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Leading the health service into the future: transforming the NHS through transforming ourselves

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Abstract
Background: Leadership development impacts on quality of care and on workplace cultures for staff. Clinical leadership embracing transformational and other collective leadership approaches is a key enabler for developing effective workplace cultures at the micro-systems level. Following the development of a shared purpose and values framework, an internal interprofessional clinical leadership programme was set up to grow a critical community of transformational leaders across one NHS organisation in England. This programme had been unsuccessful in engaging medical doctors for more than two years.
Aims and objectives: This paper shares how a dedicated, practice development-based clinical leadership programme set out to support medical doctors across one organisation with their leadership journey, equipping them to become transformational and collective leaders, and facilitators with the skills to develop and sustain person-centred, safe and effective workplace cultures.
Methods: Practice development methodology, with its collaborative, inclusive and participative approach to developing person-centred cultures, combined with clinical leadership strategies, formed the basis of the programme. It emphasised the use of active and action learning, drawing on the workplace as the main resource for learning, development and improvement. Self-assessment and collective thinking about clinical leadership, together with collaborative analysis of evaluation data, led to the synthesis of insights through the use of reflection and action planning.
Findings: These are presented at two levels:
  1. Five individual reflections by authors to illustrate their leadership journeys, which also demonstrate the use of a range of tools and their impact. Insights and learning include recognition of the benefits of peer support and networking, development of a disciplined approach to learning, and self-management
  2. A collaborative reflection and critique that embraced a sense of team ethos and community cohesion, for the first time in a safe environment, as well as a sense of shared purpose and values.
Conclusions: The programme helped to identify the impact of leadership on workplace cultures and to begin to embed ways of working that are collaborative, inclusive, participative and celebratory. This unique approach by one organisation to leadership development has enabled medical clinical leaders to embark on a journey of self-transformation.

Implications for practice:
- An internal model grows clinical leadership capacity across an organisation through peer support and networking, and collective leadership
- Investing in a safe, confidential space for clinical leads and other staff groups is a potentially effective strategy for leadership development practice
- There is need to develop more skilled critical companions to support leadership, improvement and development activities
- Clinical leadership development, informed by practice development methodology, demonstrates the potential to enable transformative and collective leadership to promote person-centred cultures in the workplace

Keywords: Clinical leadership, collective leadership, critical companionship, micro-systems, transformational leadership, workplace culture

Introduction
Leadership development has been identified as an area that will need to be addressed if healthcare services are to provide high-quality, safe and compassionate care (West et al., 2015). Developing clinicians' leadership skills has long been recognised as essential for improving the experience of patients and service users (Ham, 2003; Berwick et al., 2008), particularly at the micro-systems level (Manley et al., 2011). In addition, clinical leadership is influential in creating good places to work, retaining and developing staff, and maintaining staff wellbeing – all of which have an impact on quality of care (Maben et al., 2012; Paparella, 2015). Increasingly, the whole-systems approach to healthcare, with its core concepts of integration and interdependence of workforce partners, recognises a key role for clinical (and care) systems leadership (Manley et al., 2016). It is required to enable staff to work as a team towards a shared purpose, drawing on the talents of staff, breaking down silos and enabling everyone to flourish. Clinical leadership is the basis for ensuring quality of care at the micro-systems level but also provides the foundation for growing collective leadership across organisations and systems.

This paper focuses on a practice development programme dedicated to supporting medical doctors in the development of their leadership role and the co-creation of person-centred, safe and effective workplace cultures across a healthcare organisation. The programme's assumptions are that effective clinical leaders achieve this in the following ways (Manley et al., 2016):
- Developing their self-awareness and emotional intelligence
- Becoming transformational leaders who can engage and inspire their teams through collaboration, inclusion and participation
- Becoming facilitators and enablers of others' effectiveness through drawing on their own workplaces as the main resource for learning, development and improvement

The need for an organisation-wide programme was identified following a collaborative project that developed a shared-purpose framework aligned to shared values (Manley et al., 2014). The central purpose – the provision of person-centred, safe and effective care – was joined by an additional imperative: the need to build effective workplace cultures, recognised as essential if the main purpose was to be sustained. Clinical leadership is a key enabler for developing such cultures (West et al., 2014; Manley et al., 2011). There had been no history of clinical leadership development across the organisation; an interprofessional programme had been developed and completed by four cohorts of staff but there had been no uptake from medical colleagues. This, together with a challenging inspection report by the healthcare regulator in 2014, led to a dedicated programme being set up for doctors with a formal leadership role at the micro-systems level. The need to increase medical engagement in leadership has been highlighted (King's Fund, 2011; Clark and Nath, 2014), so the intention was to provide a safe space for this staff group before integration with the organisation's interprofessional programme.

The aim of this paper is to share insights about the participants' experiences through five independent participant reflections, and a collaborative analysis that reflects individual participants' journeys and captures the processes and outcomes they saw as influential in their development. For those who completed the programme, this journey led to the realisation that transformation of the NHS would, in part, rely on clinical leaders transforming themselves, and that a prerequisite for that transformation was the ability to develop self-awareness leading to self-empowerment and the motivation to work differently. This sentiment is reflected in the title of the paper.

Background
Leadership development is increasingly recognised as fundamental to efficient, high-quality healthcare (King's Fund, 2011; West et al., 2014). It is a key strategy for building cultures that value patient and staff experiences, learning and safety, (Francis, 2013), quality (King's Fund, 2011; Berwick et al., 2008), effectiveness and knowledge translation (Kitson et al., 2008). Cultures that provide high-quality care are characterised by shared values translated into agreed ways of working that embrace care, compassion and support, and are developed through leadership recognised as a collective endeavour rather than command and control (West et al., 2014; Stodd, 2016).

 Leadership influences organisational culture, which has been defined as:

'The values and beliefs that characterise organisations as transmitted by the socialisation experiences newcomers have, the decisions made by management, and the stories and myths people tell and re-tell about their organisations' (Schneider and Barbera, 2014, p 13).

And against the background of a rapidly changing sector, leadership needs to be more flexible and less top heavy:

'Organisations... need to picture themselves not only in terms of machines and pyramids, but also in terms of organic living systems, continuously evolving and adapting as they interact with a changing external environment' (Hartley and Benington, 2011, p 18).

The ability to recognise the dynamism of healthcare systems and the interconnectedness between all contributors is a quality required by leaders to sustain adaptability and enable people to innovate, be creative and flourish (Pslek and Wilson, 2001; Titchen and McCormack, 2010; Manley et al., 2011). Turnbull James (2011) argues that the NHS needs people who see themselves as leaders not because they are senior, exceptional or inspirational but because they can see what needs doing and can work with others to do it. He contends that leadership development needs to be deeply embedded and driven by context and the collective challenges faced by leaders in an organisation. Such development focuses on roles, relationships and practices in the specific organisational context and requires conversations and learning with people who share that context. As a result, leadership needs to be understood in terms of leadership practices and organisational interventions, rather than just personal behavioural style or competences. The focus is on organisational relations, connectedness and interventions to the system to change practices and processes (Turnbull James, 2011).

Previous leadership theory has been based on leader, follower and common goals (Bennis, 2007]. However, Drath et al. (2008) proposed that leadership is about how to produce outcomes and how people can collectively produce a shared sense of direction and purpose to create conditions for commitment to the organisational strategy. This is a subtle shift in focus from staff empowerment to staff alignment plus commitment to organisational strategy, which may be a contradiction to the empowerment principle, if leadership becomes manipulation in disguise instead of enabling empowerment.

Drath and colleagues suggest that leadership is conceived in terms of three leadership outcomes: direction, alignment and commitment. Storey and Holto (2013) identified three similar themes for the new NHS leadership model to address the circumstances and challenges faced by the health service:

- Provide and justify a clear sense of purpose and contribution
- Motivate teams and individuals to work effectively
- Focus on improving system performance

Research between outcomes and leadership practices is growing in strength, with leadership development at all levels emerging as the factor common among high-performing teams across different health systems in the US, Sweden, England and Canada (Drath et al., 2008). The identification of key mediators provide insights into the areas that clinical leaders need to develop, specifically, that:

- Climate experienced by staff is linked to employee outcomes and in turn customer satisfaction (Hong et al., 2013)
- Quality leadership enables direction, alignment and commitment within teams and organisations and safer patient outcomes linked to staff engagement (Laschinger and Leiter, 2006)
- Well-structured teams – those that have clear objectives, meet regularly to review and improve their performance, and have members who work closely and effectively together – are a strong predictor of improved patient mortality in acute trusts (Dawson et al., 2011)
- Overall wellbeing of staff and their engagement is strongly connected to effective, responsive and safe provision of healthcare. In a survey of more than 2,000 resident physicians in the Netherlands, Prins et al. (2010) demonstrated that doctors who scored more highly on engagement were less likely to make mistakes
- Engagement appears to be higher in healthcare organisations where leaders create a positive climate to ensure that staff feel involved and have the emotional capacity to care for others (Dawson et al., 2011)
- Strong entrepreneurial cultures (at all levels), where initiative taking, group learning and innovative approaches to problem solving are enhanced, inform action in dealing with patient safety issues (Hartmann et al., 2009). These authors argue that a strong emphasis on hierarchy, rules, policies and control, potentially inhibits a positive climate for safety due to fear of negative outcomes and blame for reporting safety-related problems

The King's Fund (2011) argued that the NHS needs shared leadership, rather than old 'heroic' individual leadership models, not just from board to ward, but across NHS boundaries. These include social care, local government, the voluntary sector and the wide variety of other agencies with which it interacts. Leadership development therefore needs to take in consideration all levels – systems (macro), organisation (meso) and the workplace (micro) – but it is important to recognise that it is the workplace culture at the micro-systems level that embraces the main relationships and interfaces between healthcare providers and service users (Nelson et al., 2002; Manley et al., 2011). Micro-systems have been defined as:

'Small, functional, front-line units that provide most healthcare to most people. They are the essential building blocks of large organisations. They are the place where patients and providers meet. The quality and value of care produced by a large health system can be no better than the services generated by the small systems of which it is composed' (Nelson et al., 2002, p 472).

Workplace culture, therefore, has most relevance for clinical leaders when developing the potential of staff across frontline teams and services. It is at this level that most potential exists for transformation to benefit all system users, staff and stakeholders.

The value of clinical leadership is increasingly recognised (West et al., 2014), in the context of micro-systems (Manley et al., 2011) and across organisations for its potential to deliver common purposes and greater interconnectedness. West et al. (2014) argue for a collective leadership strategy that embraces:

- Skills and behaviours that leaders will bring and develop to shape the culture, including those related to their role
- Collective capabilities of leaders when acting together, including collective learning

Clinical leaders working at the micro-systems level therefore need to be equipped to establish effective teamworking and engaging workplace cultures that are supportive, caring, compassionate and which enable and sustain staff wellbeing, adaptability and creativity. They also need to inspire and motivate others to seek common goals. These abilities are also the basis for effective collective leadership across organisations, when clinical leaders work together, but also inform clinical systems leadership when combined with expertise in using the workplace for learning, development and knowledge translation across the health economy (Manley et al., 2016).

Transformational leadership focuses on individual leaders and complements distributive and collective approaches. It is recognised by a set of behaviours that enable others to become empowered through facilitating them to take on challenges and develop ownership (Sashkin and Burke, 1990) to change and realise their full potential (Sashkin and Rosenbach, 1993).

> 'Transformational leaders are those who stimulate and inspire followers to both achieve extraordinary outcomes and, in the process, develop their own leadership capacity. Transformational leaders help followers to grow and develop into leaders by responding to individual followers' needs by empowering them and by aligning the objectives and goals of the individual follower, the leader, the group, and the larger organisation' (Bass and Riggio, 2006, p 3).

A systematic review performed with a focus on transformational leadership concluded that studies in healthcare provide strong support for transformational leadership theory. The review identified links with staff satisfaction, unit or team performance, organisational climate and staff retention (Gilmartin and D'Aunno, 2007):

Specific enablers of effective workplace cultures at the micro-systems level combine an enabling, collaborative and flattened organisational structure with the individual attributes of transformational leadership, role clarity and the facilitation skills required for engagement that enables others to flourish but this also involves developing others as leaders (Manley et al., 2011; Manley and Titchen, 2016).

Local context
East Kent University Hospitals NHS Foundation Trust (EKHUFT) is one of the largest acute trusts in the UK, providing care to a population of approximately 750,000 in rural, coastal and urban areas. The trust underwent an inspection by the health regulator the Care Quality Commission in March 2014 and was given an overall rating of 'inadequate'. The regulator has the same five questions for all services it inspects, and issues ratings of 'outstanding', 'good', 'requires improvement' or 'inadequate' (Care Quality Commission, 2016). It asks whether a service is:
- Safe
- Effective
- Caring
- Responsive to people's needs
- Well led

The trust's services were deemed inadequate in two of these areas, (safe and well-led). Two areas required improvement (effective and responsive) and only one area (caring) was rated as good.

The regulator's report (Care Quality Commission, 2014) spoke of an organisational culture of low morale and low staff engagement, with staff experiencing bullying and harassment from both other staff and from patients. There was little openness and transparency as staff feared the consequences

of raising concerns, felt disengaged and believed nothing would happen if they did speak up. Overall, staff providing care in the trust did not feel respected, valued, supported, appreciated or cared for.

The organisational leadership style was observed by the regulator as 'top down' and directive. The report noted that the lack of openness discouraged the identification of risk by leaders and hence hindered delivery of safe and effective care. There was mention of poorly developed teamwork, with a lack of clarity in terms of objectives, tasks, roles and membership across the wider organisation. There was limited collaboration and cooperation between teams and departments. The report concluded that improvements in the organisational culture were required. The clinical leadership programme was an initiative that could build capacity and capability in transformational leadership and contribute to a collaborative organisational culture.

The leadership programme
An interdisciplinary clinical leadership programme was introduced across the organisation based on practice development principles (Box 1) to develop clinical leaders at the micro-systems level and to support a collective approach to leadership across the organisation. The aim was to develop a community of transformational leaders and facilitators who could develop and sustain effective workplace cultures that are person-centred, safe and effective. The programme reported here was dedicated to engaging medical doctors, running across nine months and involving participants attending monthly day-long workshops using the workplace as the main resource for learning, development and improvement.

> **Box 1: Practice development methodology**
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> Practice development is a methodology that focuses on systematically developing person-centred, safe and effective cultures that enable everyone to flourish at the micro-systems level. It does this by using approaches that are collaborative, inclusive and participative, and drawing on the workplace as the main resource for learning, development, improvement and inquiry.
>
> The methodology's underlying concepts are active learning and critical creativity, and its underlying assumptions are that people change through addressing crisis and barriers and developing self-awareness about the impact of internal and external factors on their practice. This self-awareness leads to self-empowerment, which in turn enables people to free themselves from the things they take for granted in their everyday practice. The role of critical companions and skilled facilitation in the practice development process is pivotal as it brings high support, high challenge and critical reflection.
>
> Whilst the purpose and impetus for practice development are simple, namely improving care for the users of healthcare in a way that enables all to flourish by working with practitioners and health care teams, its methodology is complex. This complexity stems from working with a number of complementary methodologies and a set of associated methods in a systematic and intentional way.
>
> *Adapted from the nine principles of practice development (Manley et al., 2008; McCormack et al., 2013)*

Action learning (Dewing, 2008; McGill and Beaty, 2006) is a type of active learning and a core workplace learning and development strategy linked to workplace culture and to enabling the skills used to engage and develop others. It focuses on an individual's own effectiveness but also the skills that promote the effectiveness of others (Manley and Titchen, 2016). The workshop days comprised active learning strategies applied to participants' own work in the morning, and in the afternoon participants joined one of two action learning sets. A final celebration event organised by the participants enabled sharing and learning with stakeholders.

The programme introduced participants to tools and methods drawn from practice development, broader theoretical insights about leadership and conceptual clarity between leadership and management. Its main focus is on application of these methods to the participants' own leadership practice and service teams. The philosophy of the programme is based on the principles of adult

learning, self-assessment and co-creation to develop insights and understanding. The evaluation process is rigorous and informs ongoing refinement of the programme, from one workshop to the next through clarifying what matters to participants.

Participants self-assess themselves against:

• The trust's shared purpose competences at the appropriate level of the NHS Careers framework for safe, effective and person-centred care, and effective workplace culture
• Transformational leadership
• Emotional intelligence
• NHS Leadership Academy assessment tools

In addition, participants complete a qualitative 360-degree assessment (Garbett et al., 2007) to inform development of an action plan and reflection about their own leadership development. It is important to emphasise that this approach to 360-degree feedback is based not on achieving anonymised quantitative feedback but is about building relationships and cultures that value the giving and receiving of direct and honest qualitative feedback. This attribute characterises effective workplace cultures (Manley et al., 2011).

During the programme, participants learn how to use and apply the following tools and skills to their own workplaces:

• Claims, concerns and issues – a stakeholder evaluation tool (Guba and Lincoln, 1989) for creating an open workplace culture that celebrates achievement and enables all staff to have a voice (tinyurl.com/video-CCI)
• Values clarification (Warfield and Manley, 1990) – for developing a shared purpose and agreed ways of ways of working
• Observations of practice (McCormack et al., 2009) and emotional touchpoints (Bate and Robert, 2007) – relevant to service users, staff and students, these are powerful tools used in our quality peer review processes
• Developing the facilitation and enabling skills required for role clarity and to help others be effective

The programme focused on participants' own leadership development in the context of their service but also provided an opportunity to collate evidence to support academic accreditation and ongoing professional validation around the wider NHS quality agenda.

To further grow capacity and capability for leadership development across the organisation, a co-facilitator model was used, whereby two experienced leadership facilitators worked with two medical doctor co-facilitators with an interest in growing their expertise in leadership facilitation. One co-facilitator was an anaesthetist and a leadership tutor for newly qualified doctors, the other was a consultant in the healthcare of older people, who had completed an external leadership programme. Two human resource business partners for the organisation also contributed some facilitation support.

In addition, it was important that participants had access to individual support from critical companions who had already developed skills in helping others to challenge their own practice and assumptions and to develop new insights. Critical companions (Titchen and Hammond, 2016) are sophisticated mentors who have the expertise to develop mutual learning relationships based on strategies that help empower people to learn and improve. The participants chose their own critical companions from a list of internal companions or others who were assessed by the participant as being able to provide the high support and high challenge required to enable critique and reflection. Participants agreed how they would work with their critical companions to make sense of their self-assessment data and implement their action plan.

This programme was considered unique for bringing leadership development within a safe environment, linked to the context and challenges clinical leaders face individually and collectively

across one organisation. It offered them opportunities to work collaboratively outside their professional boundaries.

Methods

The programme enabled the participation of 23 medical doctors, who were leading their service, from across specialties including surgeons, specialist physicians, radiologists, pathologists and anaesthetists. A poster outlining the programme, its aims, learning outcomes and underlying approach was circulated widely across the organisation. Successful application was based on a first-come, first-served basis but participants had to be supported by their divisional manager and commit to attending the nine sessions. A total of 18 of the original 23 participants completed the programme.

The programme aimed to help participants use practice development methods systematically to reflect on and inquire into their own practice as leaders. The methods used and analysed were collectively generated, and resulted in datasets that enabled participants to evaluate their own leadership journey, and the facilitators to evaluate the programme (Table 1).

Table 1: Datasets
• **Hopes, fears and expectations for the programme**, which were revisited at the end of the programme
• **Co-constructed insights into what clinical leadership looks like and how to recognise it** and evaluate it through developing and refining a framework for implementing and evaluating clinical leadership across participants' own workplaces and the organisation (see Box 2)
• **Knowing self as a clinical leader.** Self-evaluation provided data based on self-assessment against the organisation's shared purpose framework at the consultant level, alongside transformational leadership behaviours and qualitative 360-degree feedback from own role sets. These data informed a structured reflection and subsequent action plan for leadership development across the programme applied to participants' own workplaces supported by critical companions
• **Claims, concerns and issues tool** generated data about what mattered to participants as leaders and, when used with their teams, what mattered to team members and stakeholders. This exercise always included identifying and celebrating achievements
• **Using tools in the workplace** to provide feedback to other patient-facing teams about their workplace cultures. These tools were primarily used to help participants to explore their potential and enabled participants to fulfil a collective leadership responsibility and to provide direct feedback to other teams in the organisation
• **Reflective reviews** provided summative data from participants' interrogation of their own evidence through a series of reflective questions at the end of the programme, that drew on all the datasets
• **Daily evaluation data** focused on helping participants to be reflective in their leadership journey. At the end of each workshop, evaluation data were analysed and fed back formally to participants at the following workshop. This also enabled fine-tuning of the programme and rigour and transparency in systematic development work
• **Group evaluation** at the end of the programme about what worked in the programme and what needed to change
• **Pre- and post-programme review** of confidence and perceived capability in their leadership and cultural change role.

Findings

The findings are not presented from a conventional stance, although there are data that would inform programme evaluation. This is because this paper aims to share learning and insights from the participants' own experience of their leadership journey, particularly since engaging medical doctors in day-to-day leadership roles had previously been recognised as challenging. Instead, findings are presented at two levels:

1. Synthesised insights from the perspective of five individual participants embracing authentic reflections and insights about different programme aspects
2. A collaborative reflection and collective review of the data emerging from the programme

Individual leadership journeys

The five reflections, written by five different participants in the programme (this study's authors) illustrate different processes and outcomes that were significant and catalytic in their individual journey, but also echoed other participants' feedback from the evaluation data. Each is written in the first person to illustrate individual reflections and insights. The five reflections focus on the following aspects experienced across the programme:

• Peer support and networking
• Developing self as a transformational leader
• Being supported by a critical companion
• Using qualitative 360-degree feedback
• Working with the workplace culture

The first reflection illustrates how the programme enabled the participants to begin to work together in a safe space to help each other with a collective leadership role. Previously this opportunity had not existed and therefore it marks the beginning of an emerging collective leadership culture stemming from the programme.

Illustration 1: Peer support and networking

I originally approached the clinical leadership programme with the desire to improve my leadership abilities and with a very open mind. However, in addition to the training on transformational leadership and the other insights about leadership development, an unexpected benefit, which for me proved one of the highlights of the clinical leadership programme, was the significant amount of peer support and networking that developed.

One of the points that we had raised at the beginning of the programme as a major weakness in our organisation was the presence of silo working.

I found it extremely helpful to meet colleagues, whom I had only known as names at the end of letters. I was able to listen and share their problems and found that a lot of the problems and challenges were the same.

We developed an excellent 'esprit de corps' in the group and we found that even the coffee breaks and lunch breaks at the end of the day were useful. We continued discussing the implications of what we had learned between ourselves, and were able to set up excellent links and to network. Quite a lot of work was done during the lunch breaks with clinical leaders from different sectors. We were able to sit down and explain our problems to each other and find solutions by working together and supporting each other. This enhanced our enthusiasm, which translated to significant improvements at work with better working between departments. We knew whom to speak to in order to get things done and also understood their problems and perspectives. I was not the only one who found this a major benefit to the programme; in fact the networking and peer support that ensued was rated as one of the top three achievements of the programme by practically every participant.

In fact, it was found to be so useful that there was a demand that the group keep its links together and to continue to meet and work together. In addition, I made some strong friendships, which have brought positive benefits not only on the personal side but also with a better working relationship between colleagues.

All in all, I felt that even if I had not learned anything else or achieved anything else on the programme it would have been worthwhile just for the peer support and networking that occurred – although this was just one facet of the programme.

The second reflection illustrates the benefits of the methods used in the programme on one participant, who was focusing on becoming a transformational leader, in terms of their self-awareness, confidence and skills, particularly in addressing toxic behaviours. The ability to re-energise is both an impact of the programme and an outcome of transformational leaders who are able to inspire and motivate others as well as enable others to be leaders.

Illustration 2: Developing self as a transformational leader

Early in the course we spent time assessing ourselves as leaders against a variety of standards, such as the trust's shared purpose framework, and the Kouzes and Posner (2007) self-assessment tool. In spite of previous roles as clinical director and lead clinician, I was surprised at my lack of belief in myself as a leader, and that I lacked specific skills such as praising others enough and sharing a clear common vision with the team.

We also underwent a qualitative 360-degree feedback, which was quite different to the usual electronic consultant 360-degree feedback. It involved obtaining descriptive feedback from a broad range of staff, asking about their perception of our roles, how we could improve and what we did well. This proved to be a helpful and empowering exercise, and I particularly benefited from feedback about sticking clearly to the confines of my role, but also gained confidence in my leadership abilities.

We had a helpful optional session on time management, which included more constructive tips than I have ever come across before. It was important to have this current time management update as it dealt with email communications and IT.

The programme also covered what should have been simple reminders, about only trying to influence an area we really can change/influence. Bizarrely, although this is common sense, this was the first time in my career that anyone had suggested this in a formal way.

Much of the programme was spent practising key styles of interacting with colleagues, such that we moved towards an enabling style of communication, rather than providing solutions and answers – something most consultants have spent their careers doing. We spent afternoons in 'action learning' (McGill and Beaty, 2006), supporting and enabling our fellow colleagues on the course with their most pressing issues, using our new facilitative interviewing styles. It had to be practised, in order to learn, and a variety of self-directed questions were asked, such as what were the external and internal factors impinging on a situation (Johns, 2000).

We also learned skills to change toxic cultures by rehearsing difficult conversations with overbearing members of staff. The ability to change a toxic culture also involves some deep self-reflection, as we learned that sometimes we can effectively collude with difficult colleagues by acting as a buffer in the system, rather than challenging their behaviour or helping to ensure that they receive appropriate feedback (Holloway and Kusy, 2010).

Looking back, what are the gems I am still holding on to in terms of my self-transformation as a leader? The common experience of all consultants and leads on the programme was that their greatest challenge was to deal with 'difficult' colleagues. Realising that this is everybody's struggle, and that I have not been alone in this, has been comforting. It has also given me strength and skills to address such issues. Above all, I am left with energy and enthusiasm to lead on projects I believe in, to take responsibility for my role as a leader and only to try to change areas where I can genuinely make an impact.

Since finishing the clinical leadership programme I have set up trust-wide meetings across the service to provide supervision and training. I used the claims, concerns and issues tool with the team and we are gradually making changes in order to create a more uniform service across the trust.

The next illustration provides real insight into the contribution of a skilled critical companion and how critical companions build supportive, challenging and enabling relationships that foster mutual learning and improvement. The critical companion in this instance was an expert facilitator of practice development, a nurse and midwife who was able to illustrate through her own evidence base the positive impact she had on those she supported and also the subsequent impact on developing effective workplace cultures.

Illustration 3: Being supported by a critical companion

A critical companion in this leadership context is defined as a person who facilitates the clinical lead to unravel their practice, and helps to create knowledge with conceptual connections and apply this to their workbased practices to produce a more effective culture (Titchen, 2001).

This relationship offers robust analysis of the consequences of actions and knowledge gained that is reproducible and applicable to daily practices.

As part of our clinical leadership programme all the clinical leads were advised to choose a companion. In our first meeting after introductions we set up rules and boundaries for our interaction. The principles we adhered to throughout the programme were: trust; confidentiality; high challenge/ high support; and safe environment.

Over the period, this working partnership strengthened with professional respect and willingness to engage. I discussed my leadership role and practices with my companion in a high challenge and high support model. This helped me to understand my own values and beliefs. I was able to see how a shared vision of outcomes evolved. I was able to reflect on the practices that we claimed to be using and how we were performing in reality. This encouraged me to challenge these practices.

I learned how to address the claims, concerns and issues of system users (all stakeholders) through engagement and collaboration. This understanding and reflection on conceptual work is helping me with my role as nutritional lead and national emergency laparotomy audit lead in the trust. I took up this role towards the end of the programme and applied learning from my own practice to improve the service and outcomes through a person-centred approach. It has its own challenges and requires significant collaboration and engagement using a person-centred multidisciplinary approach with a wide variety of specialties, including accident and emergency staff, theatre staff, anaesthetists, critical care and surgical teams.

The leadership required in this role focused on collectively achieving improvement in patient outcomes; 30-day mortality is the primary indicator after emergency laparotomy. In the initial phase of the programme, I performed a claims, concerns and issues exercise with the surgical and anaesthetic teams, who were major stakeholders, to identify potential hurdles in implementing the best practice evidence. I also participated in the 360-degree qualitative feedback and discussed with my critical companion throughout the identified themes to develop an action plan based on my feedback. The high challenge and high support provided by the companion throughout this exercise was valuable to identify my own practices and beliefs and then align them to the shared purpose and person-centred approach to develop an effective workplace culture. As a team, we were able to achieve a mortality percentage in our patients well below the national average for the two years since the programme.

Critical companionship played a very important role in my leadership development by underpinning the knowledge gained through workshops and providing a challenging and supportive environment to reflect on, in the context of my clinical leadership practice.

For the next participant the opportunity to use a qualitative 360-degree tool complemented the benefits from more conventional approaches. The illustration shows how the tool was used to reflect the interprofessional relationships required for contemporary healthcare leadership and also demonstrates that it is possible to achieve honest and direct feedback in an open and transparent way in the workplace without its having to be anonymised.

Illustration 4: Using qualitative 360-degree feedback

Early in the programme, we each undertook a qualitative 360-degree feedback with members of our role set (all the groups we interface with on a frequent basis, for example see Figure 1), who were invited by email to provide feedback in ways that were convenient to them using the following four questions (Garbett et al., 2007):

- *What is your understanding of my role as a leader?*
- *What have you experienced that I do well in my role?*
- *What feedback can you provide me about how I could become more effective in my role?*
- *What other feedback would you like to provide me?*

I chose senior colleagues including the lead commissioner, the matron, the ward manager, consultant colleagues, Patient Association lead and the main academic partner from the university. We were encouraged to ask for direct and honest feedback as this quality is a characteristic of effective workplace cultures.

The process emphasised the purposes of development but allowed comments on performance aspects. Similarly, it encouraged me to reflect on any discrepancy between my self-evaluation and the perceptions of other leaders. The context was set at the outset by engaging the perception of the person providing feedback about my role as a leader. The latter not only provides a reference point any further comments from the feedback, but crucially identified any omission on my part when communicating details of my roles and identities.

Since I have been regularly interacting with these colleagues for several years, they managed to identify and articulate my diverse clinical and strategic roles; the open and transparent nature of the process did not dissuade anyone asked to contribute. They were fairly consistent in commenting on the skills, behaviours and belief system, often drawing on recently observed behaviours. The attributes they focused on include developing a shared vision, enabling, inspiring, developing trust, loyalty to team, and drive for innovation and change. This strengthened my morale and resolve and also identified gaps in self-appraisal, for example: 'I thought I could sustain a relentless expansion into international research programmes even within the finite time'. I definitely will curb such enterprises and seek to delegate more. The insight into my colleagues' perceptions of my roles and identities will facilitate my future collaboration with them.

This qualitative 360-feedback was different to the one that I undertook a year ago for the professional revalidation required of medical doctors by the UK General Medical Council, and complemented more conventional approaches (Fleenor and Prince, 1997). That process had the advantage of comparing self-evaluation with feedbacks in a Likert scale. However, it was my fellow consultants who provided feedback on a range of attributes on which a doctor is viewed through the prism of the General Medical Council (GMC). However, in real life, service delivery requires working with multidisciplinary professionals. This process focused on leadership aspects only. This 360-feedback has provided a valuable insight to help me formulate a plan for my journey in my clinical leadership role. I will recommend this to all aspiring leaders.

Figure 1: Role set identified for qualitative 360-degree feedback

The final individual reflection shows how using a range of tools with insight and knowledge help develop leadership capability and address toxic behaviour. Working with feedback from staff to make improvements exemplifies staff engagement and, together with the role modelling transformational leadership is linked to positive changes in workplace culture.

Illustration 5: Working with own workplace culture

One of the main aims of the East Kent shared purpose framework is to develop effective workplace cultures and teams. The programme was designed to transform the culture of the trust by developing a number of people with the transformational leadership skills to build the required workplace culture at the micro-systems level. Effective cultures at this level include the values of person-centredness, effectiveness and joint working towards a shared vision. We were taught that transforming culture is a challenging journey that can take years to achieve and requires resilience, long-term commitment and systems of high support and high challenge. Reflection on our own behaviours, those of other members of staff and mentoring were key to the programme to provide this level of support and challenge. (Manley et al., 2014).

We were taught to recognise disruptive and toxic behaviours. Toxic behaviours can easily develop in the highly stressful environment of healthcare, especially with the cultural shift from a paternalistic physician-dominated culture to a team-based approach (Holloway and Kusy, 2010). The types of toxic behaviour include shaming, passive hostility and team sabotage. We learned that toxic individuals are often protected by toxic protectors and toxic buffers. The toxic protector has something to gain from the toxic individual such as a special social relationship, their productivity or unique expertise, whereas the toxic buffer wants to protect the team from the toxic individual's behaviour. Toxic protectors and buffers make it difficult for those in authority to be aware of the issue and take action, thereby perpetuating the problem. Toxic individuals have disastrous effects

on organisations, with victims reporting decreased effort at work and being likely to leave the organisation (Holloway and Kusy, 2010). Direct feedback needs to be given to the toxic protectors and buffers to help them recognise their roles in reinforcing the toxic behaviour. Giving feedback directly to the toxic individual has been found to be ineffective as they are not always aware that they are disruptive (Holloway and Kusy, 2010).

I was particularly interested in developing a better workplace culture; working in a non-patient facing department I felt this was the best way to improve patient care. We developed a staff job satisfaction survey as an initial measure of the culture. Then two 'Better Place to Work' workshops were held, involving approximately half of the department, with support staff, non-medical and medical staff represented. This led to the development of a shared vision and an improvement project was started to address the issues staff had raised in the survey and the workshops. Investment in more staff and equipment and several quality improvement projects have followed, where staff actually doing the job were empowered to come up with solutions and work on them. We are working on developing a 'no blame' culture, where staff are encouraged to report incidents, concentrating on system failures and lessons to be learned, while also challenging negative behaviour. Communication is also improved by daily staff huddles. I try to model leadership by asking for help so others also feel able to do so, sharing my mistakes, reporting incidents, asking for ideas and thanking staff for their efforts. However, I do agree with Swallow's (2007) sentiments, that changing organisational culture is the 'toughest task you will ever take on' (p 8), which entails the 'need to develop emotional intelligence' (p 20) and to 'delegate as much as you can' (p 21).

Collaborative insights about leadership development for clinical leads
The programme helped us to identify the impact of leadership on our workplace cultures and to embed ways of working that are collaborative, inclusive, participative and celebratory. As we were able to produce a safe environment of peer support through action learning, we developed the skills for providing high support and high challenge to enable others to be effective in the workplace.

Collaborative reflections and learning from the programme data took into consideration the fact that only 18 of the original 23 participants completed the programme. Also recognised was a variable degree of scepticism among participants about the programme and its methods and concepts, particularly at the beginning. Withdrawal was accounted for by clinical commitments and time constraints, as well as difficulty engaging with the concepts underpinning the programme, which were experienced as alien to clinical practice. No other reasons were identified for withdrawal.

Those remaining, experienced a programme that met what some described as a 'craving' for peer support and networking. We recognise this important outcome is essential for sustaining support for development and for positive morale. An internal model that seeks to grow capacity was identified as a unique feature of the programme by participants, which contributed to growing leadership capacity for our contexts, as well as a collective approach.

Despite the initial scepticism, those who persevered with participation have observed that a disciplined approach to our own learning and self-management has been developed. We started to enjoy the action learning and other programme activities.

We began to feel a sense of team ethos and community cohesion. We recognised for the first time that we were in a safe environment, where we could look at our practice collectively. It had been a long time since we had felt valued. We appreciated the investment in us by the organisation and the opportunity to 'step out', and felt that the organisation recognised us as leaders who could change the culture. We also felt that we had discovered the person in ourselves and others – the person behind the clinician:

> *'Meeting in the clinical leadership programme is not only about networking, it is about discovering the person behind the clinician, because in rediscovering the person, in discovering ourselves, we create the ethos of the organisation… the organisation becomes us'* (Participant reflective review).

The clinical leadership programme instilled a sense of shared purpose and values in us. The tools we learned to use helped us to become more aware of our role as leaders. We have a greater understanding of our leadership roles within the organisation and of the opportunities to break down barriers and silos. We also developed confidence and a greater understanding about how we are as leaders individually but also that we are collectively stronger when we work together as a group.

We felt a 'back to basics' approach combined with the use of self-assessment is a powerful tool for achieving engagement and self-transformation. The programme's combination of confidentiality and safety created trust, enabling transparency, high challenge and high support.

We do recognise, however, that only a few of the participants had access to the highest-quality critical companionship. The skills of the best critical companions are highly valuable and we note the need to increase the number of mentors who can undertake this role.

As part of our celebration event at the end of the programme, we invited leaders from other partnership organisations and were able to agree on the need to develop and share a common approach and robust dialogue across the health economy. Leadership continues to be a strong theme for the organisation and learning continues.

Consideration of the external influences and research has enabled us to appreciate that our leadership roles are not just linked to the clinical contexts in which we work, but also to the organisational and systems contexts in which we are situated. In addition, leadership development needs to focus not just on technical competencies, but also on the ability to create climates in which individuals can themselves act to improve services and care, as illustrated below in statements outlining how far the participants had come in terms of engaging their team.

> *'Improved team cohesion, better communication, strategies for service development by being more inclusive and mindful, having already presented emotional touchpoints and will promote a lot of data at our networking meeting. We've done a job satisfaction survey which we will repeat in six to 12 months to have the evidence but the involvement of the staff in the service development project is also evidence'* (Participant reflective review).

> *'Have used some of the concepts learned during the course to benefit staff and service users. This includes: running claims, concerns and issues; being more open to listening to others; allowing time for reflection rather than "firing from the hip"; improved communication; courage to raise concerns; and empowering staff in their work'* (Participant reflective review).

A clinical leadership framework, an output from the programme, was co-created and refined by participants as they underwent their journey and embraced different aspects of the programme. The insights were developed over the programme and the fact that this is the fourth version of the framework shows that it was revisited several times to include these insights, and reflects how participants made sense of clinical leadership by the end of the programme, based on understanding clinical leadership as a concept: its attributes, enabling factors and consequences and what it means to them (Table 2).

Table 2: Co-created leadership framework, fourth version		
ENABLING FACTORS **What has to be in place?**	**ATTRIBUTES** **How would you recognise it?** **(ACTION VERBS)**	**CONSEQUENCES** **What are the consequences?**
INDIVIDUAL • Caring • Respect • Flexibility • Integrity • Accessible • Tolerance • Understand self and others – insight • Clinical credibility ***Resilience qualities*** • Presence • Brave • Persevere • Decisive • 'Accept failures' as shared responsibility **TEAM** • Vision • Common goal • Effective team and team culture **ORGANISATION** • Empowerment of leaders • Time and money • Organisational support • Person-centred qualities for leadership • Personable • Financial stability • Clear transparent strategy	**LEADERSHIP BEHAVIOURS** • Developing a shared vision and direction • Developing and working to an explicit team identity/purpose and priorities • Leading by example/ role modeling / True to word/being transparent **WORKING COLLABORATIVELY AS A TEAM** • Enabling two-way communication • Listening, negotiating, responding • Enabling everyone to be a team player • Problem solving together • Celebrating successes **ENABLING OTHERS** • Empowering, inspiring and motivating • Challenging/inquiring • Supporting • Being helpful • Giving and receiving • Tackling difficult situations	**IMPROVEMENT IN ANY MEASURABLE OUTCOME** ***Individual patient level*** • Health outcome • Patient experience ***Individual staff level*** • Job satisfaction • Improved morale and motivation • Flourishing staff • Worklife balance ***Team/service level*** • Objectives/goals achieved • Action plan implemented • Safety culture • Increase in training • Recruitment and retention of staff • Responsive and proactive • Innovation development • Team happiness and cohesion ***Organisational level*** • Improvements in cost effectiveness • Positive local and national reputation

Discussion
This discussion focuses on making sense of the experiences of participants in the programme, which aimed to engage and develop medical doctors as clinical leaders, and build capacity and capability in clinical and collective leadership across the organisation.

Wilson (2013) argues there is no right way to support clinical leadership but that it is important to meet three criteria:
• Provide time and space for leaders to explore and agree collective solutions
• Work through what clinical leadership looks like for the organisation
• Achieve role clarity

Each of these is evidenced in the findings. Illustration 1 and the collaborative reflection describe how time was valued for networking and peer review with investment. Table 2 identifies time for leadership as a key enabler, but one often not previously experienced in day-to-day work. The co-created framework shown in the table also shows evidence of how staff thought about the second of Wilson's criteria – making sense of what clinical leadership means – over the course of the programme, based on their experiences and insights of their own journeys. This challenges the lack of a clear definition of clinical leadership noted by the BMA (2012). Illustration 4 illustrates Wilson's third criteria through the individual impact of the qualitative 360-degree tool. Role clarity is an individual enabler for developing effective workplace culture at the micro-systems level (Manley et al., 2011). Linked to role clarity is self-awareness – this is a key intention when using practice development, reflection and action learning strategies, as well as the self-assessment tools, with support from critical companions. The title of this paper articulates the realisation that becoming a clinical leader requires self-awareness and emotional intelligence for transformation, this is evidenced particularly in illustrations 3-5, but further endorsed in person-centred values, and the importance of 'knowing the person behind the clinician'.

The British Medical Association (2012) argues for clinical credibility as an enabler for clinical leadership but, interestingly, this was not mentioned by participants, although clinical credibility has been identified as a prerequisite for clinical systems leadership (Manley et al., 2016).

The framework in Table 2 articulates the behaviours expected of transformational leaders as attributes of clinical leadership. These are not just espoused but are aspired to, developed and evidenced explicitly in illustrations 2 and 5 in the gritty reality of practice.

A focus on engagement of teams and collaboration is evidenced in the fifth illustration but also in the activities undertaken by participants in their workplace, where they were applying their skills to make the workplace the main resource for learning, development and improvement as well as drawing on the concept of social leadership, where leadership is awarded by the communities the leaders serve rather than by position and hierarchy (Stodd, 2016).

Collective leadership, a concept promoted by the Kings Fund (West et al., 2014) and social leadership, – taking collaborative responsibility for leadership across the organisation – were demonstrated in illustration 1 with examples of how this resulted in working together across disciplines and sites, something not experienced before. This is the strength of a leadership programme focused in one organisation or locality – its potential to provide greater benefits than the policy of sending individuals from different organisations to attend national programmes and then return as sole agents to the same culture as before.

Where participants experienced high-quality critical companions there was evidence of significant impact as in illustration 3, which also demonstrates the humility that comes from mutual and authentic opportunities for learning collectively. However, some participants were unable to access a critical companion with the requisite skill set and this may partly account for withdrawals from the programme. The concept of critical companionship is complex and different from coaching and mentorship, which are goal driven, but it is a key approach to empowerment, inspiration and mutual learning for effectiveness as a clinical and collective leader (Titchen and Hammond, 2016). The participants involved in the programme will now be available as critical companions to others, and this is an approach to growing capacity and capability to learn, locally in the moment of practice. However, the incremental steps to developing full critical companionship may be helped by focusing on the precursors of being a critical ally, and then critical friend, thus developing the increasingly complex skills required for the full critical companionship skillset (Hardiman and Dewing, 2015).

Revisiting the feedback provided to the trust by the Care Quality Commission, which referred to a 'top-down' culture with poor staff engagement, bullying and poor team work leading to ineffective

and unsafe care, it is clear to see that the participants' journeys and the outcomes are beginning to tell a different story, one that counters these organisational characteristics and suggests a more optimistic future. The participants have shown not just increasing self-awareness and the ability to engage others, but also that they can facilitate effective teams and ways of working, and work collectively as leaders towards a different vision – one where the shared values and purposes of the organisation begin to become a reality. This focus is one of social leadership, where leadership is accorded by the communities that they work in and with (Stodd, 2016), and reflect the growing connectedness articulated by Hartmann et al. (2009) that is required.

This is a unique, innovative approach to leadership development in one organisation, which focuses on transforming individuals, in order to develop a person-centred, safe and effective workplace culture. The use of practice development methodology combined with concepts of clinical leadership has been shown to offer a positive route to enabling and growing self-awareness, empowerment, teamwork, and shared values in the workplace. However, it has been a hard journey, and one that not everyone was able to complete. Improvements in the programme, such as focusing on a specific initiative, may have helped participants with the application of the tools and processes in the workplace. Also, access to skilled critical companionship for all may have made the journey a little easier.

Early research with allied health practitioners in Australia using a similar programme underpinned by practice development approaches has begun to demonstrate a significant difference between participants when compared with those that access standard leadership provision. Among participants who have learned to use practice development approaches there is evidence of progress in workplace measures, person-centred approaches, transformational leadership and engagement (Bradd, 2016).

Conclusion and practice implications

The programme aimed to develop and engage medical doctors in clinical and collective leadership. The conclusions are that a clinical leadership programme based on practice development methodology combined with clinical leadership concepts such as transformational leadership can have a positive impact on participants in their role as clinical leaders. This is brought about through growing the self-awareness, motivation and skills required to change culture at the micro-systems level. Such a change promotes aspiring to, and living, person-centred values and purposes in the tough environment of day-to-day practice, as well as engaging others in this process through co-creation, collaboration, inclusion and participation.

Collective leadership is also an outcome of the programme, related to improved cross-organisational opportunities for networking and peer support.

The programme's practice development concepts of active and action learning, reflection on one's own effectiveness, facilitating the effectiveness of others and engaging team members were experienced as alien and challenging at the beginning of the programme. Perseverance led to participants becoming more disciplined in their own learning and more confident in the use of the new skills and tools, based on understanding themselves and others from the perspective of the person behind the clinician.

Creating a safe space and time to reflect and meet communally is pivotal to the clinical leadership programme's impact, and critical companionship augments the outcomes for the individual. Growing clinical leaders and critical companions internally helps organisations quickly begin to grow their capacity and capability for leadership development. The NHS faces growing demand, in part associated with an ageing population and insufficient numbers of doctors and nurses, and requires new ways of delivering health services. Its transformation to meet contemporary healthcare needs is dependent, in part, on enabling clinical leaders to transform themselves. This journey of transformation starts with discovering and developing self.

References

Bass, B. and Riggio, R. (2006) *Transformational Leadership.* Mahwah, New Jersey: Lawrence Erlbaum Associates.

Bate, P. and Robert, G. (2007) *Bringing User Experience to Health Care Improvement: The Concepts, Methods and Practices of Experience-Based Design*. Oxford: Radcliffe.

Bennis, W. (2007) The challenges of leadership in the modern world: an introduction to the special issue. *American Psychologist*. Vol. 62. No. 1. pp 2-5. doi: 10.1037/0003-066X.62.1.2.

Berwick, D., Nolan, T. and Whittington, T. (2008) The triple aim: care, health and cost. *Health Affairs*. Vol. 27. No. 3. pp 759-769. doi: 10.1377/hlthaff.27.3.759.

Bradd, P. (2016) *Building Capacity and Capability: Developing Allied Health Leaders to Enhance Person-centred Health Care.* Enhancing Practice Conference. Unearthing the Architecture of Practice Patterns, Queen Margaret University, Edinburgh.

British Medical Association (2012) *Doctors Perspectives on Clinical Leadership.* London: Health Policy and Economic Research Unit. Retrieved from: tinyurl.com/BMA-clinical-lead (Last accessed 5th October 2016).

Care Quality Commission (2014) *East Kent Hospitals University NHS Foundation Trust: Quality Report*. CQC. Retrieved from: tinyurl.com/CQC-EKHUT (Last accessed 3rd September 2016).

Care Quality Commission (2016) *CQC's Strategy 2016-2021. Shaping the Future: Consultation Document.* Newcastle: Care Quality Commission.

Clark, J. and Nath, V. (2014) *Medical Engagement: A Journey not an Event.* London: King's Fund.

Dawson, J., West, M., Admasachew, L. and Topakas, A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data.* London: Department of Health.

Dewing, J. (2008) Becoming and being active learners and creating active learning workplaces: the value of active learning in practice development. Chp 14 *in* Manley, K., McCormack, B. and Wilson, V. (2008) (Eds.) *International Practice Development in Nursing and Healthcare*. pp 273-294. Oxford: Blackwell.

Drath, W., McCauley, C., Palus, C., Van Velsor, E., O'Connor, P. and McGuire, J. (2008) Direction, alignment, commitment: toward a more integrative ontology of leadership. *The Leadership Quarterly*. Vol. 19. No. 6. pp 635-653.

Fleenor, J. and Prince, J. (1997) *Using 360-Degree Feedback in Organizations: An Annotated Bibliography*. Greensboro, North Carolina: Centre for Creative Leadership. Retrieved from: tinyurl.com/Fleenor-Prince (Last accessed 20th May 2016).

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery Office.

Garbett, R., Hardy, S., Manley, K., Titchen, A. and McCormack, B. (2007) Developing a qualitative approach to 360-degree feedback to aid understanding and development of clinical expertise. *Journal of Nursing Management*. Vol. 15. No. 3. pp 342-347. doi: 10.1111/j.13652834.2007.00692.x.

Gilmartin, M. and D'Aunno, T. (2007) Leadership research in healthcare: a review and roadmap. *Academy of Management Annals.* Vol. 1. No. 1. pp 387-438.

Guba, E. and Lincoln, Y. (1989) *Fourth Generation Evaluation.* Newbury Park, California: Sage.

Ham, C. (2003) Improving the performance of health services: the role of clinical leadership. *The Lancet.* Vol. 361. No. 9373. pp 1978-1980. doi: 10.1016/S0140-6736(03)13593-3.

Hardiman, M. and Dewing, J. (2015) Critical ally and critical friend: stepping stones to facilitating practice development. *International Practice Development Journal.* Vol. 4. No. 1. Article 3. Retrieved from: fons.org/library/journal/volume4-issue1/article3 (Last accessed 5th October 2016).

Hartley, J. and Benington, J. (2011) *Recent Trends in Leadership Thinking and Action in the Public and Voluntary Service Sector*. Retrieved from: tinyurl.com/KF-leadership-trends (Last accessed 5th October 2016).

Hartmann, C., Meterko, M., Rosen, A., Zhao, S., Shokeen, P., Singer, S. and Gaba, D. (2009) Relationship of hospital organizational culture to patient safety climate in the Veterans Health Administration. *Medical Care Research and Review.* No. 66. No. 3. pp 320-338. doi:10.1177/1077558709331812.

Holloway, E. and Kusy, M. (2010) Disruptive and toxic behaviours in healthcare: zero tolerance, the bottom line, and what to do about it. *Medical Practice Management.* Vol. 25. No. 6. pp 335-340.

Hong, Y., Liao, H. and Jiang, K. (2013) Missing link in the service chain: a meta analytic review of the antecedents, consequences and moderators of service climate. *Journal of Applied Psychology.* Vol. 98. No. 2. pp 237-267. doi: 10.1037/a0031666.

Johns, C. (2000) *Becoming a Reflective Practitioner.* Oxford: Blackwell Science.

King's Fund (2011) *The Future of Leadership and Management in the NHS: No More Heroes*. London: The King's Fund.

Kouzes, J. and Posner, B. (2007) *The Leadership Challenge.* (4th Edition). San Francisco: Jossey-Bass

Laschinger, H. and Leiter, M. (2006) The impact of nursing work environments on patient safety outcomes: the mediating role of burnout/ engagement. *Journal of Nursing Administration*. Vol. 36. No. 5. pp 259-267.

Maben, J., Peccei, R., Adams, M., Robert, G., Richardson, A. and Murrells, T. (2012) *Patients' Experiences of Care and the Influence of Staff Motivation, Affect and Wellbeing. Final Report. NIHR Service Delivery and Organisation Programme*. Retrieved from: tinyurl.com/Maben-NIHR (Last accessed 3rd September 2016).

Manley, K., McCormack , B. and Wilson, V. (2008) Introduction *in* Manley, K., McCormack, B. and Wilson, V. (2008) (Eds.) *International Practice Development in Nursing and Healthcare*. pp 1-16. Oxford: Blackwell.

Manley, K., Sanders, K., Cardiff, S. and Webster, J. (2011) Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Practice Development Journal.* Vol. 1. No. 2. Article 1. Retrieved from: fons.org/library/journal/volume1-issue2/article1 (Last accessed 5th October 2016).

Manley, K., O'Keefe, H., Jackson, C., Pearce, J. and Smith, S. (2014) A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology. *International Practice Development Journal.* Vol. 4. No. 1. Article 2. Retrieved from: fons.org/library/journal/volume4-issue1/article2 (Last accessed 5th October 2016).

Manley, K., Martin, A., Jackson, C. and Wright, T. (2016) Using systems thinking to identify workforce enablers for a whole systems approach to urgent and emergency care delivery: a multiple case study. *BMC Health Services Research.* Vol. 16. p 368. doi: 10.1186/s12913-016-1616-y.

Manley, K. and Titchen, A. (2016) Facilitation skills – the catalyst for increased effectiveness in consultant practice and clinical systems leadership. *Education Action Research.* Vol. 24. No. 2. pp 1-24.

McCormack, B., Henderson, E., Wilson, V. and Wright, J. (2009) Making practice visible: the workplace culture critical analysis tool (WCCAT). *Practice Development in Health Care.* Vol. 8. No.1. pp 28-43. doi:10.1002/pdh.273.

McCormack, B., Manley, K. and Titchen, A. (2013) Introduction *in* McCormack, B., Manley, K. and Titchen, A. (2013) (Eds.) *Practice Development in Nursing and Healthcare*. pp 1-17. (2nd edition) Oxford: Blackwell.

McGill, I. and Beaty, L. (2006) *Action Learning: A Guide for Professional Management and Educational Development*. (2nd edition) London: Routledge.

Nelson, E., Batalden, P., Huber, T., Mohr, J., Godfrey, M., Headrick, L. and Wasson, J. (2002) Microsystems in health care: Part 1. Learning from high-performing front-line clinical units. *Joint Commission Journal on Quality Improvement.* Vol. 8. No. 9. pp 472-493.

Paparella, G. (2015) *Understanding Staff Wellbeing, its Impact on Patient Experience and Healthcare Quality*. Oxford: Picker Institute Europe.

Prins, J., Hockstra-Weebers, J., Gazendam-Donofrio, S., Dillaingh, G., Bakker, A., Huisman, M., Jacobs, B. and Heijden, F. (2010) Burnout and engagement among resident doctors in the Netherlands: a national study. *Medical Education*. Vol. 44. No. 3. pp 236-247. doi: 10.1111/j.1365-2923.2009.03590.x.

Pslek, P. and Wilson, T. (2001) Complexity, leadership, and management in healthcare organisations. *BMJ*. Vol. 323. No. 7315. pp 746-749.

Sashkin, M. and Burke, W. (1990) Understanding and assessing organisational leadership. *In* Clark, K. and Clarke, M. (1990) (Eds.) *Measures of Leadership*. New Jersey: Leadership Library of America/ Centre for Creative Leadership.

Sashkin, M. and Rosenbach, W. (1993) A new leadership paradigm. *In* Rosenbach, W. and Taylor, R. (1993) (Eds.) *Contemporary Issues in Leadership.* (3rd edition). pp 87-108. Oxford: Westview Press.

Schneider, B., Ehrhart, M., Mayer, D., Saltz, J. and Niles-Jolly, K. (2005) Understanding organization-customer links in service settings. *Academy of Management Journal*. Vol. 48. No. 6. pp 1017-1032.

Schneider, B. and Barbera, K. (2014) *The Oxford Handbook of Organizational Climate and Culture*. New York: Oxford University Press.

Stodd, J. (2016) *The Social Leadership Handbook.* (2nd edition). California: Smashwords.

Storey, J. and Holto, R. (2013) *Towards a New Model of Leadership for the NHS.* London: Open University Business School.

Swallow, D. (2007) *Creating Culture Change: White Paper.* Retrieved from: tinyurl.com/Swallow-culture (Last accessed 22nd May 2016).

Titchen, A. (2001) Critical companionship: a conceptual framework for developing expertise. Chp 10 *in* Higgs, J. and Titchen, A. (2001) (Eds.) *Practice Knowledge and Expertise in the Health Care Professions.* pp 80-90. Oxford: Butterworth Heinemann.

Titchen, A. and McCormack, B. (2010) Dancing with stones: critical creativity as methodology for human flourishing. *Educational Action Research.* Vol. 8. No. 9. pp 531-554. doi: 10.1080/09650792.2010.524826.

Titchen, A. and Hammond, K. (2016) Helping health-care practitioners to flourish: critical companionship at work. Chp 11 *in* McCormack, B. and McCance T. (2016) (Eds.) *Person-centred Practice in Nursing and Health Care.* (2nd edition). pp 162-171. Oxford: Wiley-Blackwell.

Turnbull James, K. (2011) *Leadership in Context: Lessons from New Leadership Theory and Current Leadership Development Practice.* London: King's Fund. Retrieved from: tinyurl.com/KF-turnbull-james (Last accessed 5th October 2016).

Warfield, C. and Manley, K. (1990) Developing a new philosophy in the NDU. *Nursing Standard.* Vol. 4. No. 41. pp 27-30.

West, M., Steward, K., Eckert, R. and Pasmore, B. (2014) *Developing Collective Leadership for Healthcare*. Retrieved from: tinyurl.com/KF-west (Last accessed 5th October 2016). London: King's Fund.

West, M., Armit, L., Eckert, R., West, T, and Lee, A. (2015) *Leadership and Leadership Development in Health Care: The Evidence Base.* London: King's Fund. Retrieved from: tinyurl.com/KF-west-evidence (Last accessed 5th October 2016).

Wilson, K. (2013) How to be an effective clinical leader. *Health Services Journal.* 26 June 2013. Retrieved from: tinyurl.com/HSJ-wilson (Last accessed 5th October 2016).

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