ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Guiding lights for effective workplace cultures that are also good places to work

Shaun Cardiff*, Kate Sanders, Jonathan Webster and Kim Manley

*Corresponding author: Fontys University of Applied Sciences, Eindhoven, Netherlands
 Email: s.cardiff@fontys.nl

Abstract

Background: Working environments and relationships influence healthcare workers' satisfaction and intent to stay, as well as service-user outcomes. With staff shortages a global issue, co-creation of effective workplace cultures that are also good places to work is more important than ever. Since our original research in 2011, a growing body of theoretical insights into workplace cultures has shown how complex it can be to develop them. We were curious about what staff felt works or what is needed.

Aim: To develop a guiding theory with and for healthcare practitioners on effective workplace cultures in settings that are also good places to work.

Methods: A three-phase study was used, based on principles of appreciative inquiry and realist evaluation. A blog generated initial interest, followed by a Twitter chat posing provocative questions. A series of Context-Mechanism-Outcome (CMO) configurations emerged and were presented to a new audience during an international conference. Endorsements and additions enabled further refinement of the initial programme theories, which were again presented for reflections during a second Twitter chat. Subsequent analysis resulted in a realist programme theory ready for further testing in practice.

Findings/results: There are four guiding lights for co-creating effective workplace cultures in settings that are also good places to work: collective leadership; living shared values; safe, critical, creative learning environments; and change for good that makes a difference. When each is given adequate attention and all are combined, the ultimate outcomes include: high-performing teams that flourish and provide person- and relationship-centred care that is safe, effective and independent of the agency of specific individuals; and teams that develop effective partnerships within and across boundaries.

Conclusions: Based on the voices of international frontline healthcare staff, we propose the retention of staff committed to providing care valued by staff and service users can be achieved by: collective leadership; living shared values; safe, critical, creative learning environments; and change for good as determined by those providing and experiencing care.

Implications for practice:

- Healthcare managers, leaders and commissioners need to recognise and support microsystem culture development that staff and service users experience as good and safe
- Workplace culture development should be continuous, collaborative, inclusive and participatory, and driven by staff and service-user experiences, not top-down action planning and box ticking
- Responsive and person-centred leadership enables effective workplace cultures and collective leadership

Keywords: Workplace culture, programme theory, social media, realist evaluation, appreciative inquiry, outcomes

Introduction
The shortage of healthcare workers stretches across many continents. Despite some improvement, the World Health Organization's European office has warned there are still insufficient physicians and nurses to sustain stable care for an ageing population (WHO, 2020). In a survey of nurses across 12 European countries, more than one in five overall were dissatisfied with their jobs and significant numbers expressed the intent to leave (Aiken et al., 2013). While policy and strategies at national and local levels can help recruitment into the healthcare workforce, focus is also needed on retention. Several factors are known to influence satisfaction and retention, including the working environment, relationships and conditions. While organisational culture has received much attention in research, it has been argued that we need to focus more on (workplace) cultures at the microsystems level as these have an immediate and lasting influence on staff and service users' experiences (Manley et al., 2011). Manley and colleagues (2019) demonstrated that attention to patterns driving multi-professional thinking and behaviour within the workplace is required for sustainable improvements to recruitment, retention and organisational effectiveness. The study reported in this article builds on previous theory about workplace cultures and how to develop them (Manley et al., 2011).

Theories on workplace culture
Practice development is the methodology that offers a set of principles for guiding the study's focus on workplace culture, and is defined as:

> *'A continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individuals and team practices. This is sustained by embedding both processes and outcomes in corporate strategy'* (McCormack et al., 2013, p 8).

Developing safe, person-centred and evidence-informed care at the microsystems level is a particular focus of practice development as this is where staff and service users meet and care is experienced and provided. Practice development approaches also recognise that this focus requires structures and processes at the mezzo- and macro-systems levels, as well as systemwide skilled facilitation. Skilled facilitators use the workplace and active learning to enable the flourishing of all as they aim to create person-centred cultures (Dewing, 2008). The three core methodological principles guiding practice development are collaboration, inclusion and participation (Manley et al., 2008).

In 2011 we conducted a literature-based concept analysis of effective workplace culture (EWC; Manley et al., 2011), generating a theory that describes and explains the attributes of such a culture, how it is developed and its subsequent impact. EWCs were defined as local workplaces with a focus on providing effective care using person-centred, collaborative, inclusive and participatory ways of working. Three clusters of values (person-centredness, working with others, and effective care, including holistic safety) are experienced by staff and service users, embodied by staff and embedded in formal systems of evaluation, learning and development. The culture is enabled by transformational leaders, skilled facilitation, role clarity, organisational readiness and a flat and transparent management structure, as well as a supportive human resource department.

Subsequent research has built on the concept analysis, enhancing understanding of the enablers. For instance, McCance et al. (2013) discuss the need for individuals and teams to be ready to engage in developing EWCs, which may initially require the development of attributes that enable staff to engage in core person-centred processes and create healthful environments. Cardiff et al. (2018) and Lynch et al. (2017) highlight the importance of (clinical and managerial) leaders embracing and embodying person-centredness so as to lead person-centred practice and the flourishing of staff effectively.

Findings from a regional patient safety initiative, using practice development methodology with realist evaluation, enabled further refinement of how workplace cultures are recognised and developed,

with a particular focus on safety (Manley and Jackson, 2019). The study developed three programme theories relevant to workplace culture (see Box 1). Programme theories are the product of realist evaluation and explain how and why an intervention works (Manley et al., 2019). Many of the findings endorsed the earlier concept analysis (Manley et al.,2011), as well as offering refinements such as proposing the integration of the three clusters of 10 core values (see Figure 1). This is based on the contention that it is the integration and living of the values that contribute to the outcomes, in particular service users and staff experiencing person-centred relationships and their beneficial impact on holistic safety. Also, the 2019 study adds an appreciative approach to the value of lifelong learning, and to the formal systems of evaluation, development, improvement and stakeholder participation. The individual enablers of transformational leadership and skilled facilitation are expanded to specify clinical leadership, and refined by leaders and facilitators engaging staff in the co-creation of meaning and shared purpose. The organisational enabler of leadership is refined to become collaborative and authentic senior leadership accompanied by an organisational focus on supporting bottom-up change and supported by human resources recruiting for shared values. In terms of outcomes, EWCs are now proposed as enabling high-performing, self-directing teams with continuous development, improvement and innovation in practice linked to service-user needs.

Box 1: Programme theories of safety culture (Manley and Jackson, 2019).

Programme theory 1 proposes that frontline teams have a positive impact on patient and staff experience by: working towards a safety culture and quality clinical leadership via team development; living the core values of person-centredness, safety and learning; and developing a sense of shared meaning, direction and behaviour.

Programme theory 2 proposes that skilled facilitators upholding the core values while working with frontline teams will enable them to reflect, learn and co-create meaning, as well as feel supported, engaged and empowered to achieve systematic improvement customised to specific contexts.

Programme theory 3 proposes that senior/executive management and leaders demonstrating commitment and modelling strong organisational values will enable optimal and sustainable integrated systems for learning, development and improvement, as well as facilitator support and capacity building.

Figure 1: Transition of 10 core values in three clusters, from Manley et al. (2011) to Manley and Jackson (2019)
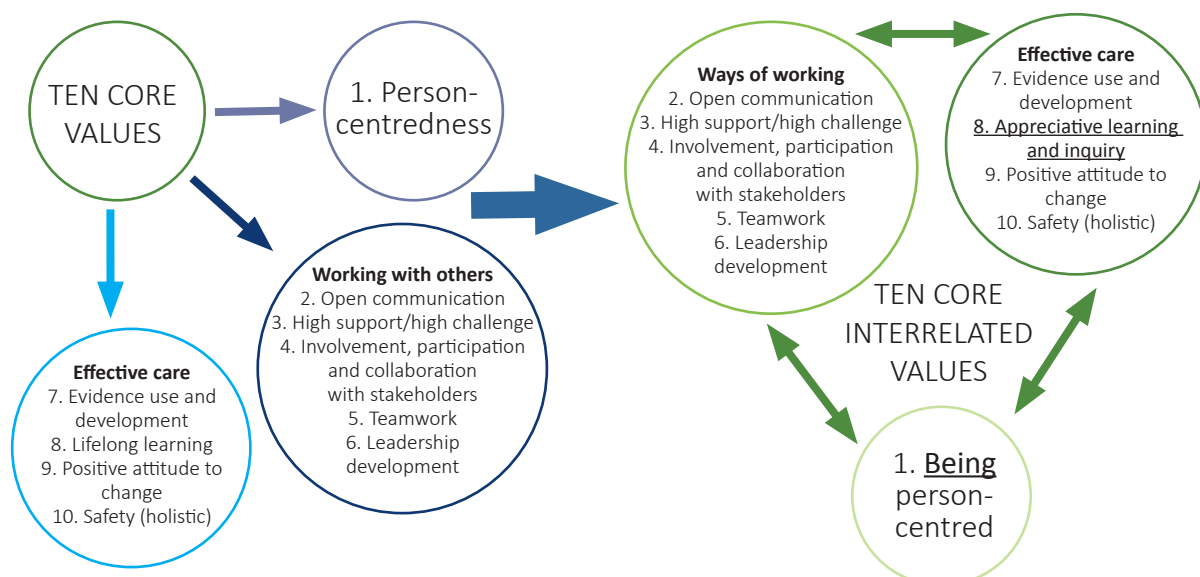
While workplace culture theory continues to grow, it is also complex, reflecting the systems in which individuals and organisations function. This complexity may deter frontline practitioners from asking critical questions, engaging in developmental activities, and/or evaluating initiatives for their impact on workplace culture. We asked: *what works for healthcare practitioners, in what circumstances and why?*
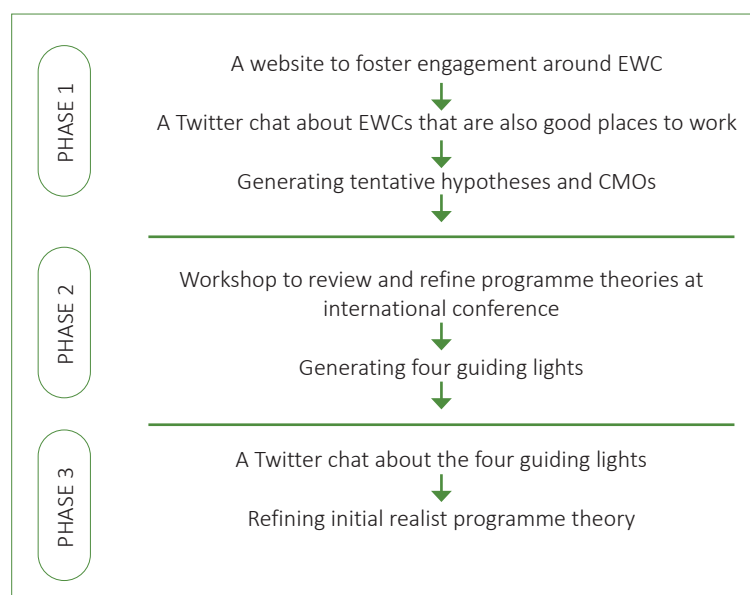
Aims

The aim of this study was to build on recent theoretical refinements and generate a guiding theory with and for healthcare practitioners about how to develop EWCs that are also good places for them to work.

Methodology and methods

The study design was based on principles associated with practice development, appreciative inquiry and realist evaluation. Appreciative inquiry (AI) aims to create new lenses (knowledge, models and/or theories) for looking at old issues (Bushe and Kassam, 2005). It is a move away from traditional 'problem-solving' approaches (problem identification followed by solution implementation). The focus is more on (lengthy) stakeholder dialogue, identifying strengths and positives through provocative questioning so that desirables and 'what might be' can emerge; these are considered more powerful generators of momentum and sustainable change. This basis for research implied a need to engage with stakeholder groups of healthcare workers who were willing to share their experiences and ideas on EWCs and positive workplaces. As we also wanted to develop a theory of practical relevance, supporting healthcare workers' awareness of aspects of EWC that they may otherwise miss (Cronen, 2001), realist evaluation was considered. This is theory driven and seeks to explain why, how and what works for whom in what circumstances. The generative principle states that underlying mechanisms, when activated in certain contexts, will generate outcomes, and is often presented as a CMO formula: Context+Mechanism=Outcome. The guiding theory would therefore describe what mechanisms are activated under which circumstances to result in EWCs that are good places for healthcare practitioners to work. The realist evaluation process starts with the construction of a tentative programme theory (or theories) on how and why an intervention/programme/policy is thought to work. These are then (repeatedly) applied, reviewed and refined to (eventually) produce a realist programme theory that describes which contexts, combined with which mechanisms, produce particular outcomes for specified groups (Wong et al., 2017).

The overall design consisted of three phases of preparation, data gathering and data analysis (Figure 2).

Figure 2: Overall research design

PHASE 1
A website to foster engagement around EWC
↓
A Twitter chat about EWCs that are also good places to work
↓
Generating tentative hypotheses and CMOs

PHASE 2
Workshop to review and refine programme theories at international conference
↓
Generating four guiding lights

PHASE 3
A Twitter chat about the four guiding lights
↓
Refining initial realist programme theory

Phase 1: Generating tentative programme theories

Having agreed on the research aim and ways of working, we initiated a website in spring 2017 (effectiveworkplaceculture.wordpress.com) in order to reach and engage healthcare staff as stakeholders and potential participants. We shared who we were as individuals and members of the International Practice Development Collaborative (IPDC), as well as our interest and intent. This was followed by four blogs/stories, written by us, expressing our experiences of EWCs as good places to work, and inviting responses. This activity reflects the 'poetic principle' of AI, whereby stories are valued as powerful, continuously evolving containers of knowledge. The website action was followed by a one-hour Twitter chat in spring 2018. While Twitter is commonly seen as a way to share information at scale, it also has the potential to generate evidence if data are systematically collected and rigorously analysed, and clear processes are adhered to (Manley, 2016).

Recruitment through the website, our networks and social media resulted in 58 participants offering 375 tweets in response to four pre-prepared powerful questions (Vogt et al., 2003). These questions were carefully formulated to be thought provoking, maintain focus on EWC that are also good places to work, surface assumptions and stimulate curiosity and creativity. Such questioning is in line with the simultaneity, anticipatory and positivity principles of AI, intended to (co-)create 'new grounds' of identity and focus on what is of importance. We asked participants to think about and share their views on: the importance of concerning ourselves with EWC; what such cultures could look and feel like to self and others; and what is needed to sustain them. Inclusion and exclusion criteria similar to those used by Ward et al. (2018) enabled the distillation of 171 relevant tweets (see Table 1).

Table 1: Inclusion and exclusion criteria for tweets			
	Type of tweet	**Definition/justification**	**Count**
INCLUDED TWEETS	Relevant	Tweets that related to the chat topic	171
EXCLUDED TWEETS	Introductions Signing out	Introductions from people joining the chat or messages when leaving	25
	Questions	Questions posed by hosts to stimulate discussion	34
	Retweets	Forwarding/reposting of a tweet by another user. As the meaning and purpose of retweeting was not clear, these were not analysed	143
	Linking out	Links to external resources	2
		Total number of tweets	375

The relevant tweets were coded and clustered into context, mechanisms or outcomes by each author independently. These were discussed in several sessions, across time, until consensus or consent was agreed about the broad tentative hypothesis and accompanying CMO configurations. The resultant framework focused on four areas and informed an initial tentative programme theory, which was fed back to participants via the website.

Phase 2: Review and refinement for an initial programme theory

In August 2018 we had the opportunity to engage with 33 international healthcare practice developers during a 90-minute workshop at the IPDC Enhancing Practice Conference in Basel, Switzerland. Initially, we invited participants to share positive stories of workplace cultures among themselves. They then moved on to discuss, critique and contribute to the four clusters of CMOs that made up

the programme theory from phase 1, using their stories and a pre-prepared tool (see Figure 3). Each person could make an anonymous contribution or consent to their completed tool being returned to them after data analysis. This activity was aligned to the AI principle of constructionism (Bushe and Kassam, 2005) and the RE process (of re-casting and refining) the initial programme theory (Wong et al., 2017) as participants generated new ideas, stories and images.

Figure 3: Example of the tool used to share initial CMO configurations from phase 1, with participants in phase 2, and gather new data

Below are several formulae for effective workplace cultures. We invite you to respond to each statement using the keywords of your narrative		
Context – *what?*	**Mechanism – *why?***	**Outcomes – *for whom?***
• Visible, authentic, credible and collective leadership (C1) • Supported by organisations to have a collective voice (C2)	• Role models and sets the mood for what good looks and feels like (M2) • Facilitates and enables collaboration and participation (M4) • Develops a shared understanding, balancing needs (M1) • Helps others to develop, enabling everyone to be empowered (M3) • Challenges respectfully and constructively to improve the workplace culture, enabling others to do the same (M5)	• Staff feel valued, respected and listened to and heard (O1) • Staff are empowered to speak out and be leaders (O2) • Everyone feels heard with a sense of mutual/shared understanding (O3)
I agree with/would add/see differently:	I agree with/would add/see differently:	I agree with/would add/see differently:

Completed tools were collated, copies taken with the consent of participants, anonymised by one researcher and distributed among all four. Again, we engaged in a lengthy and iterative process of reviewing, dialoguing and seeking consensus/consent on an evolving programme theory of EWC that are also good places to work. Once agreement was reached on four CMO configurations, these were themed as 'guiding lights' (GL). Guiding lights is a term and metaphor coined by Manley and Dewar (2019) in preference to what Best et al. (2012) call 'simple rules': broad, simple, easy-to-remember cues, flexible enough for adaptation in different contexts.

Phase 3: Exposure for further critique and/or validation
The four CMO configurations and guiding lights that emerged from phase 2 were re-presented to healthcare workers recruited again through our networks and social media in a one-hour Twitter chat, in autumn 2019. A total of 34 people (excluding the authors) participated and 125 relevant tweets were filtered using similar inclusion and exclusion criteria to phase 1 (for the outcome see Table 2). Once again, we initially engaged independently with the data, using four key questions: endorses the GL; contradicts/challenges the GL; offers new information for the GL; and offers more accessible language for the GL. This resulted in an initial realist programme theory, which is presented in the Findings section.

	Type of tweet	Definition/justification	Count
EXCLUDED TWEETS	Questions	Questions posed by hosts to stimulate discussion	29
	Other	Questions about the research; reminder to use the hashtag	8
	Linking out	Links to external resources	1
INCLUDED TWEETS	Guiding light relevance	Tweets that related to the chat topic	195
	Relevant for GL1: Collective leadership - Shaun	Endorses the GL	18
		Contradicts/challenges the GL	3
		Offers new information for the GL	7
		Offers more accessible language for the GL	
	Relevant for GL2: Safe, critical and creative environments- Kim	Endorses the GL	30
		Contradicts/challenges the GL	3
		Offers new information for the GL	8
		Offers more accessible language for the GL	
	Relevant for GL3: Living shared values- Kate	Endorses the GL	27
		Contradicts/challenges the GL	3
		Offers new information for the GL	9
		Offers more accessible language for the GL	
	Relevant for GL4: Change for good that makes a difference- Jonathan	Endorses the GL	11
		Contradicts/challenges the GL	2
		Offers new information for the GL	
		Offers more accessible language for the GL	
		Total of included + excluded tweets	233

Table 2: Inclusion and exclusion criteria for tweets Twitter chat II

Findings

The findings propose four broad, simple, easy-to-remember guiding lights for recognising and developing workplace cultures that are good places to work, and which are flexible enough for adaptation in different contexts:

- Collective leadership
- Living shared values
- Safe, critical, creative, learning environments
- Change for good that makes a difference

Each guiding light has a descriptor of elements related to the contexts and mechanisms that produce (intermediate) outcomes (see Table 3). For instance, the first guiding light on collective leadership can be read as:

In workplaces supporting and developing visible, authentic, credible and relational leadership by all (Context), leaders are enabled to focus on role modeling values in action and co-worker health and wellbeing, as well as build on quick-win improvements that contribute to sustainable change (Mechanism), whereby staff feel understood, valued, respected and empowered to speak out and become leaders too (Outcome).

Combined, the four guiding lights give rise to ultimate outcomes of strong, high-performing teams whose members flourish, provide quality care and build partnerships across settings from workplaces where sustainability does not rest on the shoulders of any one individual.

Table 3: An initial programme theory for workplace cultures that are also good places to work			
Guiding light	Descriptor	Intermediate outcomes	Ultimate outcomes
1. Collective leadership	Contexts (with formal opportunities) that support and develop visible, authentic, credible, relational and collective leadership. Enable leaders to: • Role model trust and confidence in each other, mutual respect, collaboration and participation • Engage in and foster dialogue • Balance needs with skills • Respectfully and constructively challenge each other • Focus on staff health and wellbeing • Build on quick wins towards sustainable change	Staff: • Feel valued, respected, listened to and heard • Have a sense of mutual/shared understanding • Are empowered to speak out and lead	
2. Living shared values	In contexts where the following is fundamental to the way things are done: • Compassionate care • Positivity • Learning • Teamwork (interprofessional) • Celebrating change for good Caring teams: • Co-construct shared values with patients, services users, communities and staff at all levels • Regularly revisit values to create collective goals • Build person-centred relationships • Live their values authentically by 'doing what they say they will do' • Set the mood for what good workplace cultures look and feel like	Staff: • Feel valued and supported • Have a voice • Are empowered • Enjoy being at work • Have a sense of belonging and connectedness Patients, relatives and others sense: • Enthusiastic staff • A warm, authentic, caring atmosphere • An environment that is clean, tidy and welcoming	• Strong, high-performing teams • Staff retention and low sickness rates • Staff flourish, blossom and grow their potential • Quality care: person- and relationship-centred, safe and effective • Sustained positive, improving, workplace cultures that are not dependent on specific individuals • Effective partnerships built within and across settings
3. Safe, critical, creative, learning environments	In contexts where: • Practice is caring, safe and effective • Mutual learning relationships value openness, difference, curiosity and creativity • There is space and structures to stop, think, reflect, share ideas, and plan together as a team People: • Feel respected and able to question and explore free from fear • Feel supported and enabled to take risks • Exchange knowledge, and actively notice and learn from what is working well • Are courageous and self-aware	Staff: • Build on what works well • Focus on solutions, not blame Service users experience an environment that: • Is safe (clean and tidy) • Values their feedback about what works and what can be improved	
4. Change for good that makes a difference	In contexts that focus on: • What matters to people (staff, patients and service users) and change for good • Having a collective purpose • External influences • Navigating complexity Enable staff to: • Care for patients, service users and each other with compassion • Actively seek feedback from different groups • Use positivity to enable innovation, feel energised and know that they can make a difference individually and collectively • Work with different sources of knowledge to generate evidence from and in practice	• Staff experience joy in their work and are energised for development, innovation and changes for good • Staff spread what works • There is effective service delivery with ongoing, sustained improvement and innovation	

Describing and discussing the findings

The findings of this study propose that when leadership is approached from a collective perspective instead of just the traditional individual, hierarchical perspective, all staff can feel responsible and valuable. Co-constructing and living shared values enables staff to feel connected to each other, which radiates and is experienced by those encountering the workplace culture. Safe, critical and creative learning environments foster and sustain a positive approach to developing practice. The focus is on what works and is good in terms of what matters to people, and what motivates and sustains continuous improvement and innovation. Combined, the four guiding lights enable strong teams to flourish in delivering quality care. Overall, the results are congruent with current practice development and workplace culture theory (Manley et al., 2011; McCance et al., 2013; Lynch et al., 2017; Cardiff et al., 2018; Manley et al., 2019). They also offer some new insights, which are discussed in more detail below.

Guiding light 1: Collective leadership

'I have learned that each team has natural leaders in different areas. Once you start giving them space and listening to them, they come up with and develop amazing ideas' (Tweet 8, November 2019).

This guiding light reinforces much of what is known about effective leadership in healthcare. Staff favour visible, authentic, credible and relational leaders (Stanley, 2008; Cummings et al., 2010; Wong et al., 2010). Transformational and person-centred approaches have a positive influence on healthcare professionals, their practice and the workplace culture, as well as service-user outcomes (Manley, 1997; Wong et al., 2013; Lynch et al., 2017; Cardiff et al., 2018; Suratno et al., 2018). The guiding light draws specific attention to collective leadership, thereby shifting perceptions of leadership as a practice exercised by individuals in formal or hierarchical positions of power to a process (potentially) exercised by all in mutual and reciprocal relationships – that is, everyone can exercise both leadership and followership at different times. As a participatory practice and basis for caring cultures (West et al., 2014; Sharp, 2018) this interpretation of leadership fits well with the CIP principles of collaboration, inclusion and participation in practice development.

Collective leadership is a dynamic, emergent and interactive influence process among team members as they selectively use the skills and expertise of one another to direct, motivate and support the whole team in dealing with situations and working towards team and/or organisational goals (Carson et al., 2007; Friedrich et al., 2009). It is context-bound, inseparable from the internal environment (implicit theories, values and beliefs, capacities and capabilities within the team), and the external environment (situations encountered, organisational support and leadership) (Scott et al., 2018; Zhu et al., 2018).

Leaders in EWCs that are good places to work value and enact or role model the core values of person-centredness, CIP ways of working, and effective and evidence-informed care. They engage in and encourage dialogue as well as respectful and constructive challenging of each other about what is important, what is working well or what is needed. As one Twitter chat participant wrote:

'Start with conversation about what is important or what matters to you – this is a great way for leaders to engage with their team and nurture new dialogue' (Tweet 312, March 2018).

In terms of the internal environment, a team needs to exercise collective leadership from a shared purpose and offer psycho-socio-emotional support, with all members having their voices heard and feeling respected (Carson et al., 2007; Akhtar et al., 2016). Knowing the persons one works with and leads is important for relational connectedness, commitment and momentum, and leaders are continuously balancing what is needed with available skills at the individual and group levels (Cardiff et al., 2018). Role modelling, enacting and enabling the core-values of an EWC benefits all.

'Leaders that facilitate collaboration and participation for all parties within that culture. Staff and patients alike' (Tweet 182, March 2018).

In terms of the external environment, the CMO does not exclude formal leadership attributed to hierarchical positions within an organisation. This is in line with Carson and colleagues' second condition for collective leadership: responsive and supportive vertical leadership (2007). External leadership and organisational support should be active and high when the internal environment is unable to support collective leadership, but low when a team is successfully leading itself. Also, there is always room for improvement and while 'quick wins' can energise and motivate, there also needs to be attention to how, in the long-term, they can contribute to building sustainable change for good – change that makes a difference and is valued by staff and service users. Such change is fulfilling because people feel valued, respected, listened to and heard.

'Looking for 'quick wins' so can walk the talk and show the teams you lead they are heard, you listen and respond' (Tweet 50 November 2019).

A focus on service delivery by staff who experience health and wellbeing in the workplace contributes to the outcomes of staff empowerment and community building, with an associated sense of purpose, support and belonging. This is congruent with most of the research on relationship-oriented leadership – that which is transformational, servant, congruent and person-centred. However, a combination of collective and vertical leadership also shows similarities with an indigenous Māori view of leadership. Effective Māori leadership is not attributed to one ultimate/continuous leader, as all lead and follow, using their strengths and agency on a journey that fosters belonging and the flourishing of all within the whole (Spiller et al., 2020).

Guiding light 2: Living shared values

'Values in my opinion should be owned, shared and nurtured. The permission to be authentic' (Tweet 77, November 2019).

This guiding light describes how key values of compassionate care, positivity, learning, interprofessional teamwork, evidence-informed practice and celebrating change for good are fundamental to 'the way things are'. They reaffirm the 10 core values arranged into three sets of shared values, as described by Manley et al. (2011) and Manley et al. (2019), although some, for example holistic safety and teamwork, are more implicit than others. Again, the emphasis is that these shared values be lived and enacted in practice so that workplace cultures can be effective and good places to work.

Working with values and beliefs is key to the delivery of person-centred practice (McCormack and McCance, 2017). Staff need to be aware of the values, beliefs and assumptions they hold and how they impact on the care they provide. Clarifying these values is one of the fundamental methods associated with practice development as a methodology for transforming individuals and cultures of care (McCormack et al., 2013). Additionally, 'inspiring a shared vision' is recognised as one of the five fundamental practices of exemplary leadership by Kouzes and Posner (2007). While this process needs to start at an individual level, the guiding light also acknowledges the importance of a collective approach to the co-construction of shared values. Such contexts are achieved when shared values are co-constructed with patients, services users, communities and staff, working together from the bottom up and the top down, facilitating support and buy-in at all levels. Working in this way ensures all voices are heard and valued and is in line with the CIP principles of practice development (McCormack et al., 2013).

The co-constructed values need to be continuously and positively revisited, ensuring they remain inclusive and all voices are heard and valued. This helps to identify what matters to people, bringing

teams together around a common purpose and collective actions to make a difference. Staff engagement is becoming increasingly recognised as an important predictor of outcomes across health and social care; similarly, effective teamworking is a key predictor of engagement (West and Dawson, 2012). Effective teams generate shared values that they use to create collective goals (West and Dawson, 2012; West, 2018) and to support shared decision making (McCormack and McCance, 2017). Similarly to the guiding light, Martin and colleagues (2014) demonstrate how this provides purpose and meaning for leaders and their teams, helping to energise staff towards the transformation of practice.

The collective process of identifying values encourages engagement and ownership, and the building of person-centred relationships. Articulating shared values makes the philosophy of care become more real, helping people to connect with, and to be inspired to live the reality of, what good workplace cultures look and feel like. This perspective is supported by Dixon-Woods and colleagues (2014), who acknowledge the need to build on excellent care by role modeling and reinforcing values and behaviours that facilitate positive outcomes for patients, other service users, relatives and staff. Regularly reflecting on values and goals can also ensure, as the guiding light highlights, that teams are doing what they say they will do (Manley et al. 2011) and that they remain inclusive of the perspectives of those both giving and receiving care.

Ultimately, this is about delivering better outcomes for all. As a consequence of living values, staff feel valued and supported, have a sense of belonging, feel empowered to act and enjoy being at work; patients, relatives and others sense enthusiastic staff, a warm, authentic, caring atmosphere and an environment that is welcoming. This perspective is supported by Smith and colleagues (2012, p 194) who argue that 'patients and nurses are sensitive to ward atmospheres and social relations created by ward sisters' – meaning they feel better able to care for patients.

> *'A team that care for each other are going to shine with compassion and care for their patients too!'* (Tweet 81, March 2018).

Guiding light 3: Safe, critical, creative, learning environments

> *'Safe, critical and creative environments are key to quality, innovation and improvement, with some notable exceptions, requires cultural change at scale'* (Tweet 70, November 2019).

A safe, critical, creative, learning environment is the focus of the third guiding light, where contexts are characterised by processes and outcomes about safety, critical thinking, creativity and learning. In order to develop and maintain individual, team and organisational effectiveness, a culture of active learning within the workplace is a core principle in practice development (Manley et al., 2008). Critical and creative processes are another practice development principle for the transformation of self and work practices. Much has been explored and published around the enablement, facilitation and outcomes of workplace learning in connection with practice development, and there are many examples of spaces and structures that help practitioners stop, think, reflect, share ideas, action plan and be creative as a team (Manley et al., 2008; McCormack et al., 2013).

> *'I think it is so important for teams and individuals to take time out and have the space to reflect on actions, solve issues and challenges'* (Tweet 233, March 2018).

Safety enhances learning. Edmondson (1999, p 354) defined psychological safety as 'a shared belief that the team is safe for interpersonal risk taking'. She found confidence that team members will not embarrass, reject, or punish each other for speaking up (psychological safety) affects learning behaviour, which in turn affects team performance. The guiding light reaffirms this as it describes how mutual learning relationships that value openness, difference, curiosity and creativity are combined

with the space and structures that provide opportunities to stop, think, reflect, share ideas and plan together. This combination enables people to feel cared for, respected and free from fear to question, and to exchange knowledge and actively notice and learn from what is working well. While trust is important, there also needs to be respect for each other's competence and a caring about each other as people (Edmondson, 1999) – that is, safety cannot be maintained unless we are also person-centred (Manley et al., 2019). Feeling safe enables positive risk taking and supports curiosity and creativity. This in turn enhances a solution-focused approach to continuous quality improvement and innovation, and an environment where staff can further grow their potential and flourish. Brown and McCormack (2016) demonstrate the importance of internal leadership and external skilled facilitation in developing the psychological safety needed for evidence-informed practice and person-centred cultures. Creating psychological safety for teams to reflect on 'the way things are done' enables them to develop authentic (interprofessional) relationships and action-plan ideas.

> *'An effective workplace culture will feel safe… to be courageous with ideas, safe to notice and highlight what is working well'* (Tweet 113, March 2018).

Viewing learning as a relational process that relies on interactions between people to determine what needs improving and how to do it, Carmeli and colleagues (2009) also found positive work relationships are key to enabling psychological safety. They propose the creation of structures and processes that enable relationship building and social learning. Kessel and colleagues (2012) also demonstrate that psychological safety enhances the sharing of knowledge, particularly tacit ('knowhow') knowledge, and a team's creativity (the production of ideas, products or procedures that are novel and potentially useful). The impact of psychological safety on performance, learning, engagement, information sharing, staff satisfaction and commitment is also demonstrated in a meta-analysis by Frazier and colleagues (2017).

Critical thinking is about exploring every aspect of practice, work, workplace and workforce. It includes positively revisiting our own 'what' and 'why', even when we have shared purpose and values. Critical thinking is enabled when people feel safe to share deep thoughts, leave their comfort zone and push boundaries, but making oneself vulnerable also calls for self-awareness and courage. Working critically within teams and the workplace culture means working with 'uncertainty'. From a critical stance, leaders and teams dare to be curious about the status quo, examining the assumptions, (hidden) values and (multiple forms of) knowledge that underpin 'the way things are done'. Although some organisations may perceive uncertainty as akin to unmitigated or poorly managed risk, Buetow (2011) argues that certainty is a delusion and that we should work constructively with uncertainty. Uncertainty is natural when one accepts the fallibility of humans. It feeds a critical attitude and creativity, as people wonder, imagine and question the world around them. It can signify wisdom when people combine intuitive and experiential styles of thinking with analytical reasoning, not readily accepting tradition while keeping a focus on safety. It can sustain a sense of individual and collective hope, but at the same time prevent hope turning into presumption. In a world that seeks and values certainty, to work constructively with uncertainty takes courage, self-awareness and a safe environment in which people can engage in critical and creative dialogue with self and others. This quality of working with uncertainty, translated to unstable and unpredictable contexts, is recognised as one of the guiding lights of leaders who model calmness, steadiness and the living of core values (Manley and Dewar, 2019). Approaches that support this include: reflection; supervision; informal, active and action learning; dialogue; and ethical debate. However, these approaches do need to be valued by those investing resources.

Psychological safety therefore enables critical thinking that embraces self-awareness and collaborative learning. Critical thinking is a mechanism through which new solutions and creativity emerge, enhanced by opportunities for diverse perspectives from, for example, interprofessional learning. Staff experience a safe learning workplace culture that is solution focused with a no-blame approach, and service users experience an environment that is safe and values their feedback about what works and what can be improved.

Guiding light 4: Change for good that makes a difference

'Being heard and listened to, valued and inspired to deliver better outcomes for our patients with a collective purpose is what matters' (Tweet 138, November 2019).

'Who decides what is good? If people are not involved they may not see the outcome' (Tweet 158, November 2019).

At the heart of this fourth guiding light (intrinsically linked to the first three) is a workplace context and culture that foregrounds what matters to people, person-centred relationships and ongoing development:

'You matter and I care is an interaction that takes a couple of seconds' (Tweet 276, March 2018).

Systematic approaches are used to enable practice and service transformation that nurtures and supports both professional and evidence-informed practice growth. Collective understanding and shared goals are developed through multiple approaches, to gain better insight, understanding and continuous improvement in quality.

As healthcare becomes increasingly complex, organisations and practitioners are required to navigate multiple needs, interests and demands, both external and internal, in which there '*is a growing sense of urgency about the need for radical change in order to keep the system going*' (Hannah, 2014, p 1) and '*only innovation can enable modern health care organisations and systems to meet the radically changing needs and expectations of the communities they serve*' (West et al., 2017, p 7).

The starting point for change is a collective (shared) purpose that reflects what matters to staff and service users. This helps to retain focus and prioritise 'change for good' that will both enable and consistently be experienced by all. Service users (patients, clients, residents and their significant others) are increasingly becoming 'equal partners' within health and care commissioning (Sanders et al., 2015). Actively seeking feedback with intent from stakeholder groups helps maintain a relevant collective purpose along with systematic, evaluation strategies to gather, review and adapt the service. Working with a diversity of stakeholders fosters the use of different sources of knowledge and the generation of evidence from and in practice. Working authentically with diverse staff and service users entails caring for each other with compassion to sustain the collective purpose and support positive innovation and transformation.

'Enabling and empowering individuals to do something special/have belief in themselves to make a difference…' (Tweet 155, March 2018).

This positive approach enthuses people as they know they are contributing to change that will bring benefits at all touchpoints in care and service delivery. Staff experience joy from their work and are energised to develop and innovate for the 'good' of others and self. As the 'change for good' is shaped and sustained by those experiencing service provision, it fosters positivity and encourages the sharing and spreading of what works.

Understanding workplace culture is central to developing workplaces in which care is person-centred, safe, clinically effective and continually improving (Manley et al., 2011; 2019). And yet, programmes of improvement do not always acknowledge the importance of culture and its central role in transformation and sustained improvement. Working with the complexities of culture in turbulent workplace settings requires skill and understanding and is often driven by doing what is right for people experiencing and providing care and services, whereby person-centred relationships become central. West and colleagues (2017) identify that the enabling of leadership and cultures is essential for local systems to triumph over adversity.

Improvement programmes are an approach to enabling transformation. Dixon-Woods et al. (2012) review evaluation reports of improvement programmes supported by the UK's Health Foundation and list 10 challenges. The first two are:

- Convincing people, staff in particular, of the need for change/improvement. The authors suggest aligning improvement initiatives with emotionally engaging hard data such as service-user stories, as well as engaging staff in defining how to address the issues raised
- Convincing people of the solution. Maintaining enthusiasm for the chosen change strategy requires consistent and appropriate evaluation of change

Evaluation strategies and tools need to be fit for purpose, user friendly and integrated into the improvement process from the start. Dixon-Woods et al. (2012) also suggest aligning goals and ambitions with what staff feel is achievable. This reflects guiding light 1 where leaders of change may start with 'quick wins' to instil positive energy, while keeping in sight the longer-term aim of sustainable, transformative change. They also found creative learning environments are more conducive to flourishing improvement initiatives, which further supports guiding light 3. The fifth of their 10 challenges highlights the need to navigate complexity and work with external influences, noting:

'Shifting policy agendas and regulatory requirements, can be a major barrier, because of their effects of organisational turbulence and staff distraction and instability of structures and teams' (Dixon-Woods et al., 2012, p 881).

Receptiveness to improvement programmes can be heightened when driven by service-user priorities. Staff positivity and engagement can also be upheld by feedback from service users, peers and audits. The authors hint at the importance of collective leadership:

'Sustainability is threatened when there is over-reliance on certain individuals' (Dixon-Woods et al., 2012, p 882).

While the guiding lights reflect many of these findings and suggestions, in the work of Dixon-Woods and colleagues (2012) there is an underlying sense that improvement programmes should be determined and implemented from the top down and that senior (project) leaders use the suggestions to achieve buy-in from frontline professionals. This is in contrast to our findings, which are aligned to the core practice development CIP principles as a route to EWCs that are experienced as good places to work in and be cared for, and where the role of senior leaders is to enable and empower frontline teams (Manley et al., 2019). New approaches that support complex, bottom-up change are crucial to understanding how to sustainably transform services and cultures of care within and across systems (Manley and Jackson, 2020).

Ultimate outcomes

'I strongly believe the four pillars [guiding lights] should be viewed as threads that weave together to inform and strengthen each other. They are not separate entities' (Tweet 229 November 2019).

Our findings propose that when all four guiding lights are given adequate attention, the ultimate outcomes will be:

- High-performing, flourishing teams with lower turnover and sickness rates
- The quality of person- and relationship-centred, safe and effective care will be positively evaluated as positive change for good is sustained and not dependent on the agency of specific individuals
- Effective partnerships will be built within and across boundaries as horizons are broadened

There is an abundance of research and theory showing sickness absence or (intention to) leave a position/healthcare profession is related to leadership, workplace environment, feeling recognised and respected and having a sense of purpose and accomplishment. The ultimate outcome of quality associated with person- and relationship-centred, safe and effective care and the relationship with the four guiding lights is also well documented. West et al. (2017) identify the importance of enabling leadership and cultures for innovation (see Ham and Brown, 2015) to spread and to become the cultural norm. The ultimate outcome of positive, improving workplace cultures that are not dependent on specific individuals reflects the findings of Manley et al. (2019).

Castka et al. (2001) state that team performance is a function of ability, motivation and environment, with the latter being of high importance. They suggest group culture should be based on 'empowerment, shared vision, creativity, participation, learning ability, trust, and shared consensus' (p 128). De Vries (1999) describes seven principles of effective teamwork, most of which can be linked to the four guiding lights: respect and trust; protect and support; engage in open dialogue and communication; share a strong common goal; have strong shared values and beliefs; subordinate one's own objectives to those of the team; and distributed leadership. Subordinating individual objectives to those of the team is not supported by our findings. While it is reminiscent of the values underlying servant leadership (Greenleaf, 1977; 2003) it conflicts with a fundamental value of person-centredness: mutual respect and understanding. Manley and Dewar's (2019) second guiding light for leadership in healthcare also speaks of 'seeing the light in the other person as well as oneself', with the third guiding light emphasising the importance of and yet challenge of kindling the spark and keeping it going.

Person-centred cultures are conducive to human flourishing. A transformational practice development project by McCormack et al. (2018) demonstrated that where the intention is to develop person-centred as opposed to patient-centre care, the workplace culture enables flourishing for all. Using a framework of eight conditions for human flourishing, McCormack and Titchen (2014) describe activities that enable staff as well as service users to experience a person-centred culture: staff getting to know each other as persons first; developing shared visions; small projects led by staff members; engaging in critical and creative active learning; forging working relationships outside the team; and celebrating successes. These activities reflect the four guiding lights. Outcomes are not dependent on specific individuals and the building of partnerships within and across settings reminds us we do not exist in isolation but are embedded in and linked to wider networks.

Short reflection on the research process
This study was not commissioned or financed, which posed challenges to the international group of researchers, such as planning spaces for collaboration and working with new research methodologies and data-gathering methods. We found person-centredness as a value was fundamental to our own working relationship as we saw, appreciated and worked with each other's strengths and limitations. Having a safe environment for critical dialogue during the different periods of data analysis was particularly important. The high levels of critical dialogue helped ensure the voices of participants came through and their meanings interpreted as intended by them. We encountered challenges similar to those described by Ward et al. (2018, p 14), such as 'participants were all active in online social media communities… most participants appeared to be based in the UK… some tweets were also quite hard to understand or interpret because of the character limit… the rapid progression of the discussion'. The chance to present our preliminary findings from phase 1 in workshop form at an international conference did enable us to expand the scope of international perspectives and engage with participants more deeply than during the first Twitter chat. We would therefore highly recommend such a strategy if it is available. The fact that we found no tweets that offered more accessible language in phase 3 (see Table 2) may reflect our endeavour to remain true to participant voices. This was aided by taking time to reflect between researcher dialogue sessions, and not limiting the time or number of these sessions; we would recommend this approach to foster authentic consensus on how tweets are interpreted during the analysis phase. What we did fail to do and include in Table 2, was a counting of tweets that encouraged the blending of the four guiding lights.

Member checking is another issue we encountered. Although we informed participants of the posting of findings from each phase, responses were not abundant. This could be explained by the long periods between data gathering and publishing of findings. This does pose a dilemma in research contexts such as ours: the pressure to publish analysis findings as quickly as possible versus taking the time needed to achieve consensus on interpretation. Using several methods and analysing independently with ongoing triangulation, as well as opening findings to wider feedback and critique enhanced trustworthiness, and in particular transferability. We were also committed to user-friendly language to describe the findings so they have meaning for everyday practice. However, it was observed that the term 'facilitation' does not appear in Table 3 despite its popularity in practice development literature; revisiting the tweets revealed participants would often use synonyms such as 'helping' or 'enabling'. Also, it may be that practitioners associate the term 'leadership' more with workplace culture than facilitation. This does raise a question for the practice development community: what are the similarities and differences between leadership and facilitation? Are leaders also skilled facilitators, and should they be?

Our findings offer an initial realist programme theory with four guiding lights that can potentially be used in wider research and practice, the feedback from which can further refine our understating and developing of EWCs.

Conclusion
In the current healthcare climate, it is more important than ever to focus on workplace cultures that foster safe, effective and person-centred practices that positively impact on service users and staff. While understanding of EWCs has been growing, we felt there was a need to research and identify some broad, simple, easy-to-remember cues, flexible enough for practitioners and researchers to use and adapt in different contexts. We adopted the 'guiding lights' phrase and structured them as realist CMO configurations to describe what could work for whom under what circumstances. Engaging with healthcare practitioners throughout Europe, via social media and face-to-face contact, four guiding lights were identified. We found that strategies for collective leadership, living shared values, creating safe, critical and creative learning environments, and engaging in change considered 'good' by service users and staff, resulted in positive intermediate outcomes such as empowerment and wellbeing for staff, as well as overarching outcomes such as strong, high-performing teams that collectively sustain positive change, build effective partnerships, flourish and provide high-quality care. In other words, effective workplace cultures that healthcare staff consider good places to work.

A haiku for EWCs that are good places to work
Dedicated to frontline practioners from all professions and disciplines at East Kent Hospitals University NHS Foundation Trust

Living our values
Culture; listening, speak-up
Creative learning

Collective leaders
Change for good makes a diff'rence
What matters? People!

Daily gratitude
Celebrate joy in our work
Positivity

Kim Manley, 2020

Implications for practice:

- Developing EWCs at the microsystems level needs recognition and support by healthcare managers, leaders and commissioners because this directly influences service-user and staff experiences of quality and safety
- A continuous, collaborative, inclusive and participatory approach to workplace culture development will have greater positive impact on staff and service-user experiences than top-down action planning and ticking of boxes
- Responsive and person-centred leadership is the most influential way of developing EWCs that are good places to learn, work, innovate and grow collective leadership
- When developing workplace cultures, more emphasis should be given to identifying what works well, what change will be for the good in relation to what matters to those providing and experiencing care, and living values rather than just articulating them

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Shaun Cardiff (PhD, MScN, BEd, RGN), Senior Lecturer, School of People and Health Studies, Fontys University of Applied Sciences, Eindhoven, Netherlands.

Kate Sanders (MSc, BSc Hons, HV Cert, RN), Practice Development Facilitator, Foundation of Nursing Studies, London, England.

Jonathan Webster (PhD, MSc, BA Hons, DPSN, RGN), Independent Consultant in Nursing and Practice Transformation, UK; Visiting Professor, Bucks New University; Honorary Senior Research Fellow, Canterbury Christ Church University; Associate Facilitator, Foundation of Nursing Studies, London, England.

Kim Manley (PhD, MN, BA, PGCEA, RCNT, Dip N Lond, RGN), Emeritus Professor Practice Development, Research and Innovation Canterbury Christ Church University, Canterbury, Kent, England.