynamic as it evolves. Their focus on everyday routines and micro-level activities demonstrated the different sites and context levels for leadership practices.

Ouellette et al. (1999) described how action research was used to develop a leadership model including grassroots community leaders as active members, their rationale being that such inclusion throughout systems development would facilitate more effective care delivery for children with special needs. The undertaking was seen as necessitating new leadership development conceptualisations such as understanding of leadership with extremely diverse stakeholders. Ouellette et al.'s (1999) vision incorporated ideas of action leadership, leadership teams, resiliency and collective endeavour. Ouellette et al. (1999) described the pilot stage. It is arguably too soon to draw definitive conclusions from their work.

All three described dynamic processes and commendably included voices and opinions not always heard in leadership development considerations such as service users or frontline clinicians. Strengths of their analytic procedures were that they owned their own perspective, situated their sample and gave coherent, credible accounts grounded in examples (Elliott et al., 1999). These studies suggest the possible importance of deconstructing traditional ways of promoting change and leadership and incorporating diverse views which may illuminate why current leadership strategies are only partially effective. A criticism could be that these studies lack generalisability to other settings and cause-effect relationships are difficult to establish given the methodologies. Conversely, however, they enrich understanding of the complexity of diverse real-life settings, and the human realities for leaders within day-to-day work. These intermeshed processes are hard to study using randomised trials.

Unlike these four studies, Law and Aquilina (2013) drew from an existing coaching model and carried out action research to achieve a more detailed leadership development model for a target professional group of potential leaders. Law and Aquilina's (2013) used two iterative Plan-Act-Reflect cycles to encapsulate nurse ward manager participants' perceptions of important leadership qualities and implemented a corresponding coaching programme. Their resultant healthcare leadership model incorporated authentic-transformational (Bass, 1985; Nichols, 2008) and servant leadership (Greenleaf, 2003) methods at its core. Echoing Conroy's (2009) focus on ethical considerations, Law and Aquilina (2013) cited ethical leadership as valuable, underlining the importance of accountable working. The study adds to the burgeoning evidence base for coaching as a leadership intervention, such as in the qualitative studies later in this review; Law and Aquilina (2013) reported that this beneficially impacted participants both professionally and personally.

National and strategic programmes. Four of the case studies (Borkowski, Deckard, Weber, Padron, & Luongo, 2011; Crethar & Brown, 2011; Edmonstone, 2011; Marinelli-Poole, McGilvray, & Lynes, 2011) gave descriptive overviews of system-wide or national leadership development programmes, all of which were designed following research with multiple key stakeholders as part of iterative review and programme development processes. All four interventions were based on transformational leadership theory. Three (Borkowski et al., 2011; Crethar & Brown, 2011; Edmonstone, 2011) utilised competency frameworks while Marinelli-Poole et al. (2011) took the opposite position in employing a leadership as practice approach (Carroll, Levy, & Richmond, 2008). Edmonstone (2011) himself critiqued competency frameworks as possibly compartmentalising leadership at the expense

of considerations of more abstract qualities. Crethar and Brown (2011) emphasised experiential processes, while Edmonstone (2011) blended structured input with such learning; experiential learning was considered by both studies' participants to make programmes valuably personal. In contrast, Borkowski et al.'s (2011) intervention was more curriculum-based and Marinelli-Poole et al. (2011) took participants from their workplaces for the programme which perhaps raises challenges in translating learning to everyday healthcare settings.

Of the four, Crethar and Brown's (2011) programme development appeared most authentically iterative in nature. Their study described how Queensland Health implemented systematic programmes strategically aligned with the organisation's safety, quality and improvement agenda. Evaluation therefore surveyed both individual leadership capability and organisational culture, with feedback from these used to shape future programme design. The programme evolved over several phases: organisational leadership development; programmes tailored for individual and team requirements; and a rolling rural leadership programme due to Queensland Health's extensive geographical area, where remote workplaces manifested distinctive leadership challenges. Outcomes were used to refine specialist programmes which promoted leadership development in an inclusive way. Notably, the senior indigenous health workers leadership programme was formulated to build leadership amongst senior indigenous health workers. Marinelli-Poole et al.'s (2011) programmes similarly diversified but arguably less successfully; a leadership programme was established for Maaori, Pacific and Asian staff, aligned with an organisational vision to nurture leadership more reflective of the population, which was 60% Maaori, Asian or Pacific peoples. However, their sample size for evaluation was small and evaluation, though overwhelmingly positive, was not

rigorous. In contrast, 10,000 staff participated in Queensland Health's organisation-wide programmes and their comprehensive evaluation included Kirkpatrick's evaluation model (Kirkpatrick & Kirkpatrick, 2006). Unlike with Crethar and Brown (2011) and Marinelli-Poole et al. (2011), both Edmonstone (2011) and Borkowski et al. (2011) described programmes where participants were selected leaders which perhaps discourages ownership of leadership across the system, when organisational transformation was a purported objective for both programmes. Edmonstone (2011) acknowledged the difficulty with conceptualising and defining clinical leadership. Borkowski et al. (2011) reported themes of transformational leadership, including the credibility checks of multiple qualitative analysts, some grounding of the themes in examples (Elliott et al., 1999) and some description of triangulation in the analysis process (Yin, 1994). However, the value of a system perspective which Borkowski et al. (2011) identified as a theme may be undermined somewhat by not including staff at all system levels, similarly to Edmonstone (2011).

Micallef and Straw (2014) reported on junior medical staff in a hospital in a Western Australian health system who undertook service improvement projects. This more strategic, smaller scale approach particularly focused on systems efficiency, employing a lean improvement approach (Womack & Jones, 2003) to minimise waste and thereby increase care quality. However, lean thinking has been criticised as having limited applicability in healthcare contexts, lacking high quality evidence and provoking resistance in mental health workers due to the emphasis on greater productivity to the detriment of the therapeutic process (Joosten, Bongers, & Janssen, 2009). Additionally, the authors acknowledged the need for comprehensive, longitudinal evaluation which was too early to carry out at the time of publication.

The four national studies offered positive practice amongst leadership interventions which attempted balancing organisational and individual needs. The inclusion of indigenous leaders reflective of population demographics in order to improve access for harder to reach clients is applicable for the NHS and the changing demographics of the UK. Moreover, the success of the iterative review processes offers a useful example to the NHS where continual refinements in leadership development interventions may be necessary to meet the diverse needs of the multifarious workforce and changing demands upon NHS organisations. In parallel, Micallef and Straw's (2014) study suggested the value of tailoring leadership projects which may also offer an approach to meeting diverse NHS demands in a strategic way.

Overview Studies

McAlearney (2006, 2007, 2009) conducted three extensive studies collating views of American leadership development programmes which were generally in favour of interventions. McAlearney (2006) identified several challenges to leadership development in healthcare organisations. Leadership development in the healthcare industry was viewed as lagging behind other industries. There was a challenge in developing leaders representative of both patients and communities. McAlearney (2006) found that cultural differences across healthcare professions, time constraints, technical and economic considerations impacted upon leadership development. McAlearney (2006) asserted that, since healthcare organisations are intrinsically complex, examining both the challenges her data identified and the significance of organisational commitment to leadership development within her conceptual model could help the effective implementation of leadership programmes. The conceptual model, however, remains untested and, though coherent, lacked

credibility checks in how it was built from the data, despite clearly describing the earlier analytic procedures with grounded examples for her themes (Elliott et al., 1999).

McAlearney (2007) concluded that interventions improve quality and efficiency in healthcare through growing workforce capabilities, making organisational training more efficient, lowering turnover and raising the profile of strategic priorities. The imperative for achieving efficiency in healthcare through interventions is further supported by McAlearney's (2009) study which seemed to show such programmes are worth the financial investment since they enhance executives' leadership skills, the attainment of strategic goals, and succession planning. Though McAlearney's (2009) study was mixed methods, qualitative data and survey findings were separated when triangulating the qualitative data with the quantitative would have added rigour and been informative, though this was acknowledged by authors who gave the reason of protecting participants' confidentiality.

McAlearney's (2007, 2009) studies support the growth of leadership interventions and perhaps offset some challenges McAlearney (2006) identified. One criticism is that demonstrable outcomes regarding patient care need to be a priority in evaluating quality in healthcare leadership, which is not directly addressed by any of these three studies. Additionally, the broad-brush approach of aggregating data across multiple American organisations may result in very general findings which may not have concrete or practical applications in a UK context.

Quantitative Studies

There were three quantitative studies of leadership development programmes. All three used nurse participants. Two studies were underpinned by workplace empowerment theory. MacPhee et al. (2014) posited that participation in a leader

development programme using an empowerment framework would both indirectly and directly increase empowering behaviours in staff. Though the authors acknowledged that self-perceptions and reports are subject to bias, their multiple regression analyses supported their hypotheses. Dahinten, MacPhee, Hejazi, Laschinger, Kazanjian, McCutcheon, and O'Brien-Pallas (2014) reported on the second part of this study, determining if attending the intervention was associated with greater perceptions of support from their organisation and greater staff commitment to their organisation. Dahinten et al. (2014) produced mixed findings for different aspects of conceptual pathways of the empowerment framework yet concluded that the intervention may result in greater staff commitment, which can predict employee turnover, which may have required substantiation not provided by these studies.

Both parts of the study provide some supporting evidence for how training interventions can support leaders to be relational via empowerment. One limitation is that corroborating feedback was not elicited from other colleagues. Both studies were limited by small control and comparison groups which affected the studies' power. This limitation also raises the issue of what happens more generally in leadership development in the absence of leadership interventions, which is not examined in the literature but arguably is what often happens in healthcare organisations.

Cleary, Freeman, and Sharrock's (2005) Australian study reported on a clinical leadership programme employing transformational and transactional leadership models which aimed to advance and consolidate leadership skills. Pre- and post-programme, mental health nurse participants completed the Nurses' Self- Concept Questionnaire. There was some variance in results but findings tentatively

suggested that interventions involving leaders in non-management roles can enrich clinical practice. The small sample size was a limitation, meaning comparison of pre- and post-scores would have lacked statistical power, though the authors stated that such a comparison was not attempted due to the small sample. Lack of a matched control group made it hard to establish if the intervention itself caused reported changes. The intervention involved a written portfolio which may warrant concern regarding construct validity as this may not usefully develop clinical leadership skills. The authors rightly acknowledged that an examination of nurse-sensitive patient outcomes would have been a beneficial aspect of programme evaluations. Healthcare improvement is a key objective of leadership development interventions.

Overall, the quantitative studies were small scale and with mixed results for the benefits and impact of leadership interventions, with much scope for future research to substantiate these findings and incorporate a breadth of other factors in the evaluation method.

Mixed Methods Studies

Seven studies in this review employed a mixed methods design. Interestingly, all of these were of bespoke programmes.

Three of these (Block & Manning, 2007; MacNeill & Vanzetta, 2014; Phillips & Byrne, 2013) featured interventions focusing on organisation-wide strategies. MacNeill and Vanzetta's (2014) intervention was a customised appreciative leadership programme, with the appreciative inquiry approach emphasising interdependencies and creatively engaging together in dialogue to co-create new futures (Whitney, Trosten-Bloom, & Rader, 2010). MacNeill and Vanzetta (2014) reported a statistically significant link between the intervention and sustainability of

the learning and engagement throughout the organisation. Block and Manning (2007) focused on a systemic approach to developing frontline healthcare leaders in a sizeable Canadian organisation. The intervention emphasised the leadership life cycle and systemically driven leadership development. Block and Manning (2007), corresponding to the effect of time constraints McAlearney (2006) reported, referred to issues with occupying the employee's position in order to enable programme attendance. Additionally, some of Block and Manning's (2007) participants were noted to have lacked the time to apply programme learning; managers described this as a time delay in integrating new knowledge, since the process of development required continuous learning and practice. This raises the issue of the potential value of longitudinal data to capture slower leadership development processes, which most studies in this review did not collect. Phillips and Byrne's study (2013) aimed to strategically develop one staff group's leadership in order to enhance delivery of key organisational goals. They reported on a specific NHS Trust leadership programme for ward managers. Evaluation suggested that participants perceived course aims to have been met.

All three studies provide empirical support for the importance of the organisational context for leadership. However, all three studies lacked rigour in evaluation. MacNeill and Vanzetta (2014) used facilitators as opposed to delegates to provide themes. Block and Manning (2007) noted a disparity between supervisors' and participants' ratings which is worthy of further investigation, especially given the systemic approach. Block and Manning's (2007) programme aimed to train an entire workplace community yet the programme was voluntary, which means the positive feedback may be due to self-selected, highly motivated participants and sponsoring managers who created development prospects in an atypical way within the

organisation for study purposes. Of the three studies, Phillips and Byrne (2013) most overtly aimed to improve the patient experience and yet their evaluation method did not elicit patient feedback. These studies raise the issue of the difficulty of evidencing the impact of leadership interventions at an organisational level.

The remaining four mixed methods studies all used some form of transformational leadership approaches in their interventions. Both Lee, Spiers, Yurtseven, Cummings, Sharlow, Bhatti, and Germann (2010) and Chappell and Willis (2013) presented studies emphasising more relational attributes in leadership development. Lee et al. (2010) highlighted the importance of interventions creating an opportunity for leaders to be better supported through refreshing their support network and handling burnout. Participants reported being under-staffed, rapid changes and being sceptical about practical application of programme learning. Lee et al. (2010) recommended clear vision-setting from organisational leaders supported by subsequent role modelling which may enable congruence of values between organisational vision and workplace behaviours.

Chappell and Willis (2013) aimed to ascertain the impact of the "AVC Fellowship", a nursing leadership development programme. The programme focused on emotional and social intelligences as key nursing qualities since these create workplaces that are founded on relationships. Chappell and Willis' (2013) themes were of personal development, communication, conflict resolution and negotiation competencies and career action. There were methodological concerns: the small sample prevented generalisation of conclusions to all programme alumni; findings could not be generalised to other types of nurse leadership programmes; survey distribution was not guaranteed; common demographic information was not collected so variable results could not be examined in light of these. The survey tool was new

and its reliability and validity were untested. Despite lack of rigour in the evaluation, the study is a useful reminder of the importance of more long-term follow up of participants and the way that evaluating impact at an individual level can enrich the literature on leadership development interventions.

Chappell and Willis (2013) and Lee et al. (2010) provided a complementary picture of the nuances of relational leadership, how this can beneficially create support (Lee et al., 2010) yet can detrimentally impact in terms of the subjective and emotional reactions evoked in conflict (Chappell & Willis, 2013). Together, these studies depict some of the complexity inherent in interacting to lead within healthcare settings.

Both Stoddart, Bugge, Shepherd, and Farquharson (2014) and Miskelly and Duncan (2014) presented recent studies of nurse leadership programmes through which participants reported enhanced self-confidence and relating the intervention to more organisational and team ways of working. Miskelly and Duncan's (2014) quantitative results showed an increase in reported self-confidence. Stoddart et al.'s (2014) quantitative results indicated general impressions of positive changes though their survey was limited by its poor response rate. Both studies used thematic analysis. Stoddart et al.'s (2014) lacked credibility checks and a clear account of their analytic procedures, despite grounding in examples (Elliott et al., 1999) for themes using participant quotations. Miskelly and Duncan (2014) described several credibility checks (Elliott et al., 1999): triangulated data; research diary; field notes; participants' own comments used to illustrate analysis and theory development. Miskelly and Duncan (2014) suggested the intervention generated a maturation and 'growing up' process in participants in their identity as professionals. Stoddart et al. (2014) reported that the intervention was associated with participants

achieving visibility in leadership roles with regard to team performance and quality improvement though a gap was identified for further development in political and strategic engagement and gaining more prominence at a structural level.

Overall, the mixed methods studies covered a diverse array of leadership interventions and commendably collected different types of data to evaluate impact. Issues with sample size and type of participant generally hindered generalisability. Moreover, statistical analyses tended to not be overly conclusive. Tentatively, it seems these interventions procured advantages at both an individual and system level; however, it was difficult to ascertain the stability and longevity of these and, less so than the case studies generally, it was not always clear by which processes leadership capabilities were developing.

Qualitative Studies

Nine qualitative studies are included in this review.

Competency based studies. Three qualitative studies were formal clinical leadership programmes that were competency based.

Two of the competency based studies (Graham & Wallace, 2005; Leigh, Wild, Hynes, Wells, Kurien, Rutherford & Hartley, 2014) foregrounded learning via action learning or reflective groups. Participants in both of these studies valued the safe context these created for exploring their personal leadership trajectories.

Leigh et al. (2014) reported some credibility checks for their themes (Elliott et al., 1999); interpretations were checked in team meetings. Leigh et al. (2014) reported, regarding personal leadership development, a crucial area of impact was in emotional intelligence, especially in developing personal integrity. Leigh et al. (2014) found that organisational leadership development was advanced in participants through cultivating understanding of broader political and Trust-wide factors.

However, their emphasis on programme learning resulting in transforming community services was not evidenced by study data.

Graham and Wallace's (2005) evaluation of a three year interactive learning process for consultant nurses used a focus group of fifteen participants, which was the entire cohort. In terms of rigour, no examples of data were provided to illustrate the analytic procedure (Elliott et al., 1999) and reported findings did not appear systematic. Workplace complexities were discussed, such as the competing perspectives of the nursing and medical professions. Graham and Wallace (2005) reported on how infrastructure and attitudes within healthcare were considered restrictive for leadership development. Participants detailed the asymmetry across men and women at work, often reflected in professional power or responsibility, which is imparted through professional role. This asymmetry occurred in their accounts of opposing perspectives of the medical and nursing professions. There was some acknowledgement that for the participants to fully become leaders, the current power structures would need to be dismantled. These data usefully spotlight difficulties in enacting competencies gained on leadership development training.

The third competency-based qualitative study focused on empowering individual leaders to equip both staff and organisations. MacPhee, Skelton-Green, Bouthillette, and Suryaprakash (2012) reported positive findings such as greater self-confidence in nurse leader participants. Changes seemed aligned with perceived growing emotional intelligence. MacPhee et al. (2012) stated that the theoretical basis of the study was that programme participation would empower leaders who consequently would empower staff yet staff outcomes were not included in the evaluation.

Competency frameworks used in these three studies were evidence-based and encompassed some of the varied and complex skillsets leading in healthcare

requires. The studies appear to value developing emotional intelligence as a feature of healthcare leadership. However, competency frameworks have been criticised for reductionism in their underlying objectivist assumption that the employee and their work are separate entities and in neglecting to consider the broader social context within which leadership qualities and behaviours operate (Bolden & Gosling, 2006).

Coaching interventions. Two qualitative studies used coaching in leadership interventions.

McNally and Lukens (2006) reported on an intervention where an external and an internal coach partnered to coach sixty-four clinical leaders within a health organisation. McNally and Lukens (2006) did not report specific outcomes but stated most participants said the intervention met or surpassed expectations. McNally and Lukens (2006) posited that healthcare systems are demanding and continually changing, which means that effective leadership requires skills in stress management, resilience and being able to be invigorated periodically. Some participants stated that coaching helped to validate their feelings which seemed to enable them in their leadership.

Ponte, Gross, Galante, and Glazer (2006) interviewed four coaches and four nurse leaders who had received coaching. Coaching relationships were perceived to contribute to advice, understanding, work performance and decision-making processes. Ponte et al. (2006) concluded that coaching may be beneficial to different professionals for different reasons. Coaching can offer support to nurse leaders who lack confidence or feel inadequate. Coaching can also improve the leadership effectiveness of senior leaders who may otherwise struggle to find peers to assist their reflective learning.

The studies indicate that coaching interventions, due to the often close working between coach and client, provide interpersonal support in a variety of ways. These may provide important contributions to leadership development since healthcare environments can often contain multiple interpersonal challenges. However, both studies lacked both detailed specification of methods (Elliott et al., 1999) and rigorous evaluation. Both were very small scale and generalisability to larger samples cannot be assumed.

Studies without interventions. Two qualitative studies reported on leadership development where there was no intervention. They provided examples of leadership in practice and how this supports leadership development which can serve as a leadership intervention in and of itself. Both Martin and Waring (2013) and Nilsson and Furåker (2012) owned their perspectives, situated their sample and gave coherent, credible and resonant accounts of their qualitative methods and results (Elliott et al., 1999).

Martin and Waring (2013) interviewed mainly nurses who had been designated as "team leaders" and "theatre co-ordinators". They found participants expressed strong knowledge of leadership in practice yet experienced limitations in translating this understanding into their new roles, often due to entrenched practices such as divisions of power they encountered in different professions and levels of management. They felt this impeded care delivery and obstructed their contributions, echoing Graham and Wallace's (2005) findings. Promisingly, some exceptions were discussed such as using mandatory protocols to influentially lead higher-status professionals. Martin and Waring's (2013) study underlines the difference between everyday leadership practice and leadership theory and policy.

Nilsson and Furåker (2012) reported on practical scenarios that healthcare manager participants felt constituted leadership learning. Nilsson and Furåker (2012) found that approximately half the narratives consisted of conflict management, limiting findings to learning predominantly from conflict scenarios. Participants also described personal development including gaining courage. The subjectivity of perceived learning value and the limitation of perspective of critical incident technique limits generalisability of findings. Yet their conclusions support Conroy's (2009) findings about ethical conflicts being part of leadership learning. Nilsson and Furåker (2012) also draw attention to how significant managing conflict is to leadership and the possible necessity of supporting leaders in conflicts both practically and with training. Like several qualitative studies in this review, Nilsson and Furåker (2012) underscore how interpersonal qualities play a role in good leadership.

These two studies without interventions support findings from other studies reviewed, namely the importance of emotionally intelligent leadership and the impact of power divisions on leading. The studies provide insight into how development occurs in the absence of formal leadership training. These studies are useful for examining how leadership discourses translate into real world contexts.

Interventions for strategic outcomes. Two of the qualitative studies used particular leadership interventions to strategically achieve certain outcomes. Both MacPhee, Chang, Havaei, and Chou (2014) and Martin, McCormack, Fitzsimons, and Spirig (2014) evaluated interventions designed to promote team-working and shared process in healthcare staff.

MacPhee et al. (2014) reported on an inter-professional collaborative leadership workshop aimed to shift leaders from "I" leader development to "we" in collaborative

leadership development. Their analysis was transparent and their evaluation fairly rigorous. MacPhee et al. (2014) stated that the intervention prompted participants to identify the need for a more democratic approach, which they believed could be accomplished by relational, values-based means. Corroborating numerous findings of qualitative studies in the present review, MacPhee et al. (2014) emphasised emotions and values as leadership dimensions. They concluded that their study discovered emotionally intelligent, authentic leaders were key to creating a platform for team objectives and core values from which collaboration and leadership could flourish.

Martin et al.'s (2014) study with six purposively sampled participants was specifically to explore how a leadership intervention had assisted with vision development. Participants reported a variety of ways of achieving this such as cognitive-analytical or intuitive processes or a blend of these. Visionary thinking, considered an important aspect of leadership, seems to necessitate conditions which healthcare organisations with complex, often demanding environments may not naturally foster. Strengths of Martin et al.'s (2014) study are the clear specification of methods and lucid descriptions of stages of data analysis including verification through peer review (Elliott et al., 1999).

These studies offer support for leadership interventions being utilised in healthcare organisations to promote strategic changes. However, their specific rationales and small samples may limit generalisability of findings, though some analytic generalisation may be possible due to well situated samples, particularly Martin et al.'s (2014).

Discussion

Exploring Realities of Leading

Many studies usefully distinguished between individual and organisational needs and the balancing act required to lead at both levels which is relevant for NHS workplaces. The importance of leaders remaining self-aware and developing emotional intelligence was noted. Less well defined issues which impact on leading were frequently raised such as ethics and ethical dilemmas, resource deficit and power structures. Such issues illuminate the situational context for leadership development, highlighting realities which may be important in NHS settings.

Replicability

Some studies presented findings with limited generalisability. The overview, national and larger case studies demonstrated creative approaches attuned with organisation-wide needs yet may not be replicable across the NHS. However, concepts around the realities of leadership may be relevant due to well described samples and contexts.

Evaluation

Similar limitations emerging from dissimilar studies implied underlying problems with leadership development interventions more generally. Many studies reviewed were problematic to evaluate in terms of effectiveness and direct impact on leadership development. Issues of appropriate, rigorous evaluation highlighted by these studies are also important within the NHS.

Leadership Development Processes

A lack of process models and mechanisms of leadership development over time in the studies was noticeable. Most studies in the review lacked data showing how training gets incorporated in a longer term way in how clinicians work. Dinh et al.

(2014) proposed the need for methodological approaches facilitating the testing of dynamic processes in leadership covering multiple levels of analysis and time periods.

Consideration of Research Sample

Multiple professions, particularly nursing, were represented in research samples across studies yet certain healthcare professions were absent, pointing to a gap in the evidence base. Typical healthcare organisations are compartmentalised into professional groupings socialised to their individual disciplines rather than to the entire organisation, at a time when healthcare mandates call for effective leadership over comprehensively integrated services (Roberts & Coghlan, 2011).

Notably clinical psychologists were not represented in the review. There has been no research to date into leadership development for psychologists and how they develop as leaders within the NHS. This may be important to investigate given their relatively senior positions and the breadth of their professional identities, shifting between therapist, consultant, researcher and leader, with the distinctive strength of utilising a range of varied psychotherapeutic models (Turpin & Llewelyn, 2009).

Limitations of the Review

The present review perhaps was overly inclusive of studies to the detriment of quality of studies included. Stronger exclusion criteria may have been exercised to exclude studies where evaluation was minimal, particularly given that the focus of the review was empirical investigations. Conversely, however, the broad coverage allowed for diverse settings and for studies that attempted to represent the complexity of real-world leadership. Due to the extant literature itself, not many NHS-based studies are represented in this review which means applications for the NHS can only be tentatively suggested, though several studies included clear

descriptions of participants, their roles and context, which means generalisable principles are possible in some cases.

Implications for Research and Practice

Several studies commendably spotlighted contextual factors. A paucity of research which accounts for actual practices of NHS leadership has been noted in the literature (Howieson & Thiagarajah, 2011; Hartley & Bennington, 2010). Future research could build on studies in this review by exploring lived experiences of clinical professionals leading in the NHS. The review highlights the need for future empirical studies to be developed within the NHS context as healthcare contexts can be idiosyncratically complex and require tailored approaches.

With evaluation of leadership development being problematic in many of the studies, careful consideration of outcomes would enhance future research. Within the NHS, how interventions impact on patient outcomes would also be useful to evidence.

Future empirical research could adopt longitudinal approaches to capture leadership development processes across time. Lack of process models was a noticeable gap in the review.

Broader research samples including psychologists may assist with illuminating leadership processes in an NHS context. Flexibility to draw on different approaches may allow psychologists to conceptualise and implement leadership in unique ways as leaders. For example, Gilbert (2014) advocated exploring aspects of caring and affiliation from compassion focused therapy beyond therapy, where these inner potentials may be more broadly cultivated to promote well-being. It may be important to investigate whether psychologists may be able to engage effectively

with NHS directives for leadership and quality of care through applying their diverse competencies and acquired knowledge base.

Conclusion

The variety of studies in this review showcases the richness and diversity in approaches to leadership development interventions in healthcare. Future research directions implicated are more longitudinally orientated methodologies, further qualitative investigations to capture NHS leadership realities and inclusion of other healthcare professionals such as psychologists, who are not represented in the extant leadership literature.

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Section B: Empirical Paper

Building a Preliminary Model of the Transformational Process of How Clinical Psychologists May Evolve Into Compassionate Leaders: A Grounded Theory Investigation

Word Count: 8305

(excluding abstracts, references, tables and figures)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology
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Abstract

Clinical leadership and compassionate care in the NHS have become priorities in influential papers and policies. There is a paucity of research to underpin conceptualisations of compassionate leadership and of leadership development in clinicians in the NHS, particularly clinical psychologists who may be able to lead in healthcare environments in unique ways due to the values and competencies of their profession. This present study sought to use a grounded theory approach to build a preliminary model of the transformational process of how clinical psychologists may evolve into compassionate leaders. Twelve clinical psychologists from varied specialities and with different years of experience took part in semi-structured qualitative interviews. Their data were analysed using a grounded theory methodology involving open, selective and theoretical coding. The findings indicate that psychologists may develop as leaders through their personalities and sense of mission, through reaching out to and being accepted by colleagues and through leading by experiential practice. Participants who became compassionate in leadership seemed to be enabled by reflection, supervision and being treated with compassion. These findings are discussed with regard to extant theory and literature. Clinical and theoretical implications and a methodological critique are discussed.

Keywords: compassion; leadership development; clinical psychologists.

Introduction

The Agenda for Both Compassionate Care and Leadership in the UK National Health Service (NHS)

Both clinical leadership and compassionate care in the NHS have been recently and frequently emphasised in influential papers and mandated in policy (Care Quality Commission, 2014; Darzi, 2008; Department of Health [DoH], 2009, 2010, 2012, 2013; Francis, 2013; West, Eckert, Steward & Pasmore, 2014; Parliamentary & Health Service Ombudsman, 2011). This has led to widespread examinations of what is effective leadership in healthcare and how such leadership can enable the delivery of high quality compassionate care. However, it has not been clearly demonstrated how these objectives are to be achieved.

Conceptualisations of Compassion

Theoretical models of compassion focus mainly on the practice or activity of compassion. However, the compassion literature is not substantiated by an empirical evidence base that supports methods to enhance the delivery of compassionate care (Adamson et al., 2012) nor compassionate leadership.

Definitions applicable within healthcare. Neff (2003a) and Neff (2003b) considered self-compassion to be a nurturing attitude and way of relating with oneself. Neff (2003b) theorised self-compassion as having connection to one's own suffering which leads to desiring and acting to ameliorate this pain. In parallel, definitions of compassion with regard to the healthcare professional's role are underpinned by profound perceptions of suffering in others which prompt humane

responses of understanding and wanting to act to relieve the suffering (Chochinov, 2007; Youngson, 2008; von Dietze and Orb 2000).

Evolutionary approaches. Goetz, Keltner, & Simon-Thomas (2010) asserted that compassion is an affective experience, distinct from sadness, love or empathic distress, evolved from the promotion of kindly responses towards the weak and suffering.

Gilbert's (2010) evolutionary approach emphasised interactions between threat, drive and soothing systems. The threat-based system engages survival mechanisms and is associated with negative emotions (Gilbert, 2010). The positive affect systems are the drive system, connected with motivation and reward based systems, and the soothing system, connected with the attachment system (Macbeth & Gumley, 2012). A social mind-set arises from attention, emotional attunement, distress, non-judgemental understanding and empathy derived from the interplay within the two positive affect systems (Gilbert, 2010). Such an evolved motivational system is theorised to regulate negative affect via attending to the suffering of self and others (Gilbert, 1989).

Compassion as emotional labour. Firth-Cozens and Cornwell (2009) drew attention to how compassion may be harder due to exposure to human suffering arousing strong, primitive fears of death and sickness in contemporary, industrialised, relatively non-religious societies. Compassion may be costly in these contexts. The emotional labour involved in the nursing profession is recognised (Gray, 2009). Hochschild (1983) proposed that for others to feel cared for, carers may need to suppress their own feelings to appear hospitable and safe, which creates inner stress. The disparity between outer appearance and internal affective

state can contribute to emotional disconnection from others (Brotheridge & Grandey, 2002).

Gilbert (2009) suggested that lack of self-compassion may gradually translate to a lack of compassion towards patients. A state of compassion fatigue may be reached, where compassionate energy is depleted beyond the reach of restorative processes, through protracted and intense patient contact (Coetzee & Klopper 2010). Menzies-Lyth's (1957) series of in-depth qualitative studies reported that high anxiety and negative affect in a nursing service led staff to deny feelings, detach and deny the significance of the individual. The organisational response to subconsciously adopt defence mechanisms in the form of various procedures further exacerbated the anxiety-provoking, intense nature of the nursing task (Menzies-Lyth, 1957). This work illuminates how compassion can be hindered in difficult settings at the level of psychological defences. These findings still appear salient given recent high profile care failings.

Compassionate leadership. There is a lack of theoretical conceptualisation of compassionate leadership in the extant literature. Guidance exists on compassionate leading in times of trauma (Dutton, Frost, Worline, Lilius, & Kanov, 2002) but not specifically in healthcare contexts. Though there is growing understanding of organisational capacity for compassion (Crawford, Brown, Kvangarsnes, & Gilbert, 2014; Madden, Duchon, Madden, & Plowman, 2012), at a time when there are calls for compassionate leadership in the NHS, there are few theoretical or research models to draw on.

Leadership Agenda for All Professionals, Including Clinical Psychologists[1]

The leadership agenda has been extended to all professional groups. Clinicians within the mental health workforce are particularly important for leading change to achieve parity in the treatment of mental and physical health conditions (DoH, 2013). There is significant financial investment in the training and development of a staff group who will progressively improve mental health services and promote a recovery culture (DoH, 2013). Interest is growing in how compassion relates to mental health outcomes (Macbeth & Gumley, 2012). Moreover, psychologists have stated a case for developing therapies that are compassion focused (Gilbert, 2005; 2010).

Though there has been no research to date into the understanding clinical psychologists have regarding their leadership or into how they develop as leaders within the NHS, the core values and competencies of psychologists dovetail appropriately with emerging theories of leadership and current NHS priorities for quality of care. Some psychologists themselves are calling for reinforcing local professional leadership including leadership from psychologists to promote a more ethical working culture in the NHS (Wainwright, 2014). There are calls for psychologists in leadership roles to become effective role models and be supported to find their own leadership style (Whomsley, 2014). Psychologists are trained to work with complexity, teamwork effectively, communicate sensitively, and be person-centred (British Psychological Society [BPS], 2008). They therefore may be able to engage relationally in a unique way as leaders and perhaps be instrumental in demonstrating compassionate leadership.

[1] Throughout this report, the terms clinical psychologist and psychologist are used interchangeably. The term psychologist is not used to denote any other type of psychologist.

Empirical Literature of Leadership Development Within Professional Groups

Despite the dearth of literature of how psychologists function as leaders, some studies of other healthcare professional groups may share commonalities with how psychologists develop their leadership.

Studies of nurse leaders. The majority of healthcare leadership studies use nurse participants (Gilmartin & D'Aunno, 2007). In their review, Gilmartin and D'Aunno (2007) found strong support for participative, person-focused leadership styles and transformational leadership practices from nurses. They highlighted a research gap in examining the role of different professionals as health sector leaders and in how leadership develops within the complexity of manifold, shifting and incompatible demands of healthcare settings. A systematic review of studies by Wong, Cummings, and Ducharme (2013) reported a strong link between relational leadership in nurses and patient outcomes. Wong et al. (2013), however, observed that mechanisms of leadership development were unclear and warrant future research. They recommended longitudinal, interventional studies in varied settings with more diverse samples for this purpose. Akerjordet and Severinsson's (2008) review study reported that nurse leaders who were emotionally intelligent facilitated a healthier work atmosphere where new thinking grew out of treating the intelligence of emotions seriously. The authors recommended attempting to deepen current understanding of emotional intelligence linked to leadership in future research.

Studies of medical leaders. Studies of medical doctors as leaders tended to be concerned with hierarchical and managerial leadership. Superior NHS trust performance was associated with greater medical leadership though the underlying processual mechanisms were not determined (Dickinson, Ham, Snelling, &

Spurgeon, 2013; Hamilton, Spurgeon, Clark, Dent, & Armit, 2008). There appeared to be difficulty in establishing acceptance of medical leadership (Hamilton et al., 2008). These correlational studies cannot illuminate direction of influence or causality, indicating a need for different research methodologies in investigating leadership development. Dickinson et al. (2013) underscored the need for research with doctors not occupying formal leadership roles to expand perspectives on medical leadership.

Rationale

The extant literature of leadership development in professionals in healthcare is notable for a lack of theoretical and processual mechanisms for leadership development. This is important to address given the current emphasis on leadership development in the NHS. A longitudinal focus and a qualitative research methodology would aid theoretical understanding of processes that may be involved in leadership developing over time. There is a paucity of studies examining both compassionate care and compassionate leadership development, a research gap which may become problematic given recent policy directives. Another gap in the literature is leadership development in psychologists. Psychologists may be appropriate healthcare leaders to lead in compassionate care delivery though there is no literature about leadership development in this professional group.

In response to some of these research considerations, the present study aimed to build a preliminary model of the process of how clinical psychologists may evolve into compassionate leaders through qualitative interviews with psychologists. The main research questions were:

a. How do a sample of clinical psychologists perceive themselves in relation to developing leadership capacity?

b. How might clinical psychologists incorporate training into leadership actions?

c. How do clinical psychologists understand compassionate leadership in relation to their own practice?

d. What appears to facilitate and what appears to hinder compassionate, engaged leadership in clinical psychologists in the NHS?

Methodology

Participants

Individuals were eligible for the present study if they were a qualified clinical psychologist and working in the NHS. Twelve participants were recruited. This was considered a sufficient number to build a preliminary theoretical model. Their demographic information was used to situate the sample (Table 4).

Table 4: Participant Demographics

Participant[2]	Years Qualified	Speciality/Work Experiences	Leadership training experiences
Alan	35	Mental health hospitals.	No formal training.
Damien	16	Trust deputy head of psychology. Clinical role within specialist HIV mental health team.	Short course at the Tavistock.
Hans	6	Senior clinical psychologist in a psychosexual therapy service.	Action learning sets.

[2] Throughout this report, these pseudonyms are used for each participant. Some details in this table have been disguised to protect anonymity.

Beatrice	9	Autism lead within an autism adult mental health directorate.	No formal training but interested in enrolling on a leadership course at the NHS leadership academy soon.
Agatha	2	Works in personality disorder service.	No formal training but expressed a feeling of being well prepared for supervising by a supervision training course.
Charlene	5	Looked-after children's and adopted children's team within CAMHS.	No formal training.
Lesley	25	Head of a forensic psychological therapies service.	Avoided leadership training but felt equipped from meetings with psychoanalytic consultants who used systemic thinking.
Terri	2	Split post in CAMHS.	Mentioned supervision training as helping her to transition into leading as a supervisor.
Sebastian	16	Head of a psychology and	Action learning sets.

		psychotherapy service.	
Sophie	10	Split role across a community recovery team, psychiatric intensive care unit, acute ward and mental health and rehab ward work.	No formal training.
Roger	30	Trust head of psychology. Leads on patient experience across a directorate.	Used to be part of an action learning set.
Bruce	43	Trust head of psychology. Involved in Increasing Access to Psychological Therapies (IAPT) training.	No formal training.

Psychologists were recruited through emails sent to three separate year group cohorts of psychologists who had qualified at one training programme. A snowballing approach was adopted to recruit through one contact at the training programme who was able to contact a small number of psychologists. Psychologists were also recruited from a nearby NHS Trust if they had attended leadership development workshops and action learning sets taking place within the Trust. Recruiting through these two different pathways enabled recruitment of psychologists with varied leadership experiences, ranging from extensive to minimal and with either the presence or absence of training, across specialities, and of different years in clinical practice. This variety allowed for some theoretical sampling during data collection.

The interview schedule was semi-structured. A sample of the questions used is provided in Table 5.

Table 5: Sample of Interview Schedule Questions

How have things changed for you in terms of taking a lead in the time since first qualifying? Can you give me some examples from your practice setting?
Has it got easier or harder to show leadership? How? Can you give me any examples?
What is your view – not your understanding of it but your view of it – of what is referred to as being people-centred in leadership? [Show card] This is a formal definition I am giving everyone whether or not they have had training on it. Do you feel there are any factors at play that facilitate this or perhaps make this difficult to implement in your own experience or from what you have observed? Is there an example you can draw on from your own practice or someone else's to give me more of a sense of what you mean?
How important is being people-centred in the way that you lead at this stage in your career? Are there factors at play now that facilitate this or perhaps make this difficult to implement?
Can you describe your experiences of listening with compassion/empathy now? What facilitates this and what hinders it? Has this changed over your career? How and why?

Design

A grounded theory design within a critical realist framework was used, since this framework assumes that data inform about reality yet looks to other information to examine subjective influences upon its generation and interpretation (Willig, 2001).

Measures

A semi-structured interview schedule (Appendix D) was used which incorporated questions about the time when the psychologist first qualified, the midpoint of their career and the past year so as to generate retrospectively recalled longitudinal data to illuminate the leadership development process. The interview questions were piloted on the first potential participant with a view to adapting them if they did not elicit adequate data. The interview schedule elicited rich data, therefore the interview constituted the first of the study and the interview schedule was not substantially amended, other than as part of the usual process of grounded theory. Questions regarding a definition of person-centred leadership based on Chochinov (2007) were used in the interview (Appendix A). This definition was chosen as it seemed to concisely summarise several other definitions of compassion which seemed applicable to the concept of person-centred leadership.

Procedure

Data collection. Twelve participants were interviewed face to face over the time period March to September 2014. Participants were emailed the participant information sheet (Appendix E) in advance and given a paper copy and the consent form (Appendix F) at interview. Opportunities were provided before and after the interview to ask questions. Interviews lasted forty-five to sixty minutes and were audio-recorded.

Data analysis. Verbatim transcripts of recordings were made and analysed using Glaser and Strauss's (1967) grounded theory method: line by line open coding; selective coding into many categories; integration of categories in theoretical coding. Concurrent theoretical memo writing was carried out during analysis for each participant. Throughout coding procedures, continual reflection and analysis

occurred through constant comparisons (Glaser & Strauss, 1967) for each transcript to verify coding. Selective and theoretical coding were not discrete nor linear (Glaser & Strauss, 1967), being more reflexive than sequential (Urquhart, 2012). For example, during theoretical coding, selective codes and categories were sometimes regrouped. Appendix G contains an open coded transcript for one participant, Appendix H contains selective coding for this participant and Appendix I their associated memos. Appendix L shows early theories for three other participants.

Quality assurance checks. Adherence to good practice guidelines (Henwood & Pidgeon, 1992) provided quality assurance. Good fit was demonstrated in detailed and transparent accounts of coding processes. Extensive documentation supported this. Memos were made throughout coding to make the rationale for integration of units of analysis evident. Some theoretical sampling occurred in the form of adapting the emphases of the interview questions. For example, informed by reflective diary memos (Appendix K), midway through recruitment it was apparent that more data needed to be elicited about compassion developing as well as leadership which led to the more compassion focused questions being emphasised in the next research interviews conducted. Moreover, the high response rate to the recruitment email (Appendix B) allowed choice of participants which enabled selection of participants who appeared less involved in leadership. This was necessary for negative case analysis as the emerging theory was being extended and refined.

Validity and rigour were enhanced by ongoing discussions and presentation of data to a research supervisor and a colleague also carrying out a grounded theory research project. Interpretations that did not seem grounded in the data were highlighted and modified. Participant validation was attempted by sending each

participant the overall grounded theory model and their individual theory diagram. Their comments (Appendix M) supported the theories. This was further corroborated by the research supervisor and one of the author's colleagues checking the theory diagrams, both of whom thought the theories were well integrated and made sense.

Reflexivity. Several activities were undertaken to uphold reflexivity, given that the main researcher was a trainee psychologist and could have made unhelpful assumptions in interpreting the data. A reflective diary (Appendix K) was kept and a bracketing interview was carried out prior to data collection. Researcher preconceptions from the interview included the assumption that psychologists were generally compassionate, wanted to be compassionate and wanted to be compassionate leaders. Realising that person-centred can mean different things to different individuals was also highlighted. The research was also approached with a sense of leadership being an important concern for psychologists due to recent policies; it was helpful during data collection to remember that this may not be the case.

Ethical considerations. The study received ethical approval from the Canterbury Christ Church (CCCU) Ethics Committee and from an NHS Trust ethics department (Appendix C). All participants, the NHS Trust ethics and CCCU ethics panel were provided with a summary of this study's findings (Appendix N).

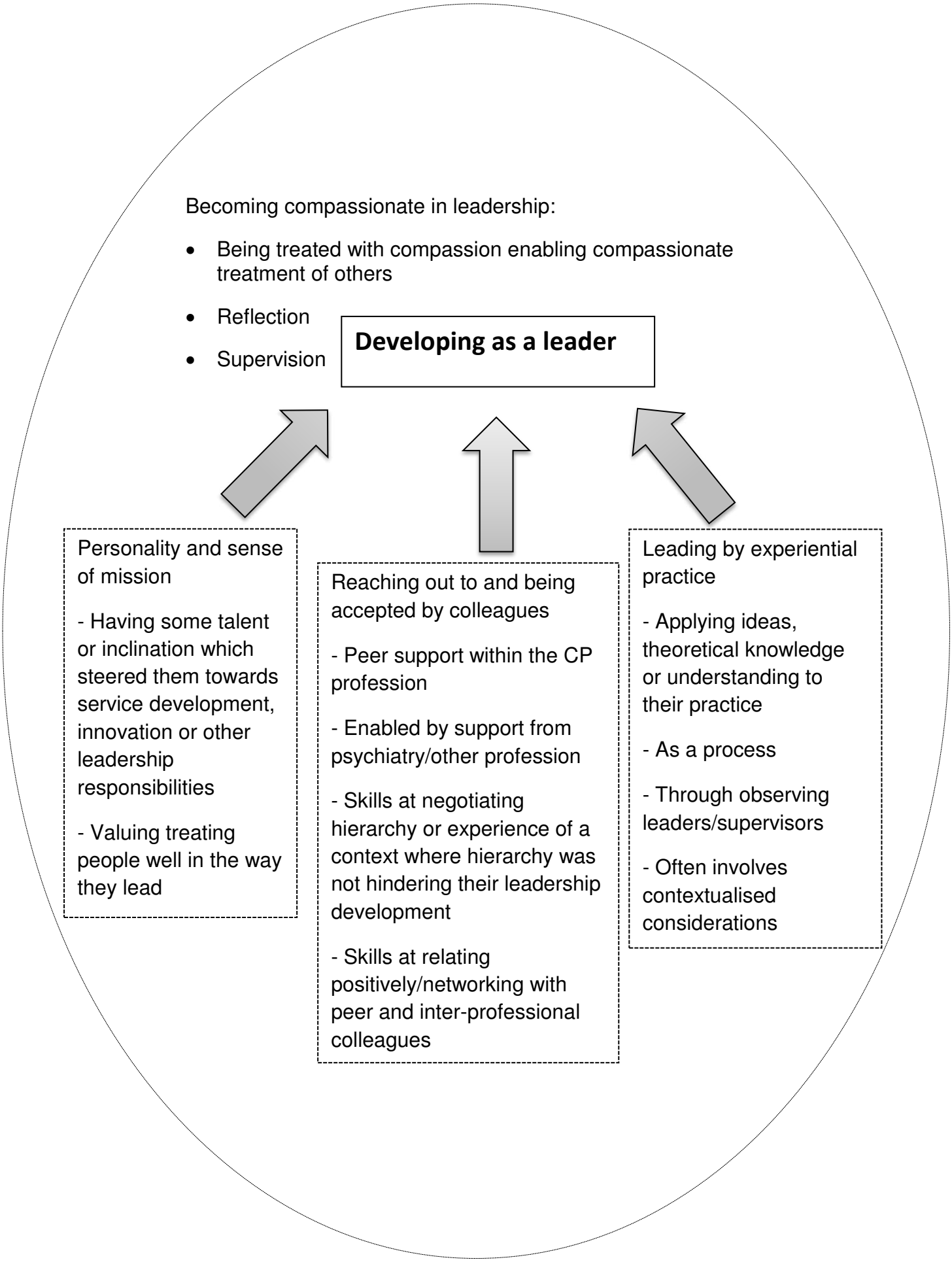
Individuals were not interviewed if they were personally known to the main researcher to protect privacy. Disguising identifying data from the interviews was discussed with several participants and transcripts amended accordingly.

Results

The model of leadership development resulting from a grounded theory analysis of participants' data is presented in Figure 2. The model attempts to show how

psychologists develop as leaders through their personality and sense of mission, their reaching out to and being accepted by colleagues and their leading by experiential practice, as suggested by the data. The model includes the processes of enabling of compassion that contributed to the participants' development as leaders, which the data suggest was via reflection and supervision. The model is discussed in these next sections with reference to each category and illustrated with examples.

Figure 2: Theoretical Model of Compassionate Leadership Development



Personality and Sense of Mission

This category relates to how participants' personalities and sense of mission appeared to shape how they developed as leaders.

Having some talent or inclination which steered them towards service development, innovation or other leadership responsibilities. Participants reported personal talents or interests which led them into leadership activities. For several participants, this was a particular specialist clinical interest which led to service innovation. Some participants cited an interest in organisational dynamics which led to leading in building a positive organisational culture. For one participant, this took the form of gaining technical expertise with organisational variables across his career, viewing working organisationally as the way to change practice. Other participants had particular skillsets or competencies which meant that they were able to lead when their skills were required since within a team this would be their contribution. An example was leading on evidence based practice which led to being offered increasing responsibilities around this when evidence based practice was mandated. Most participants had a strong idea of wanting more of a psychological voice within services, especially with a view to including service users' opinions, which was a passion they were able to act upon as they rose up the NHS hierarchy. These interests, abilities or ideas that participants possessed appeared to be starting points for their development as leaders which then seemed to propel them into leadership actions within a service context. Participants charted this trajectory with descriptions of how they applied these passions first at a clinical level and then gradually, at a service level, often with positive feedback from within the system to support their development in this way:

> And that my organisational skill and efficiency is actually very useful in leadership, which I had kind of realised but I hadn't really realised quite how much of an advantage it could be. So people were asked to do tasks and I found myself being asked to do more and more tasks because I kept doing them effectively…It spiralled from there that I did more of it. [Agatha].

Several participants who had developed their leadership hierarchically described specific characteristics they had which helped them to be positioned as leaders within NHS workplaces:

> …I have two aspects about myself which I think are quite helpful with this regard. The one is I just happen to be creative in different ways. So for me to create something out of nothing comes very naturally. I can make that happen. Not entirely separate but it feels a bit separate is I do take initiative. That comes perhaps more from a passionate place. [Hans].

These characteristics seemed to be part of their personas as opposed to gained via experiences or training. One participant expressed a sense of being a natural leader, that this was something innate and temperamental. These leader-orientated characteristics included a sense of going against the grain within healthcare services in ways which did not hinder leadership progression and were accepted by other staff members:

> Somebody needs to say the emperor is not wearing any clothes and that is slightly my job within the team. We all have our role to play and that is slightly my role and I think as long as I'm in the NHS with all the bonkers constraints that the NHS puts on people there is always going to be something to say… [Beatrice].

Sharing personal views and beliefs was a part of expressing their individual interests and seemed to indicate a carving out of their own path within an organisation. This sometimes led to leadership opportunities since their passions coincided with a focus on practical and quality improvement which was beneficial for an organisation.

A minority of participants also noted where their personality traits or limitations of their competencies curtailed the leadership they were able to offer. One participant distinguished between leadership with a small 'l' and leadership with a big 'L', expressing a preference for the former over greater leadership responsibilities which bring undesirable demands. This participant stated that interacting with people was personally important to her and what she was good at so she avoided managerial or hierarchical development that detracted from this aspect of her role. Her experience of leadership appeared restricted to governance and accountability. Another participant spoke of needing to consolidate her learning when first qualified which meant that she did not want to take a lead on anything. It appeared that to have taken a lead may have been disruptive of her enjoyment of the autonomy of no longer being a trainee. Additionally, her clinical responsibilities took priority over developing further leadership responsibilities, resulting in less inclination to lead in any other way.

Valuing treating people well in the way they lead. Participants expressed a value of treating people well which often meant being interested in the well-being of both staff and service users in the ways they led. One participant spoke of how across his career, his basic leadership principles had not changed; he continued to value attending to people's needs and remaining connected with individuals rather than being a distant and authoritarian leadership figure. This included co-creating with service users, genuinely eliciting their ideas and designing services around their

needs. Participants spoke of being humane with colleagues and those they managed:

> …getting the best out of people is to do with listening and understanding really. Giving time and support as well as advice. [Sebastian].

These values appeared rooted in their leadership style. One participant spoke of having a feminine leadership style which brought a non-competitive, collaborative approach to her team which meant they were generally happy. Participants expressed a sense of wanting workers to enjoy their work and that this came from workers being treated well.

Reaching Out to and Being Accepted by Colleagues

This category relates to how participants interacted with colleagues in ways that seemed to assist their development as leaders.

Peer support within the Clinical Psychology profession. Participants expressed a strong sense of solidarity among psychologists which often substantiated their leadership actions. Where participants worked in teams that were described as psychology-heavy, participants acknowledged the impact on their developing leadership capacity that came from being understood, having their value accepted without having to fight for it, having a shared language and being buffered from possible inter-professional tensions which could hinder potential leadership development. There was an implication that in a team where the psychologist was seen more as a technique specialist, their leadership capacity may be less visible than in a team predominantly made up of psychologists. It appeared that participants' role and leadership development were facilitated by being around like-

minded colleagues. Being around other psychologists could mean welcomed exposure to those who led by using skills of formulation broadly to combine competent clinical work with considerations of the wider context and survival and thriving of the service given the NHS climate of threat. Moreover, where psychologists were positioned as leaders, this often enabled participants to develop in similar ways:

> …there was a very highly regarded psychologist and he was my boss there in the early days and so because he was highly regarded and took a lead on certain things I suppose I sort of followed in his footsteps. [Lesley].

Peer support within the Clinical Psychology profession also took the form of presenting compassionate leadership to participants. There was some sense of compassion being an integral part of the personal temperament of psychologists. One participant referred to compassion as a state of being rather than something concrete, a quality she saw in her psychologist manager. When compassionate leadership seemed integral to the role of psychology and present in psychology colleagues, it modelled to participants a way of leading which may have influenced them.

Enabled by support from psychiatry/other profession. Several participants reported significant clout gained in their role from being supported by psychiatrists who were deemed more powerful in the medicalised setting they worked in. Often, these psychiatrists were portrayed as unusually supportive or progressive:

> I then paired up with a psychiatrist who was very sensible, very experienced, very knowledgeable and didn't have any desire to pretend to be the person in charge so was happy to support me but actually came with quite a lot of

> weight and authority, so that I think gave the solidity to the team and a bit more, not authority, but legitimacy to what we were kind of trying to do and that was very helpful. [Lesley].

Working with psychiatry colleagues successfully enabled some participants to have more impact as psychologists, in raising the profile of psychological issues for example. Some participants were able to gain support from colleagues such as social workers who were managers in their workplaces. Where colleagues from other professions were more powerful yet welcoming of psychology, participants were often able to bring their own leadership more.

Some participants reported differences with psychology colleagues in other professions making it harder for them to work effectively. One participant reported challenges to his leadership from other therapists who clashed with him on theoretical models. This showed him how personally professionals hold their theoretical orientation, that a discussion becomes less a technical disagreement but something more personal, akin to criticising someone's religion or their culture, which he had experienced as existing between medical and psychology models but had not seen within psychology disciplines previously. Lack of support from other professions seemed to require a different approach from participants which may have involved using a different form of leadership than they would usually aim for.

Skills at negotiating hierarchy or experience of a context where hierarchy was not hindering their leadership development. Most participants working in more medicalised settings reported struggling with the established order, particularly early in their careers. Several participants discussed negotiation skills at navigating existing hierarchies in order to bring their leadership, gaining acceptance by meeting attendance for example. Some reported enhanced understanding over time of the

hierarchy and developing political and negotiating skills to be more active within it. One participant reported offering leadership in a way that was pragmatic and slightly avoidant about professional differences. Some reported being able to lead getting easier due to colleagues becoming more familiar with them and their feeling more confident despite initial wariness regarding power differences:

> I think it's got easier and also just naturally in terms of your own sense of process: becoming more confident, consolidating your own set of skills but also in terms of being with the service for a period of time and people getting to know you. They kind of invest in you– take leadership from you in a way, you know? [Terri].

Where hierarchies were non-traditional and flatter, some participants reported collaboration, bi-directional and wider influence, including being able to influence their mentors and bottom up initiatives from early-career psychologists being incorporated into management structures. Particularly when there was a lack of hierarchical leadership, participants could move into managing and leading actions though not positioned by the existing hierarchy to do so, which felt challenging yet possible in their context:

> I naturally fall into that role. We felt quite awkward because I felt like I was overstepping my role. But it was okay. [Agatha].

Being relational and being known by others in the system seemed to facilitate leadership and role development in participants and these connections appeared easier over time, which coincided with several rising up the NHS hierarchy which perhaps also created more formalised authority.

Skills at relating positively/networking with peer and inter-professional colleagues. Participants explained how they frequently were enabled in their working through networking with both peers and non-psychologist colleagues, which seemed possible due to their interpersonal skills. There were comments from the participants who were nearing retirement regarding long term working relationships with staff due to their career longevity and how it was important to them to sustain peaceful, amicable relationships including working through difficulties, which seemed more to do with kindliness than a management strategy:

> I suppose apologising, because you know if I do get something wrong or if I, you know, make a statement and maybe it's sort of hurtful or just wrong I will try and apologise. I suppose keeping my relationships as positive as possible is probably what I work on most and where, probably the values lie. [Alan].

Participants seemed knowledgeable about how to adapt their leadership so as to be received better; one participant considered how to communicate differently in supervision to correspond with more senior workers or with self-critical clinical trainees. Participants spoke of negotiating the role of a psychologist within inter-professional working relationships, which included deliberations on the presentation of the clinical psychology profession to others.

Participants generally appeared to have team experiences which enriched their leadership. Collaboration seemed a way for some participants to offer leadership to multi-disciplinary teams (MDTs) where there was joint work in thinking about development areas and psychology expertise was invited. Some participants described learning leadership qualities from peers. Where teams were composed of

psychology staff, teams facilitated reflective processes which made it possible to consolidate one's own position as a pre-cursor to offering leadership:

> …initially having a good grounding in a team to have that space to kind of think what's manageable, what's not, and what is it like to try and do this and being accepting of our own experiences has been a really important place to start, if that makes sense. [Charlene].

Others were able to use their skills at relating positively with non-psychologist and psychologist colleagues to build strong teams where flexibility was a feature of their leadership style, combining a non-negotiable framework with enabling people to do their jobs well, and building genuine working relationships and facilitating the contributions of all team members.

Leading by Experiential Practice

This category relates to how participants' appeared to develop as leaders through the actual doing and observation of leadership activities.

Applying ideas, theoretical knowledge or understanding to their practice. Participants felt equipped from clinical training to apply theoretical and psychological knowledge in work contexts. Training helped some participants to be thoughtful about consulting with staff around change and developments. Participants appeared to value the exchange of ideas, thinking and reflection from their experience of clinical training. This often gave confidence and opportunity to lead:

> Someone said, 'Oh do you mind leading on that and working with so-and-so and running a training project', I was just like, 'Yeah, that's fine', because the

> training and the knowledge that we got from the [clinical] training I could sort of apply to this training project that we had to do... [Sophie].

Disseminating psychological ideas seemed a way for participants to lead in consultancy and vision, such as in helping teams think about decision-making within referrals systems, and carrying out audits based on research knowledge which fed service development at a commissioning level. Several participants referenced psychodynamic theory as relating to their practice. For one this was applied to improving practitioner working alliances and creating new dialogue which met some resistance yet created new possibilities. For another, systemic ideas were used to consider how to lead when not line managing directly:

> The idea that I have been finding helpful recently is systemic influence, so kind of how do you influence individuals, teams, organisations, you know? [Damien].

It seemed that theoretical knowledge could shape leadership thinking which seems pertinent in complex NHS environments which may necessitate strategic approaches.

As a process. Most participants expressed a sense of process and working through stages as they developed their leadership capacity. Often this occurred in parallel to gaining further hierarchical position with corresponding responsibilities. For some participants, leading was expressed in spearheading service innovation, a process of starting an initiative, developing this, then examining outcomes. Some participants saw the process as a combination of experimenting outwardly and feeling ready inwardly:

> So I think it's a bit of a developmental process really, of having that secure base and going out and trying something and then consolidating that and then venturing a bit further and eventually growing up so you are getting more senior and a leader. [Terri].

For other participants, the stages were less externalised and more about their personal process. There appeared to be stages in growing in inner confidence in higher positions and working through an initial discrepancy between actual role and sense of fully occupying that role:

> I needed somebody to authenticate my authority if you like…when I became a consultant I still operated a bit like that, I still didn't believe I had the authority to say, I require you to do, this is what needs to happen. [Beatrice].

Participants who said that they were less interested in leadership described their journey as being gradual, natural progression in discovering transferable skills and models, moving from clinical to broader organisational concerns, their leadership trajectories being more about role development and even specialisation with increased familiarity and confidence.

Through observing leaders/supervisors. For some participants, supervising others was a significant part of their leadership role. Some participants described this as beginning with imitating their supervisor's style to get a sense of what might be appropriate. Several were impacted by unhelpful supervisors who served as examples of how they did not want to be as supervisors. Participants internalised their own experiences of being supervised which informed their own practice. Participants valued their supervisors' input particularly as they transitioned into becoming supervisors, a stage which several commented on as something they

gave a lot of thought to, indicating the importance of this in the developmental process of the role of a psychologist. Supervisors often played a crucial role in participants' leadership development by providing examples for them to learn from in difficult clinical situations. Some expressed a preference for learning leadership from examples at work rather than training due to these seeming more accessible:

> I had a direct clinical supervisor and I did talk to him quite a lot about how to try and manage those sort of situations because some of it you've obviously got to learn on the job, you know, in the actual situation and, you know, that was supportive, yes. [Roger].

Supervision seemed a way of reflecting on situational learning with a more experienced psychologist which felt supportive. This fitted with how participants described learning leadership practically and experientially.

Often involves contextualised considerations. Participants' leadership trajectories were characterised by contextual factors which required thoughtful incorporation into practice, which sometimes shaped how they led. Beneficially for psychologists who had qualified at a time when the profession was expanding, their external context was one of burgeoning recognition of psychologically orientated services where leadership opportunities flourished as the profession grew:

> …so there was a lot of support for how you developed a service, it was a bit like at that time, there was something going round called the hero innovator role, which I think gave one an opportunity, if you came in with some good ideas, to actually get on and develop them. [Bruce].

These participants reflected that they had been fortunate in this regard, that such opportunities were of their time and context. They noticed that this granted freedom

to innovate. Other participants described how certain priorities were side-lined due to contextualised considerations. One participant discussed how risk and responsibilities took precedence over reflecting on practice as she set up a children's therapy group due to confusion over shared responsibility for looked after children when referrals were cross-borough, which led to less reflecting than she personally would have preferred. The importance of being knowledgeable about the context was acknowledged:

> I think the other thing about leadership is really, really having a good idea of what's happening in the external environment so that you can sort of anticipate and respond to changes in the external environment that are likely to either be able to, you know, dealing with threats or dealing with the opportunities to enhance. [Alan].

Being aware of changing NHS systems and structures was seen by participants as increasing their effectiveness as leaders.

Becoming Compassionate in Leadership

This category refers to how participants became compassionate in their leadership. This appeared to undergird and surround both the way participants developed as leaders and the way the other three categories contributed to leadership development.

Being treated with compassion enabling compassionate treatment of others. It was nearly unanimous amongst participants that they were enabled to be more compassionate when they were treated compassionately at work themselves. Some participants also developed compassion in their leadership development due to not

being treated compassionately making them determined to be different. This included encouraging others to develop as leaders:

> I mean, I wasn't encouraged very much by some managers to go on courses and develop myself and so I've made sure that I do let people know about opportunities that they might be interested in, even if I don't necessarily think that I would see them as, you know, top notch leadership material. [Sebastian].

There was a lot of expressed positivity about psychologists being naturally compassionate due the personalities of people who train as psychologists and the impact of clinical training itself. There was a sense of a ripple effect from this which could radiate out into MDT work and NHS systems. Generally this was seen by participants as a beneficial aspect of leadership from a psychologist.

Reflection. Reflecting compassionately on personal and emotional processes in both self and others seemed key for participants to experience compassion towards themselves and others. There was some acknowledgement that noticing distress and acting on it was part of leadership. Reflection was seen as helping to process clinical work both individually and within teams, which had an observable effect in generating compassion. Participants who had personal therapy found that experiencing being a patient helped them to be more reflective as clinicians due to fuller understanding of the impact of difficult emotions:

> So I think the ability to contain anxiety and those kinds of pressures is utterly crucial and that is partly what I'm like, having been in therapy myself. [Roger].

Participants appeared to think they were becoming better leaders by gaining insight about themselves and their leadership style through reflection. Reflection on weaknesses and the reasons behind their reactions and actions as clinicians was perceived to strengthen their work performance and also sometimes facilitated compassion around workplace pressures:

> But learning to not be so hard on myself really about if I didn't manage to get somewhere with, or when I didn't manage to finish pieces of work on time or when I didn't manage to, or when people stopped turning up for sessions, being accepting that these things will happen almost like being more compassionate to myself as a clinician… [Charlene].

Where reflection did not necessarily enable compassion was highlighted by some participants' accounts of when reflecting on their leadership showed that sometimes a more relational style was limited in situations which required a more directive stance from a leader. Several participants commented that on reflection, compassion in addition to other types of leadership created good leadership. A minority of participants recognised that their own compassion was tested in their clinical work. Moreover, enabling compassion through reflection was perceived by one participant as being harder to practise in higher managerial roles:

> …I think that then psychology, if they display compassion in that role are seen as weak or woolly or avoiding the issue or fudging the topic or being overly concerned about people's feelings rather than getting the job done. [Beatrice].

Reflection was seen as sometimes stirring complex considerations around leadership which did not seem straightforward to resolve, though awareness of dilemmas sometimes usefully led to compassion.

Supervision. Supervision was mentioned frequently by participants, indicating how crucial experience of supervision was in their profession and their role of being a psychologist. Good supervision was valued by most participants and seemed valued for providing containment. There was a sense that this demonstrated compassionate leadership towards them. Participants gave examples of having acknowledgement in supervision that they were working hard and that their supervisors were holding their emotional world plus their work role in mind. The multiple functions of supervision appeared to enable an understanding of the multiple forms compassion could take:

> I don't really see how you could be a good leader without being, having that compassion there, but I guess there are other skills that are important as well so I think that you need that balance between compassion and some kind of structured, boundaried sense as well. [Terri].

Supervision also seemed to be a space to explore how to be compassionate when participants' recognised that distress in their supervisees may be hidden. Where work settings contained much acute distress and disturbance, supervision was seen as helping adjustment and easing shock, particularly with less experienced trainees. However, some participants realised that their own acclimatising to the work could affect their sensitivity to distress of others, perhaps a self-protective function or due to not knowing. Some participants discussed how even within supervision some topics may be difficult to raise which may sustain hidden distress in some workers, particularly if power differences within supervision contribute to this. There was

some self-awareness shown by a minority of participants of how they may appraise themselves differently from what is their actual practice. Supervision seemed to also be a space to discover how to take action about distress, which appeared to result in more compassionate leading from some participants.

Discussion

This section relates findings to the extant literature and research.

Being Person-Centred and the Followership and Engaged Leadership Literature

Psychologists appeared to develop as leaders in several main ways. Leadership development seemed facilitated by being person-centred and relating well with people, namely in the categories of personality, sense of mission and their reaching out to and being accepted by colleagues. These categories align with the personal qualities, relational expertise and effective communication espoused within the clinical psychology leadership development framework (BPS, 2010) as components of effective leadership for psychologists to demonstrate across their careers.

The study findings may represent psychologists being engaging leaders. Engaging leadership creates an organisational culture of integrity, care for staff wellbeing and sincerely appreciating others and their contributions (Alimo-Metcalfe & Alban-Metcalfe, 2009), which is what the findings suggest participants attempted in their leadership. Engaged leaders are theorised to delegate in an empowering way, be open to shared vision, and be able to cope with change (Alimo-Metcalfe & Alban-Metcalfe, 2009), which may be particularly appropriate for current NHS conditions. Shamir (1995) theorised that nearby leaders were viewed as sociable, considerate and with a high level of technical expertise. These qualities appeared to characterise some of the ways participants in the present study interacted, as

opposed to being distant leaders (Shamir, 1995). Such engagement is encouraged by the BPS (2010) in its clinical psychology leadership development framework where working with others through developing networks and sustaining relationships are seen as leadership competencies for clinical professionals.

Acceptance of participants' leadership from colleagues was indicative of followership. A followership perspective considers how followers influence leaders (Carsten, Uhl-Bien, West, Patera, & McGregor, 2010). Followership literature asserts that co-construction of leadership occurs between leaders and followers due to a shared social context (Meindl, 1990; 1995). This position is advocated in current policy; the NHS Commissioning Board consider this to equate to reciprocally supportive relationships across organisational boundaries which increases collaborative capabilities (DoH, 2011). Followership was also evident in participants' accounts of upholding service user views in service development. The category of follower in the NHS is seen as encompassing clients (Grint & Holt, 2011). Followership flattens traditional, established hierarchies and fits how participants navigated existing power structures by networking and relating positively to others.

Compassion Developing Through Supervision and Reflection

More compassionate perspectives in reflection and supervision and being treated compassionately enabled participants to develop as compassionate leaders. The use of psychodynamic language used by participants implied a working through of psychological defences in these processes which beneficially impacted their leadership. The counter-transference and transference from client work (Freud, 1922) is often identified and explored in reflection (Lemma, 2003), which is crucial for ethical practice as a clinical psychologist (Lavender, 2003). Moreover, for psychologists to develop an ability to reflect on and be aware of systemic issues

occurring in teams and to both encourage team reflection and routinely practise self-reflection are leadership behaviours endorsed in the British Psychological Society's clinical leadership competency framework (BPS, 2010). Supervision and reflection may have allowed participants to go beyond applications of technical knowledge to reflections both in the moment and retrospectively (Schön, 1983). This seems to have incorporated considerations of unconscious processes, which may have offset any potential adaptive or defence mechanisms towards the complex, often anxiety-provoking and intense nature of the clinical and caring task (Menzies-Lyth, 1957). This may have facilitated compassion in participants since having their needs attended to whilst engaging in emotional labour (Gray, 2009) may have avoided splitting, depersonalisation or detachment (Menzies-Lyth, 1957).

Leading by Experiential Practice

That participants felt they learned more experientially at work than through training is corroborated by one study where psychologists consistently highlighted learning through doing once qualified (Nel, Pezzolesi, & Stott, 2012). There is a paucity of other relevant studies with clinical psychologist participants. The practice of psychologists learning to lead experientially is in accordance with learning on clinical training being not wholly didactic, but rather accomplished through a blend of clinical, research and academic tasks, and requiring personal development including a sense of identity, functional methods of self-care and interaction with others (Hall & Llewelyn, 2006). Leading by experiential practice is an outcome advocated in the British Psychological Society's clinical leadership competency framework (BPS, 2010) in its mapping of leadership competencies which includes leading through creating and sharing service development plans and learning from mistakes in specialty services. Findings correspond with Kolb's experiential learning model

(1984) which posits that learning is a process grounded in experience in which knowledge is continually transformed through adaptations. The way participants learned to lead through observing others and through including contextualised considerations agrees with both social learning theories (Bandura, 1977), where new behaviour is acquired through observing others, and with theoretical views of relational interdependency between individuals and social and cultural structures of the world, where learning is intrinsically socially negotiated (Lave & Wenger, 1991).

Clinical Implications

The present study tentatively lends weight to the role psychologists have to play in clinical leadership. Psychologists appear to lead in ways that inspire followership and through engaging, shared or collective leadership. Compassion enabled in their leadership through reflection and supervision processes, widely regarded as tenets of the profession, may be a unique contribution from psychologists as leaders. Leadership may be an increasingly valuable additional role for psychologists given NHS reforms calling for leadership from clinicians (Darzi, 2008). Within the BPS's leadership development framework (2010) there are calls for psychologists to acquire leadership competencies such as setting direction through applying knowledge and evidence, working with others through building relationships and personal qualities such as self-awareness, which correspond with some of the leadership trajectories described by participants. This may however represent a culture shift; Darzi (2008) did not place psychology within NHS workforce groupings considered to hold clinical leaders (Turpin & Llewelyn, 2009).

Theoretical Implications

Though exploratory in nature and preliminary in theoretical modelling, the present study suggests that psychologists develop as leaders through experiential learning

processes at work rather than through specific leadership training, though clinical training was being applied as they practised leadership. This supports theories of leadership necessarily being an emergent and interactive dynamic due to workplace complexities and contentions that leadership interventions may be insufficient for ongoing leadership challenges (Day, Fleenor, Atwater, Sturm, & McKee, 2014). Clinical training itself may inform the leadership style of psychologists, perhaps through providing theories and conceptual possibilities to draw on in reflective practice processes (Lavender, 2003).

Methodological Critique

The sample was self-selecting and may have included participants more involved in leadership than psychologists may typically be, though efforts were made to include psychologists who were less interested in leadership. This means the model built may not necessarily be widely applicable outside of the present study. Data triangulation to include views of others on participants' leadership was not attempted though it was a possibility. Data triangulation would have enriched the data and perhaps have enabled theoretical saturation to be reached. Due to time constraints theoretical sufficiency (Dey, 1999) rather than theoretical saturation was aimed for. My preconceptions may have influenced data interpretation or questioning, though I safeguarded as far as possible against this using supervision and the reflective diary. The focus on compassionate leadership may have prompted some fitting of experience into this notion by interviewees, though some expressed questioning of the concept.

The initial research questions were somewhat answered in the present study. The research question regarding training actions was explored less as categories emerged from the data which suggested that training processes were not integral to

the leadership development of the research participants in the sample. This is in keeping with a grounded theory approach, where research questions are not fixed and can become more focused through theoretical sampling and data collection.

Conclusion

This study aimed to build a preliminary model of the process of how clinical psychologists may evolve into compassionate leaders. The findings indicate that psychologists may develop as leaders through their personalities and sense of mission. Individual talent or inclination seemed to steer towards service development, innovation or other leadership responsibilities. Participants tended to value treating people well in the way they led. Reaching out to and being accepted by colleagues enabled development as leaders. This took the form of peer support within the profession or support from another profession. Participants negotiated NHS hierarchies to develop as leaders or developed as leaders in a context where hierarchies did not hinder. Participants who developed as leaders tended to possess skills at relating positively with peer and inter-professional colleagues. Participants developed as leaders through leading by experiential practice, which involved applying ideas, theoretical knowledge or understanding to their practice and observation of supervisors and leaders. Leading by experiential practice was a process and often involved contextualised considerations. Participants who became compassionate in leadership seemed to be enabled by reflection, supervision and being treated with compassion. The study has some methodological weaknesses yet offers promising theoretical and clinical implications for psychologists to potentially develop as compassionate leaders.

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Rosemary Linda Gomes BSc Hons

Section C: Appendices of supporting material

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology
June 2015

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A: Definition used in questions in semi-structured interviews

Person-centred leadership

Noticing the distress of others and acting to do something about it

Appendix B: Recruitment Email

[Letterhead]

[Date]

Dear Sir/Madam,

Preliminary Model of the Transformational Process of How Clinical Psychologists May Evolve Into Compassionate Leaders

Salomons Ethics Reference: V:\075\Ethics\2013

I am sending you the message below on behalf of Rosemary Gomes, a second year trainee clinical psychologist,

Message from Rosemary:

I have asked …….. to send you this message on my behalf because you are a Clinical Psychologist associated with the Salomons Centre for Applied Psychology, Canterbury Christ Church University, and I would value you as a participant for the above named study. You have been selected randomly from a list of supervisors and associate speakers connected with the Salomons Clinical Psychology Programme. In addition I wished to ensure that I only interview people who I do not know, as this minimises potential ethical issues due to any pre-existing relationships. The study is my MRP. I would be interested in carrying out a one-off interview with you lasting forty-five minutes to an hour. I would be asking questions about compassion in leadership and your experiences in clinical practice on this topic. If this topic interests you, please could you take a look at the attached information sheet. Please email me at r.l.gomes202@canterbury.ac.uk if you think you might like to take part and would like or to ask any questions.

Yours faithfully,

Rosemary Gomes

Trainee Clinical Psychologist

Supervised by: Dr Sue Holttum, Dr Al Beck and Dr Helen Quigley

Appendix C: Copies of Ethical Approval Letters from both CCCU and the NHS Trust Ethics Panels

These have been removed from the electronic copy

Appendix D: Interview Schedule

Draft interview schedule

At the start of interview ask:

What is your current role? What are your leadership responsibilities currently?

How long have you been a qualified CP for?

(Based on this, divide up the interview schedule into three sections-when they first qualified; the point halfway between now and qualification; the last year. For example, someone with ten years of experience would be i. newly qualified, ii. five years post-qualification, iii. the last year).

Maybe also provide some explanation of how you mean leadership not necessarily in terms of their place on the hierarchy with the questions you will ask?

Section One

I'm going to ask you a few questions about what things were like for you early on in your career as a CP.

-What's your earliest memory of taking a lead on something once you were qualified?

- Can be a minor action, not necessarily a formal role
- What was that like for you?
- What sense did your get of what it was like for others?
- How did it come about that you took a lead in that situation?

-Had you experienced any kind of leadership training at that stage in your career, or not?

-Was it something that occurred to you at the time – that you could do leadership training – or not?

-It had occurred to you... Can you say what sort of aspirations or thoughts you had in regard to such training – where it might lead?

-It hadn't occurred to you. [If they have now had training] Given that you have now had some leadership training, can I ask you what prompted the change from not considering it to considering it? Is that something you are aware of or not? Was there a specific moment or…

-To what extent did you feel, when you were first qualified, that your pre-qualification clinical psychology training course had prepared you to take on leadership roles or activities?

-Okay, so it did in the sense that… Could you say more about that? /Okay so there wasn't really any… Would you have liked there to have been or was it not a concern?

-How important did you think of leadership or leaders in the NHS as being at that time? Was it something you thought about much or not?

What was your experience of leadership in teams back then? Were you able to participate in providing leadership to a team (not necessarily a formal role)? How? Can you provide an example?

Section Two

Now I'm going to ask you think about how things have been more recently.

-How have things changed for you in terms of taking a lead in the time since first qualifying? Can you give me some examples from your practice setting?

-Has it got easier or harder to show leadership? How? Can you give me any examples?

-How has any training you have experienced [if on the workshops then say] including the recent workshops contributed to your being able to lead in ways that are meaningful to you? Can you give an example?

-Were there aspects of leadership you know about and have wanted to put into practice but were not able to? Can you give an example? What happened?

-What is your view – not your understanding of it but your view of it – of what is referred to as being people-centred in leadership? [Show card] This is a formal definition I am giving everyone whether or not they have had training on it. Do you feel there are any factors at play that facilitate this or perhaps make this difficult to implement in your own experience or from what you have observed? Is there an example you can draw on from your own practice or someone else's to give me more of a sense of what you mean?

-Are there things that can get in the way of listening with compassion/empathy at times?

- Prompts: -At what times is this more/less apparent? -Why?

What was it like leading from within a team? Have you any examples from your personal experience? [What sort of team? – multi-disciplinary or single discipline, not that there are many of those now]

Section Three

Now I'm going to ask you to think about how things have been in the last year.

- Do you have any examples of how any leadership training you have experienced has impacted your practice?

-Can you give examples of things from the training that you have tried to implement?

- Prompts: -What have you learned? –What difficulties have you encountered?

-Have you been involved in any extended "learning sets" or peer supervision groups on leadership during or after training? What was that like?

- Prompts: -If no. What prevented you from being involved, if you don't mind my asking?

-Has it been harder to put things into practice from the training or different from what you expected? How?

-What is your view of the idea of a compassionate leader? Not what it is, but what is your view of it as an idea? Does it make sense to you? …Because…? [Perhaps again have a card to show with a formal definition]

- [If positive about the idea] It can be difficult to put into practice sometimes. To what extent do you yourself find you are able to put it into practise? What helps or hinders you in doing so? For example – can I ask for an example?

-[If not so positive] What would you say is the most effective kind of leadership? Can you give an example of that from your own practice or from a colleague perhaps?

-Can you give any other examples from your own experiences – either your own practice or perhaps a colleague you have encountered - of how CPs can lead well?

-You have said you value compassionate leadership [Only ask those who have said this] How do you know when you're being compassionate? How do you know when you're not? I realise this could be a sensitive question and you don't have to answer. Can you give me examples of when you felt you perhaps could have been more compassionate? And an example of where you felt you were able to be so? Has this changed over time? How?

-How important is being people-centred in the way that you lead at this stage in your career? Are there factors at play now that facilitate this or perhaps make this difficult to implement?

-Can you describe your experiences of listening with compassion/empathy now? What facilitates this and what hinders it? Has this changed over your career? How and why?

Is there anything else you would like to say about your experience of taking the lead over the years? Thank you for your time.

Appendix E: Participant Information Sheet

Participant Information Sheet

Project Title

To build a preliminary model of how clinical psychologists may evolve into compassionate leaders.

Invitation to the Above Study

Hello, my name is Rosemary Gomes and I am carrying out the above study as part of my doctorate in clinical psychology. I am inviting you to take part in a research study on leadership in Clinical Psychologists. You have been approached because you have taken part in the leadership workshops at [name of Trust] or because you are a member of the [groups at Trust]. Alternatively, you may be a psychologist linked with Salomons. Participation is entirely voluntary and saying yes or no to the study has no bearing on your involvement in the leadership workshops or your work role in general.

I am aiming to look at how clinical psychologists evolve as leaders and how they incorporate any relevant training into clinical practice. I am interested in how they bring compassion into their leadership and how this may be reflected in their practice.

I am being supervised by:

- Dr AL Beck [name of Trust].
- Dr Sue Holttum, Salomons Centre for Applied Psychology, Canterbury Christ Church University.
- Dr Helen Quigley [name of Trust].

The project has been reviewed and approved by the ethics panel at Salomons Centre For Applied Psychology.

Risks or Benefits

There are no known benefits or risks for you in participating in this study. You may enjoy the opportunity to discuss and reflect upon your experiences at a time when NHS leadership is very topical.

What is Involved?

In this study, you will have a one-off interview with me lasting 45 minutes to an hour approximately. I will ask questions around the topic of evolving leadership using a semi-structured interview schedule.

I can interview you at your place of work, a workplace within [name of Trust] or we can meet at an interview room in the [name of Trust workplace].

Participants' Rights

You may decide to terminate your involvement in this research study at any time without needing to provide any explanation. You have the right to ask that any data you have supplied up until then to be withdrawn or destroyed.

You have the right to miss out a question or aspect of a question or to refuse to reply to any question that I ask of you without there being any negative consequences.

You have the right to have your questions about the procedures answered. Please ask if you have any questions arising from reading this information sheet and we can discuss before you make a decision regarding participation.

If you are concerned about being identified through the content of your interview, we can have a discussion about disguising details in order to appropriately safeguard your personal or sensitive data. There is also the option of your reading through the transcript I will make of our interview recording and letting me know if you want any details amended to further protect your identity or to avoid damage or distress to other individuals or organisations.

In the event of an interview causing distress for a participant, I will offer to hold a reflective space in the interview, asking the participant what they would find helpful and trying to follow this. Participants also have the option of a short confidential debrief afterwards in which they can talk about any distress with Dr Helen Quigley, who is one of the supervisors of this study. I will also remind participants working in [name of Trust], if necessary, of [name of Trust] staff counselling details which are available through the occupational health department for further support in the time period following the interview.

Expenses

Participation in this research study is voluntary. No financial reimbursement for participation in this project is provided.

Confidentiality and Anonymity

I am recording interviews using a Dictaphone in order to analyse the transcripts. The Dictaphone will be kept securely and there will be no identifiers on it to link your recording to your name. Paper-based data will be anonymised by allocating participant numbers instead of names. Electronic data will be transferred from different locations on an encrypted memory stick. When stored on a hard drive, it will be password protected.

In the event of the discovery of unprofessional or unethical practice in the course of the interview, or if I become otherwise concerned about possible risk of harm to you or others as a result of something you say, I will have to break confidentiality and inform the appropriate individuals and organisations. Unprofessional or unethical practice includes but is not limited to criminal activity and fraud. I would speak to you about my concern if possible before passing on any information.

I hope to make use of the findings of this study to present at conferences, and to submit for publication in a suitable journal. I will ensure that your data will be completely anonymised and your confidentiality protected in the final report and throughout the publication and presentation process. I may use some quotes from transcripts but they will be anonymised.

Who is Responsible for the Organisation and Funding of the Research Study?

Canterbury Christ Church University.

Further Considerations/Complaints

If you require more information or have a concern about this study, you can speak with me and I will try to answer your questions. My email address is

r.l.gomes202@canterbury.ac.uk

If you would like to discuss any of this with her, or if you are unhappy and have a need to complain about any part of this research study, my lead supervisor is Dr Sue Holttum. Her details are below.

Email: sue.holttum@canterbury.ac.uk
Work Telephone Number: 0333 011 7113

Alternatively, with a complaint, you may wish to contact Professor Paul M Camic, Research Director at Salomons:

Email: paul.camic@canterbury.ac.uk
Work Telephone Number: 0333 011 7114

Additionally, you may email [name of Trust complaints email address] or call [Trust telephone number].

If you want to find out about the final results of this study, please let me know at the end of the interview and I can contact you when I complete the write-up.

Thank you for taking the time to read this participant information sheet.

Appendix F: Consent Form

Title of Project: Building a Preliminary Model of the Transformational Process of How Clinical Psychologists May Evolve Into Compassionate Leaders.

Name of Researcher: Ms Rosemary Gomes

Please initial box

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is entirely voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	
3. I give permission for the interview to be recorded on a Dictaphone. I am free at any point to ask for the recording to be stopped and the information destroyed. I can also ask at any point to hear the recording myself.	
4. I understand that my information will remain confidential to the above research study. The recording will be stored safely and my name will not be attached to it.	
5. I agree that anonymous quotes from my interview transcripts may be used in published reports of the study findings.	
6. I agree that, after the study is completed, the transcript of my interview will be kept in locked, secure storage at Salomons Centre for Applied Psychology for ten years before being destroyed.	
7. I agree to take part in the above study.	

Signature of Participant:

Print Name:

Date:

Signature of Researcher:

Rosemary Gomes (Clinical Psychologist in Training)

Appendix G: Example of an Open Coded Transcript

This has been removed from the electronic copy

Appendix H: Some Selective Coding for Charlene's Data

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Appendix I: Examples of Memos for Charlene's Data

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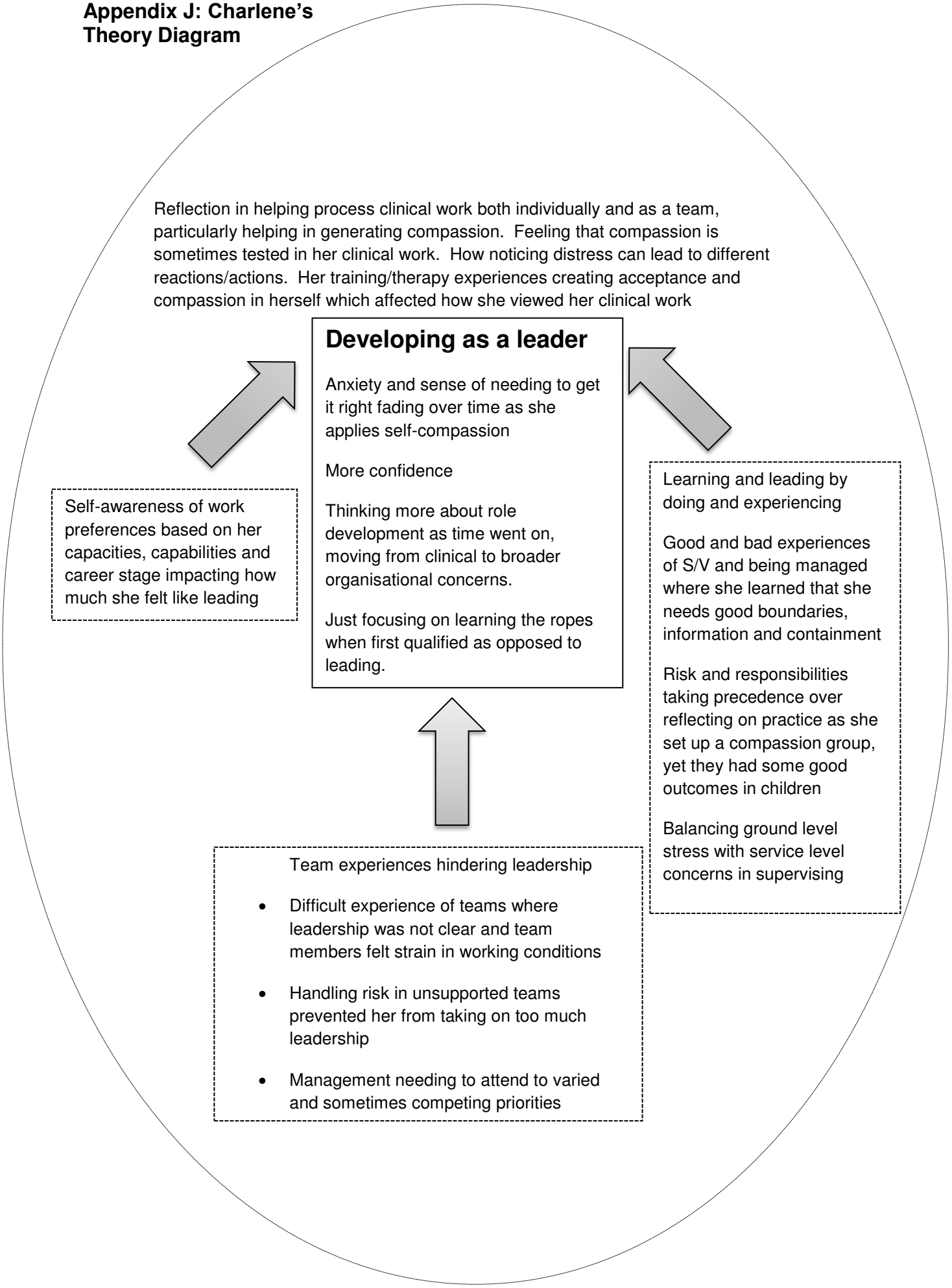
Appendix J: Charlene's Theory Diagram



Appendix K: Abridged Research Diary

Before getting R & D approval	Still feels really frustrating to not have gotten R & D approval yet. Going to send off the amended forms in the post tomorrow. I really hope I can count ten days from now and have approval. Who knows what other details they will need. With a bit of luck, I can do all my data collection in two months. My ideas about leadership are changing all the time. I keep feeling very critical of how polarising the British media are about politics. It also feels a very British thing to put down our leaders. I wonder if this is why CPs do not step up to the plate? They tend to be the criticisers rather than the do-ers. I had a strong reaction to [name of lecturer]'s teaching from Thursday about how she became an Approved Clinician on the ward but still felt powerless in a medicalised setting. I felt she was a bit worn out, defeatist, and in need of supervision from a less problem-saturated perspective. I felt that she had gained position on the hospital hierarchy, and power, which is what CPs indirectly hint that they lack, and yet did not put herself forward to use it. I felt she was conflict-avoidant, perhaps people that put their heads above the parapet need to be robust enough to speak up for their principles even when nobody else agrees? And even if the whole system is saying you are wrong, to continue to fight the good fight? Maybe there is no getting away from the reality that it is a fight? And perhaps CPs are reluctant to be clear and specific about taking a side and fighting for it? Ramblings…
After Interview One	It felt like a long interview and he had such an energy about his job. I felt a sense of envy at what was possible back in the day, it sounded so creative and not structured till the CPs decided what the structure was, such freedom. It seemed a million miles away from talks now about cuts and there not being enough CP jobs and the ones that exist being way more responsibility than the grading and not enough time to do all the work. He sounded like his work was enabled partly by the freedom from outcomes/record keeping/targets pressures that are so strong currently. I was struck by how he said he led all the sports teams as a boy. He seemed like a natural leader, put him in any context, he would lead it. Yet when he talked about crying and in his soft manner, he didn't seem like a stereotypical, boss type…I guess psychology leadership, thoughtful leadership looks so different from stereotypical people-in-charge, dictatorial types. I came away feeling quite enthused.
After Interview Twelve	That was my best interview! I wonder if it is because I completed all my reading and literature searching for Section A and now feel I have a "framework" for some of the processes being described, so I can understand their narratives a bit more? I felt I set the interview up better at the outset, saying I was investigating compassionate leadership, maybe that is why she said so much about this too? Perhaps I primed her to answer a certain way though. Certainly felt I let her tell her story more than I did the others, I felt confident to follow it without adding too many of my own questions to steer. She was also strikingly honest about her experiences of failure. We all fail at things, I wonder why the other CPs were less forthcoming about

things they had truly messed up in. Anyway, this interview really struck me as having a lot to contribute to how CPs evolve as compassionate leaders because that was her natural trajectory, without my having to ask questions to prompt her thinking. Whereas for other participants, it seemed more about leadership development more generally, not compassionate leadership development.

On Beginning Coding

I think I will have to decide not to code too much of their day to day work as I've ended up with too many codes that will not be relevant to the theory or their journey/trajectory. It feels like coding the "filler" material as I think much of what they say could be classed as generic job description-esque descriptions typical of anyone at their banding/grading level. Maybe I can use these chunks of data in my write up to situate the sample.

I have absolutely no idea what the theory will look like! I am starting to suspect that the evolving of compassionate leadership may not even be a key part. I wonder if the way I conducted the interview felt like I shoe-horned in compassionate leadership for them to talk about, I am not sure they all would have mentioned it as part of their leadership style if I hadn't brought it up. Also, me bringing in a definition of what I call person-centred leadership may have been a bit leading, maybe they weren't able to say directly "actually my leadership is not person-centred" even if it were true? Then again, some were able to question my definition. I just assumed that my being young looking, a bit green, a trainee, compared with participants who have tended to be fairly powerful and high up in the NHS, they would have felt able to reflect in an unselfconscious way about their leadership. Perhaps within clinical psychology there is always a sense of needing to be socially acceptable within one's profession's accepted ideologies e.g. of person-centredness. I'm glad there was a range of opinions on the idea of person-centred leadership. That even amongst CPs, there are different ways of relating to this, and this seems to inform leadership style.

On Selective Coding

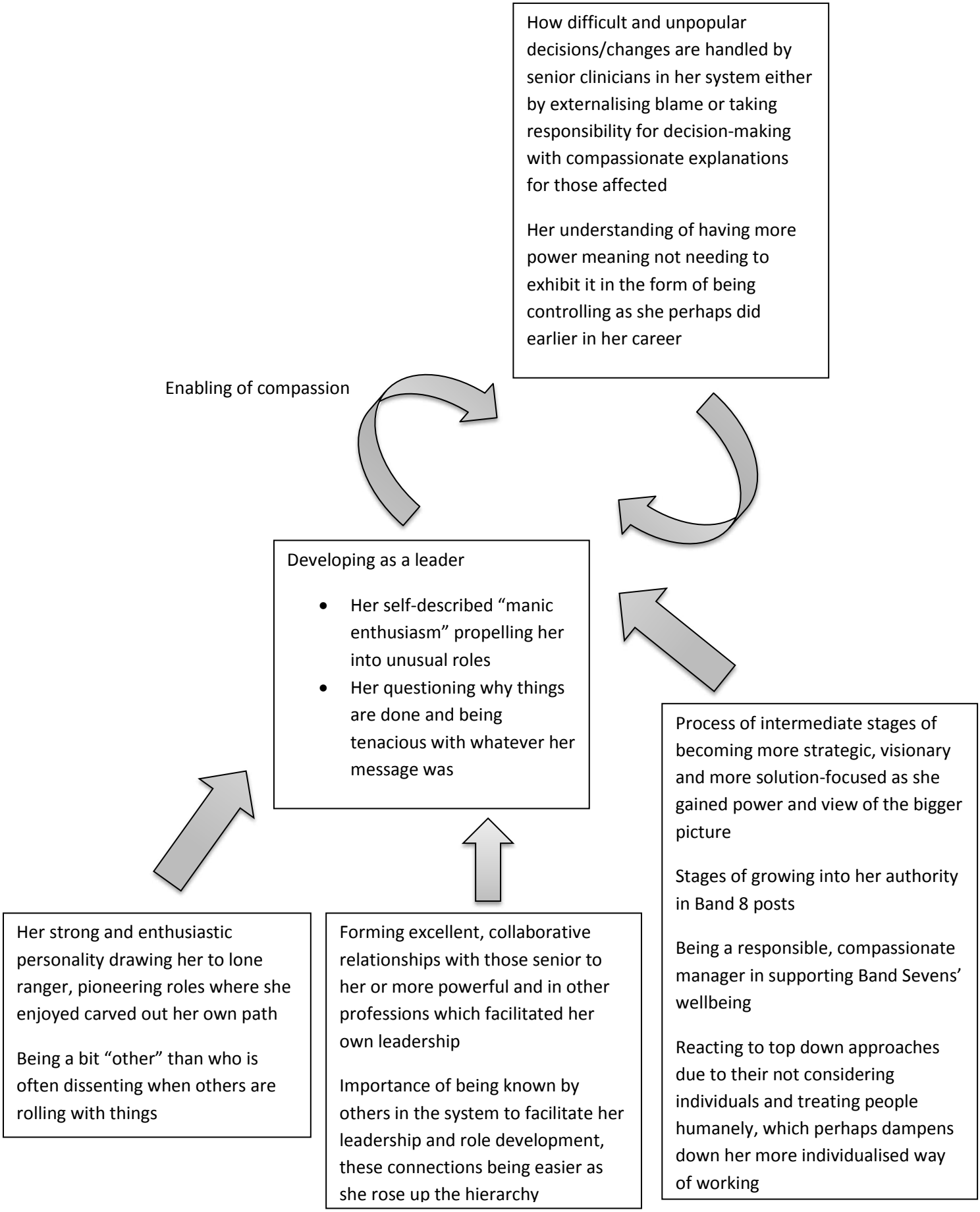
Looking across the selective coding for different participants, though it is not emerging from the data, I have noticed some really interesting gender differences between the participants. The way the men were more "natural" innovators and held passions they then put forward which seemed to propel their leadership. Whereas the female participants spoke more about support and collaboration and having their leadership invited. The men did not wait to be invited! This has interesting implications considering that the CP workforce is largely female yet lots of the higher grade CP jobs go to men. But this is not really the focus on my study, gender differences as such, and it was not explicitly talked about by any of my participants, so I may have to put it to one side.

It seems lots of the ones who developed quite a bit as leaders were really passionate about one thing or another and this seemed to lead to them stepping forward in some way. People talk about natural born leaders but I wonder if this is what it can mean in CPs, those with a particular, quite natural to them, interest, which pushes them to take initiative.

On Theoretical Coding	Interesting that a real commonality across participants was this idea of leading/learning by doing. It seems to be a part of the culture in the profession. I will be careful to use examples from the data to back this point up in the write up as I am aware that I suspected this may be a finding and I don't want to let my preconceptions guide my analysis. What did surprise me was that CPs sometimes expressed embarrassment about this. Why would learning on the job be embarrassing. Being compassionate in different contexts is probably a very flexible, responsive thing, it may not be something that is gained from training. Yet it seems that training validates a way of working. I wonder if this is a factor behind the push for leadership development in the NHS. Safe certainty, solid learning.
After showing the overall theory diagram to others	I'll change the direction of the arrows for compassion category. I knew it was more central than the double arrow indicated but I didn't quite know how to represent that diagrammatically. It needs to be surrounding the categories, to show how over-arching it is. The enabling of compassion was not as obvious as I'd hoped, even with the two arrows showing a sort of feedback loop. That is what my colleague and also a participant said and to be honest, I knew it already, you know when you know a diagram is not quite finished. So glad a few of the participants emailed back after seeing their individual theory diagram and the overall theory model diagram, it has really helped in these final stages.

Appendix L: Three Examples of Early Theory Models for Individual Participants

Beatrice's Theory Diagram

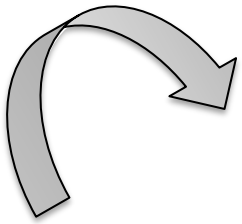


Terri's Theory Diagram

Enabling of compassion

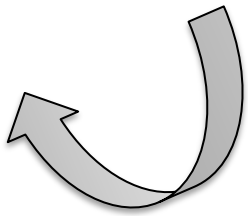
Being led with compassion, reflection, S/V, mindfulness case discussion and reflective groups

- Giving out what one has first received
- Containment and compassionate leadership from manager
- Using reflection to think about her own/others S/V experiences and needs

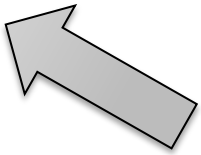


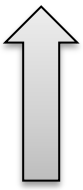
Developing as a leader

- Gaining compassion, sometimes through mindfulness practice
- Analogy of a young person moving from a secure base into mature adult roles



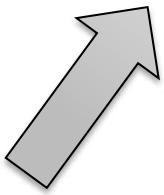
Gentle, gradually taking on more leading. Formally and informally supervising.

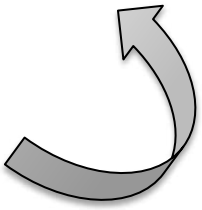




CP colleagues

- Strong, psychology-heavy teams protected her from inter-professional tensions and allowed her leadership capacity to be developed as she was valued professionally
- Colleagues accepted her leadership, they were willing followers
- Compassion being key in clinical psychology as a profession
- Flexible service structure allowed her to take a lead as the shared language meant her initiatives were understood





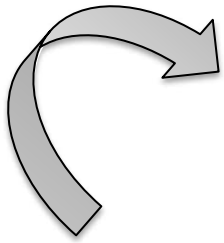
Compassionate listener. She believes that compassion is essential for leading

Bruce's Theory Diagram

Compassion being inherent in CP temperaments and in clinical training, being a part of honest communication yet being subject to being side-lined due to other external forces

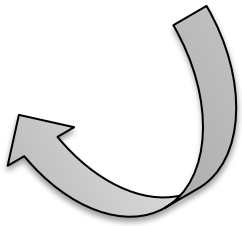
He has a vision for the role for CPs higher up the NHS hierarchy in bringing in compassionate leadership

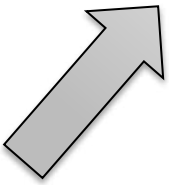
Enabling of compassion at different hierarchy levels

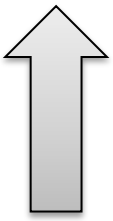


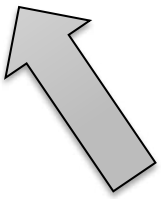
Developing as a leader

- Keen on service development
- Developed as the CP profession grew in respect and importance which opened opportunities









Being driven into leadership by strong desires for service development and stepping up when he notices a gap

Being a part of crucial management meetings and intra- and inter-professional groups

- Skills at inter-professional networking with more senior colleagues which furthered both service development and his leadership development over his career
- Skilled at collaborative working with other CPs to bring about service development and innovation
- Prioritising networking and genuine work relationships

Learning through collaborative practice enabled by growing profession

- Learning through his practice, through collaboration with relevant experts/leaders, rather than training
- Experience of incorporating external pressures/factors into the way he works
- Process of the external context for CPs evolving to facilitate his leadership, from no CPs going into management when he started out, to leadership opportunities flourishing as the profession grew

Appendix M: Selected Comments From Participants in the Participant Validation Process

“Thanks for contacting me, it’s great to see you have almost finished your project!

I really like my personal diagram, I think you have captured it well. It’s helpful to see the process mapped out and I feel like you have captured my experience nicely.

The overall map is good too. I wondered about the ‘enabling of compassion’ bit that seems a bit out on a limb. Does that link to the arrow it is next to, and if so, is it a circular process, i.e. should this label also be next to the return arrow? Could you make it clearer what you mean by ‘enabling of compassion’ (e.g. how takes place or what it is)?

I wonder if in general you could make how compassion fits in to leadership a bit more central in the visual of your model. You could possibly afford to reduce the bullet points (you’ll describe these in the text anyway) and be more bold with the visual impact and more bold with the cross-contextual role of compassion in CP leadership. Don’t be afraid to really go for the over-arching interpretation! As a reader, I would also want to think about how I could take this model and use it in some way (e.g. in running leadership training?), so maybe keep that in mind too.

Thanks again for feeding back your findings and best of luck with finishing the project, and training!”

“The diagrams are fine and make sense.”

“Many thanks Rosemary. That's really interesting.”

Appendix N: Research Summary For Participants, CCCU Ethics Panel and NHS Trust R & D Department

A Grounded Theory Investigation to Build a Preliminary Model of the Transformational Process of How Clinical Psychologists May Evolve Into Compassionate Leaders

Introduction

Clinical leadership and compassionate care in the NHS have become priorities in influential papers and policies. There is a paucity of empirical investigation to underpin conceptualisations of compassionate leadership and of leadership development in clinicians in the NHS, particularly clinical psychologists who may be able to lead in healthcare environments in unique ways due to the values and competencies of their profession.

Methodology

Twelve clinical psychologists from varied specialities and with different years of experience took part in semi-structured qualitative interviews. Their data were analysed using a grounded theory methodology involving open, selective and theoretical coding.

Findings

The findings indicate that psychologists may develop as leaders through their personalities and sense of mission, through reaching out to and being accepted by colleagues and through leading by experiential practice. Participants who became compassionate in leadership seemed to be enabled by reflection, supervision and being treated with compassion.

Participants' personalities and sense of mission appeared to shape how they developed as leaders. Participants reported personal talents or interests which led them into leadership activities. These appeared to be starting points for their development as leaders which then seemed to propel them into leadership actions. Participants also expressed a value of treating people well. These values appeared rooted in their leadership style.

Reaching out to and being accepted by colleagues seemed to assist their development as leaders. Participants expressed a strong sense of solidarity among psychologists which often substantiated their leadership actions. Peer support within the Clinical Psychology profession also took the form of presenting compassionate leadership to participants. There was some sense of compassion being an integral part of the personal temperament of psychologists. Several participants reported

significant clout gained in their role from being supported by psychiatrists who were deemed more powerful in the medicalised setting they worked in. Several participants discussed negotiation skills at navigating existing hierarchies in order to bring their leadership, gaining acceptance by meeting attendance for example. Participants explained how they frequently were enabled in their working through networking with both peers and non-psychologist colleagues, which seemed possible due to their interpersonal skills.

Participants' appeared to develop as leaders through the actual experience of leadership activities, including observing others. Participants felt equipped from clinical training to apply theoretical and psychological knowledge in work contexts. Most expressed a sense of process and working through stages as they developed their leadership capacity. Supervision seemed a way of reflecting on situational learning with a more experienced psychologist which felt supportive. This fitted with how participants described learning leadership practically and experientially. Participants' leadership trajectories were characterised by contextual factors which required thoughtful incorporation into practice, which sometimes shaped how they led.

For participants who became compassionate in their leadership, this appeared to undergird and surround both the way participants developed as leaders and the way the other three categories contributed to leadership development. Participants were enabled to be more compassionate when they were treated compassionately at work themselves. Reflecting compassionately on personal and emotional processes in both self and others seemed key for participants to experience compassion towards themselves and others. Good supervision was valued by most participants and seemed valued for providing containment. There was a sense that this demonstrated compassionate leadership towards them.

Clinical Implications

The present study tentatively lends weight to the role psychologists have to play in clinical leadership. Psychologists appear to lead in ways that inspire followership and through engaging, shared or collective leadership. Compassion enabled in their leadership through reflection and supervision processes, widely regarded as tenets of the profession, may be a unique contribution from psychologists as leaders. Though exploratory in nature and preliminary in theoretical modelling, the present study suggests that psychologists develop as leaders through experiential learning processes at work rather than through specific leadership training, though clinical training was being applied as they practised leadership. Clinical training itself may inform the leadership style of psychologists, perhaps through providing theories and conceptual possibilities to draw on in reflective practice processes.

Appendix O: Publication Guidelines of Journal Chosen for Publication

Clinical Psychology & Psychotherapy

Edited By: Paul Emmelkamp and Mick Power

Impact Factor: 2.59

ISI Journal Citation Reports © Ranking: 2013: 28/111 (Psychology Clinical)

Online ISSN: 1099-0879

Author Guidelines

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Manuscript style. The language of the journal is (British) English. All submissions must have a title, be printed on one side of A4 paper with numbered pages, be double-line spaced and have a 3cm wide margin all around. Illustrations and tables must be printed on separate sheets, and not incorporated into the text.

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The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

- During the submission process you must enter the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** .
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- All articles should include a **Key Practitioner Message** — 3-5 bullet points summarizing the relevance of the article to practice.
- Include up to six **keywords** that describe your paper for indexing purposes.

Research Articles: Substantial articles making a significant theoretical or empirical contribution.

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Book Reviews: Published on invitation only. Critical summaries of recent books that are of general interest to readers of the journal.

Reference style . The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication .

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited .

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary .

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year .

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears .

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al* . (meaning "and others") .

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al* . in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author .

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

l. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Journal Article

Gardikiotis, A., Martin, R., & Hewstone, M. (2004). The representation of majorities and minorities in the British press: A content analytic approach. *European Journal of Social Psychology, 34* , 637-646. DOI: 10.1002/ejsp.221

Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean* . Hartford, CT: University of Hartford Press.
Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world* . Hartford, CT: Capital Press. and so on.
The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the inital citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials* . Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website:
http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

Stand-alone Web Document (no date)

Nielsen, M. E. (n.d.). *Notable people in psychology of religion* . Retrieved August 3, 2001, from http://www.psywww.com/psyrelig/psyrelpr.htm

Journal Article from Database

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence, 15* , 503-522. Retrieved May 20, 2000, from ProQuest database.

Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology, 20* , 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

Article or Chapter in an Edited Book

Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press.

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