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**Leadership and management development
within the NHS: A phenomenological and
critical account**

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Declaration

I certify that this work is my own work and that appropriate reference has been made to the work of others where appropriate. This work has not been submitted for any other degree.

Signed *M. G. P. E. A. D.*

Date *28th September 2018*

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Abstract

Regarding the failures of Mid Staffordshire NHS Foundation Trust between 2005 and 2009, Sir Robert Francis QC commented to the then Secretary of State for Health '*that above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement of managerial and leadership responsibilities*' (The Francis Report, 2013, p. 9). This was a criticism directly laid at the feet of those NHS leaders and managers who were charged with caring for vulnerable families and friends during that time. Understanding how leaders and managers are developed within the NHS is of a notable concern, especially if we wish not to see the likes of what occurred at Stafford Hospital again. Even after significant investment in NHS management training, Lake (2016) of the NHS Leadership Academy suggests that there are still vague barriers which prevent a culture of effective leadership development from embedding itself within the NHS workforce. This view is supported by others including Ahmed *et al.* (2015), West *et al.* (2015) and Tull (2018). It can be reasonably asserted that this unclear picture starts with a need to explore the recent experiences of NHS staff who have been participants on NHS leadership and management development (LMD) trainings.

The primary aims of this thesis were 1) to explore how NHS LMD training participants experience their training and 2) to examine potential barriers which impacted upon the LMD participant's learning within their NHS workplace. With a focus on the need to understand the experiences of NHS LMD participants, a qualitative methodology was proposed as a suitable research method (Creswell, 2017). Thus, a retrospective, cohort sample of nine recent (within the past 10 years) NHS LMD participants partook in nine; 40-60-minute individually recorded then transcribed, semi-structured interviews. Recognising Alvesson and Deetz (2000) concept of '*interpretative repertoire*' (2000, p. 166) and Mabey's (2013) recognition of the neglected organisational and leadership development discourses; an Interpretative Phenomenological Analysis (IPA) (Smith *et al.* 2009) and a modified Critical Discourse Analysis (CDA) (Fairclough, 2003; 2013) were chosen as multi-methods of analysis to be applied to the same nine transcribed interview transcripts.

Findings revealed 1) some LMD interventions and participant opinions regarding LMD's role within the NHS workplace are more appreciated and supported in the literature than others 2) NHS LMD as a discourse and social practice is inherently vulnerable to manipulation and the agendas of others due to a range of influences and vested interests involved within the field 3) overall NHS LMD trainings are well liked and appreciated by participants.

This thesis concludes with a series of recommendations, which can be summarised as 1) that increased integration, collaboration and closer working relationships between the NHS LMD training providers, the NHS LMD participant and the NHS workplace may enhance the LMD experience for all involved 2) the use of both IPA and CDA in exploring organisational and LMD related issues is a novel and informative approach, which should be encouraged to address a notable deficit of research approaches and practices within this field.

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I would first like to acknowledge and say thank you to the participants of this research who volunteered their time and experience to allow me to create this work. I would also like to thank my DPM supervisors at The University of Nottingham and my colleagues from Sheffield Hallam University for their time and guidance.

I am going to dedicate this work to my Nan, Anne Taylor who sadly passed away just before I began my professional doctorate journey. I am going to also recognise a man who I never met, Michael Gallagher who would have been my father in-law. I have on good authority that he would have loved to have discussed and read all about this work.

My final thanks go to my parents John and Christine Read, my wife Paula Gallagher-Read, my mother-in-law Breeda Gallagher and my friends. Without their support and care, none of this would have been possible.

When Steve Kerr (former Chief Learning Officer at GE) was once asked about the basis for changing GE's leadership development programme "It's organisation development 101" he quipped "You should never send a changed person back to an unchanged environment"

(Joseph A. Raelin, 2004)

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List of Abbreviations

APEL = Accreditation of Prior Experiential Learning

BME = Black and Minority Ethnic

CD = Critical Discourse

CDA = Critical Discourse Analysis

CI = Chief Investigator

CIPD = Chartered Institute of Personnel and Development

CME = Critical Management Education

CMI = Chartered Management Institute

CMS = Critical Management Studies

CQC = Care Quality Commission

CR = Critical Realism

CT = Critical Theory

DoH = Department of Health

DPM = Professional Doctor of Public Management

GP = General Practitioner

GT = Grounded Theory

HR = Human Resources

HRD = Human Resource Development

HRM = Human Resource Management

ICSs = Integrated Care Systems

ICT = Information and Communication Technology

IiP = Investors in People

ILM = Institute of Leadership and Management

IPA = Interpretative Phenomenological Analysis

LMD = Leadership and Management Development

LMX = Leader-Member Exchange Theory

MBA = Master's in Business Administration

NHS = National Health Service England

NPM = New Public Management

NU = Nottingham University

NVQs = National Vocational Qualifications

OD = Organisational Development

REC = Research and Ethics Council

SHU = Sheffield Hallam University

SMEs = Small Medium Enterprises

Chapter One: Introduction

1.1 Introduction

This chapter offers an introduction to this thesis by establishing a rationale for research, followed by a statement of the relevant research aims and questions. A structure of this thesis is presented, including a description of each of the chapters. This chapter concludes with a summary and highlights the main issues which have been addressed within this introduction and how they will be taken forward.

1.2 Rationale

As an NHS professional with over 15 years' experience and having worked in many areas of the NHS, I have witnessed and have been subjected to various types and styles of leadership and management. Some of which, have been exceptional and inspirational and others less so. Having seen first-hand how poor leadership and management within the NHS can impact on patient care, practitioners, teams and organisations; this area of concern became of interest to me.

When I undertook my first NHS leadership role, I was encouraged to attend several NHS leadership and management development trainings. I found these trainings fascinating and quite confusing; the agendas of the facilitators and of those who sent me on to these trainings seemed unclear and far apart at times. What was being taught did not fit with the reality of my organisational life. These trainings were clearly expensive (both in time and physical resources), so I queried could my developmental needs have been met differently? Was the outsourcing of my leadership development really required? I did enjoy, and felt that I benefited from the leadership trainings, but as a concept I believed this area required much further exploration from a personal, organisational and academic perspective. Hence, my professional doctorate journey began three years ago when I was an NHS manager and a trained Psychotherapist. This has been quite a journey for me as I no longer work within the NHS, but I am now a Lecturer in Clinical Leadership and I consider myself to be a student of sociology.

Building on my personal intentions, the following subsections will explore the academic rationale for this research, which will successively inform the research aims and questions. Section 1.2.1 considers this topic from the general perspective of management education, development and the workplace. Section 1.2.2 contemplates the current state and application of leadership and management development (LMD) within the NHS. Drawing from the early exploration of this topic and the common literature; the final section (1.2.3)

acknowledges the aims of this research and how these inform the research questions.

1.2.1 Management learning and the workplace

Historically, the concepts of management education and management development have belonged to different institutions (the academy for education and the organisational workplace for development). This split has resulted in different managerial learning discourses, which have invariably focused on the achievement of unrelated results. More recently these two management learning domains have increasingly become augmented, as the need for management education has become increasingly relevant (Mintzberg, 2004; Cummings and Bridgman, 2017; Walker, 2017). Spicer *et al.* (2009) suggest that management education has frequently been the knowledge and application of management practice, which promotes the sustained goals of organisational performance. Yet, the distinction between management education and management development is important, as both can be fundamental to personnel, executive and national performance (Mabey and Finch-Lees, 2008; Chartered Institute of Personnel and Development known as the CIPD, 2017a). This distinction requires further consideration, particularly when the workplace is ultimately connected to the event of management learning itself (Mintzberg, 2004).

Regularly, the workplace is progressively being viewed as an appropriate venue for management learning and practice to occur outside of the academy (Bolden *et al.*, 2006; National Occupational Standards, 2010; Institute for Apprenticeships, 2018). This type of learning is reinforced by the subjectivist epistemologies of knowledge that incite a re-conceptualization of knowledge and in what way and where learning occurs (Kellie, 2012). There is a presumption here, in that both management development and management education have the capacity to blend to attain advantageous outcomes (Pfeffer and Sutton, 2006). From this combined perspective, both management education and development can be understood to benefit the workplace and the academy sector. This is formed by the consistent endeavour of developing management knowledge and competence via the achievement of academy accredited management qualifications. This observation brings many questions regarding the role of LMD within the NHS. Some of these questions concern where LMD is best provided and who by? And how does the NHS workplace with its various structural complexities, effectively interface with LMD classroom delivery?

In relation to my earlier queries regarding the agendas of those involved in LMD, the field of Critical Management Studies (CMS) may assist here. Among other considerations, literature linked to CMS questions the motives and agendas behind organisational management and management development (Learmonth, 2007; Adler *et al.*, 2008; Spicer *et al.*, 2009; Fournier and Smith, 2012). Through a brief review of the NHS LMD literature (chapters two and three), the void of research within this field from an NHS and general LMD perspective is

notable. It is worth recognising Burgoyne and Reynolds (1997) who assert that within the management learning field, diverse stakeholders hold incompatible ideas and standards. These can be strengthened, resigned or promoted depending on the agendas of the actors involved. It can be suggested that NHS LMD is not particularly favoured or considered to be that important by prominent NHS stakeholders. Both West *et al.* (2015) and Tull (2018) of The Kings Fund allude to this. Lake (2016) of the NHS Leadership Academy suggests that the following barriers to effective NHS LMD implementation exist:

- Limited funds (even with infrequent boosts of NHS money directed at organisational development known as OD).
- Lack rigour (too much variation and inconstancy across the sector).
- Lack of support (keeping NHS managers in positions is typically difficult).
- Lack of strategic direction (with a workforce containing 1.4MM people; a coherent strategy is going to be difficult to implement).
- Lack of respect for leadership development.
- The demonisation of leaders and managers (politics and the media often present NHS management in a negative light and subsequently may put people off from aspiring to senior roles).

Lake's (2016) understandings of the barriers towards effective NHS LMD are assumptive but as a previous worker within the NHS, I can relate to these views. With more focus and consideration this thesis will endeavour to deliver a more critical lens towards NHS LMD. This will be through an investigation of the insights and experiences of previous NHS LMD training participants. Other than a few notable exceptions (Day, 2001; Willmott and Alvesson, 2011; Edwards *et al.*, 2013) most research in generic LMD has frequently assumed a normative, and typically, a prescriptive/descriptive approach towards the application and research of LMD (Mabey, 2013). This thesis will proceed to explore this gap, with an eventual contribution to knowledge being the application of two methodologies to explore the constructionist and critical discursive domains related to NHS LMD participant experience.

1.2.2 Leadership and management development within the NHS

Considering concerns regarding poor NHS leadership and management practices highlighted within The Francis Report (2013) and other related reviews (Berwick review into Patient Safety, NHS England, 2013a; The Keogh Urgent and Emergency Care Review, 2013b); NHS England initially invested £46MM through the NHS Leadership Academy, with the aim of developing and increasing leadership capacity across the NHS (Department of Health known as DoH, 2013). Evidence is absent, but approximations of between 20 and 29 per cent of NHS training and development budgets are devoted to LMD training and improvement (O'Leonard and Lamoureux, 2009; West *et al.*, 2015). Lake (2016)

suggests that NHS providers on average dedicate as much as £260 per employee to LMD per year. With this financial commitment, two central questions require consideration; to what degree are NHS LMD trainings effective? And after such an allocation of resources during a period of austerity, do all participants from these trainings go on to lead within the NHS?

NHS LMD trainings generally last between six months to two years, with some trainings being a dedicated full-time endeavour for some medical staff (Stoll *et al.*, 2011; NHS Improvement, 2015). Yet, most are comprised of part-time learning in combination with the participants' job role. Some trainings are academically led i.e. accredited master's programmes delivered by universities as leading partners, others are less academic and administered in collaboration with corporate partners i.e. Arup and East Midlands NHS Leadership Academy Emerging Leaders Programme (2017). The job roles and bandings of NHS LMD participants do vary, though it is notable that most participants on these trainings are from a clinical background (West *et al.*, 2015). NHS LMD trainings usually contain combined interventions provided by LMD facilitators, lecturers and guest speakers. Service improvement work-based projects, 360-degree feedback, job rotation, action learning sets and one-to-one coaching and mentoring are also all prominent LMD interventions (West *et al.*, 2015). The evidence for these interventions is imperfect, nevertheless it is suggested that one-to-one coaching and mentoring, work-based projects and action learning sets are all favoured interventions by LMD participants (Fielden and Sutherland, 2009; Enterkin *et al.*, 2013; Mahoon *et al.*, 2015).

Frequently LMD interventions are conveyed in a way to promote desired behaviours and skills which match certain leadership competencies. These leadership competency frameworks are utilised in NHS LMD trainings such as the NHS Healthcare Leadership Model (NHS Leadership Academy, 2013) and NHS workplaces (in mostly standardised appraisal form). It can be argued these frameworks assist in the embedding of learning and promote focus and continuity through the delivery of training and outcomes. Nevertheless, the benefits of leadership competency frameworks are contentious; Bolden *et al.* (2006) propose that such competency frameworks focus too much on measurable outcomes, to the exclusion of subtler leadership qualities. Buchanan (2003) argues that competency frameworks are in fact unhelpful and do not enable or enhance leadership effectiveness. Pawson and Tilley (1997) propose that LMD can work as much through a generative causation (creating the conditions where change can emerge, and the person can move on to destinations unknown); as much as succession causation (achieving predictable and pre-known outcomes through direct linkages between means and ends).

Whilst studying general leadership practice within the UK, Holman (2000) identified four contemporary models of management development. These are based on differing theories about knowledge construction and the roles of managers. These being:

- Academic liberalism, the search for objectivity to create the management scientist (discussed in section 2.4).
- Experiential liberalism aims to develop the reflective practitioner able to apply theory to practice (discussed in subsection 2.5.1).
- Experiential vocationalism aims to prepare managers with the skills they need for their role. This is where competence-based approaches dominate (discussed in subsection 2.5.4).
- Experiential/critical, a reflexive approach aiming for a critical leader who can effectively challenge the status quo (acknowledged in section 8.4).

Holman (2000) suggests that an over-reliance on either model of leader development will not achieve desired results. However, Holman (2000) does propose that approaches which are innately built around critical reflection and action learning, will ultimately be more likely to meet the needs of individuals and organisations. Even with much of the debate around the use of competency frameworks, the application of these deductive tools continues. It could be argued that the continued use of these competency tools promotes the agendas of stakeholders who are particularly concerned with a performative agenda.

Attempting to understand Holman's four models of management development in relation to NHS LMD training, the general evidence for the effectiveness of NHS LMD is not very well established (Jasper and Juma, 2005; Yukl, 2013; West *et al.*, 2015). What evidence there is mainly derives from participants with medical and clinical backgrounds (West, *et al.*, 2015). Still, McKimm *et al.* (2009) and Levenson *et al.* (2010) advise that these staff groups (owing to their non-managerial experience and strong technical expertise), are frequently reluctant or not prepared to assume leadership positions, thus needing significant levels of support, compared with leaders at similar levels in other fields. Stoll *et al.* (2011), Bagnall (2012), Edmonstone (2013a) and Mahoon *et al.* (2015) all propose that there is no one true way to develop NHS leaders, they suggest that 'good' leader development is situational and context sensitive. Most frequently when effective LMD is observed, the evidence for improvement has been based on the participants' desire to lead rather than the capability of the participant to do so (Mahoon *et al.*, 2015). The desire to lead is clearly an important factor in LMD achievement, though other significant variables recognised in the evidence include the NHS LMD participants belonging to supportive organisational cultures (Bagnall, 2012; Phillips and Byrne, 2013; NHS Improvement, 2017).

Evaluative studies of NHS LMD indicate that LMD training effectiveness is empirically difficult to assess and the demonstration of positive effects on patient outcomes and outputs are considered indefinable (Hardacre *et al.*, 2011). What has become apparent is that the evidence justifying the purpose of LMD is limited, with nothing further defining the skills or knowledge required of NHS LMD providers (Edmonstone, 2013b). It is suggested here that NHS LMD training requires further attention and clarity.

As Hardacre *et al.* (2011) proposes, effectiveness of NHS LMD trainings is difficult to assess, Mahoon *et al.* (2015) place an emphasis on NHS LMD participant motivation to lead and Bagnall (2012) acknowledges the important interplay of organisational culture. These disjointed assertions lack clarity and are unable to effectively offer clarification to the concerns proposed by this thesis thus far. Hence, it can also be reasoned that NHS LMD is an important area to explore, due to the amount of NHS resources invested in to these trainings which invariably divert funds away from frontline patient care. Bearing in mind the aims of this research established in the next section (1.2.3) and Lake's (2016) barriers to effective NHS LMD provision; this thesis will attempt to deliver an examination of a under researched aspect of organisational life. Consideration of LMD participants' views, the roles of various stakeholders involved in NHS LMD delivery and the exploration of how pursuits of stakeholders related to NHS LMD can converge and diverge, will be examined. Ultimately, this research will present some of the tensions and inconsistencies which develop as NHS LMD is practiced and attached to the NHS workplace context.

1.2.3 The research aims and questions

Drawing on sections 1.2.1 and 1.2.2, two aims for this research can be summarised as follows:

- To explore how NHS leadership and management development training participants experience their training.
- To examine potential barriers which impacted upon the participant's NHS leadership and management development learning within their NHS workplace.

With the above research aims in mind, presented below are research questions and understandings. These questions will assist in supporting the research aims and the development of the research methods:

- How did participants feel about attending their NHS leadership and management development training?

Willcocks (2012) contends that *'clinical leadership is not just about the development of aptitudes or proficiencies; effectiveness is also about the willingness and desire of clinicians to develop into a leadership role'* (2012, p. 12). This desire of participants wanting to learn and develop into leaders requires further exploration. If NHS LMD participants are opting to avoid NHS LMD after attendance, what were the participants' original reasoning and ambitions before attending the training? Did they even wish to attend the training, or were they told they had to attend?

- How did the participants' organisation respond to the participant during and after their NHS leadership and management development training?

Many evaluative studies of previous NHS LMD trainings (Hardacre *et al.*, 2011; Bagnall, 2012; Mahoon *et al.*, 2015) highlight how a participants' organisation responded to the participant during and after their training, was a crucial factor in the realisation of benefits. Edmonstone (2013a) also highlights the need for consistent and visible stakeholder engagement from commissioners, who can assist in the embedding of leadership and organisational learning. Further exploration of the assertions made by these studies is required from a critical perspective.

- How does the participant feel their NHS leadership and management development training influenced them?

Linking with the previous question, this transitional query considers the real experience of the NHS LMD participant. Limited evidence indicates poor training facilitators and learning experiences leads to poor outcomes (Arnulf *et al.*, 2016). This may progress the topic away from the organisational issues, to the consideration of the ability of the participant, the ability of those involved in the facilitation and the vested interests of the evaluators of NHS LMD (Willcocks, 2012; Mahoon *et al.*, 2015).

- What, if anything, effected participants' engagement with the NHS leadership and management development training and the NHS workplace?

There is a notable gap in the evidence, which pays little attention to the participants of these NHS LMD trainings who chose not to lead afterwards. This may influence the future career development of these participants, how the training they attended played a part in this decision and the consideration of any blockages or cultural issues which prevented learning from being embedded (Bagnall, 2012; Lake, 2016). The substantial cost of attendance of these NHS LMD trainings also requires recognition and as such, it can be reasonably asserted that NHS money is wasted if NHS LMD participants do not benefit from attending these trainings (Stoll *et al.*, 2010).

With these research aims and questions in mind, this next section will present an overview of the individual chapters presented within this thesis.

1.3 The structure of this thesis

Building on this introductory chapter, chapter two defines and explores the concepts, context and discourses associated with leadership and management.

Further consideration is given to the notion of management learning, before moving to the recognition of managerialism within the NHS. Chapter three offers a more refined search of the contemporary NHS LMD literature and begins to provide a reasoning for the research aims and questions.

Chapter four establishes an important conceptual framework for this thesis and proposed research. Chapter four demonstrates how significant amounts of LMD literature arise from a performative/descriptive approach to LMD research and practice. During this exploration other more neglected, LMD discourses associated with LMD research are explored in the forms of the interpretive, critical and dialogic discourses (Burgoyne and Reynolds, 1997; Alvesson and Deetz, 2000; Mabey, 2013). This triggers an examination of the ontological and epistemological obligations attached to researching LMD. At this juncture a multi-method approach towards the analysis of potential research data is proposed, by the acceptance of an '*interpretative repertoire*' (Alvesson and Deetz, 2000, p. 166). Chapter four concludes with recognition of the need for more LMD research drawing on the neglected LMD discourses, thus providing a theoretical underpinning for this thesis. This understanding additionally fits well with the writer's perception of knowledge and may help address some of the more critical concerns expressed towards the practice of NHS LMD.

Chapter five discusses the methodological approaches and arrangements to be utilised for research. A greater rationale for the research is established and a subsequent qualitative retrospective case study, with a multi-method research design is planned. Approaches to sampling, an acknowledgement of critical realism and research methods are also determined. Applied and ethical issues concerning the data gathering processes and analysis, alongside an awareness of the principles of good research practice are presented. A summary of the research endeavour is offered, demonstrating how the author applied an Interpretive Phenomenological Analysis (IPA) and a modified Critical Discourse Analysis (CDA) approach to research. The final section of chapter five, addresses concerns around reflexivity, credibility and transferability with reference to the conduct of this research.

Chapter six demonstrates the findings from an IPA applied to nine interview transcripts, which have been recorded and transcribed from the undertaking of nine NHS LMD participant semi-structured interviews. This analysis investigates how LMD participants experienced their LMD trainings, and the associated issues these participants faced. Chapter six focuses on ascertaining the '*lived experience*' (Smith *et al.*, 2009, p. 33) of the LMD participant, by dividing parts of the interview transcripts into emerging themes. This process highlights similarities, differences and inconsistencies between the LMD participants' accounts while also attempting to create an in-depth understanding of the NHS LMD experience.

Chapter seven will demonstrate the findings of a modified Fairclough (2003; 2013) CDA applied to the same nine interview transcripts. The focus of chapter seven will be on how participants utilise language and depict various discourses

to create their account of NHS LMD. What is presented is a discursive interpretation of being an NHS LMD participant, and how the LMD discourse is shaped, permitted or denied through organisational arrangements belonging to the NHS workplace. The application of the CDA approach focused on reported aspects of organisational discourse, and as such attempts to satisfy the research aim of examining the barriers which impacted upon the participant's LMD.

The concluding chapter eight will bring together the results of the findings chapters (chapters six and seven) and establish how they link to the earlier themes, definitions and concerns which have emerged throughout this thesis. Initial attention will be applied to the IPA findings with reference to how NHS LMD participants appreciated some LMD interventions over others. Further consideration will also be paid to the CDA findings, from the perspective of language used by participants to recognise the prominence of formal and informal power structures within the NHS. Acknowledgement of the research aims, and research questions are made, while ascertaining how LMD theory, research, practice and policy may be influenced by this research. This concluding chapter will offer a few generic conclusions and thoughts developed from this thesis via the combined approaches to research. While establishing its key contributions and limitations, a summary with recommendations for future LMD research, practice and policy will complete chapter eight and this thesis.

1.4 Summary

This introductory chapter has offered a rationale for this thesis and contextualised the need for a better understanding of the NHS LMD participant, thus adding to the field of NHS LMD research. The uniqueness of this research will be in its application of both an IPA and a CDA towards the collected research data provided by NHS LMD participants.

As acknowledged, present research within the LMD arena mostly occurs with a dominant performative agenda and as such there is a tendency to solely focus on the deductive functions of LMD. Therefore, homogeneity exists regarding the purpose of LMD and the intentions and interests of stakeholders, commissioners and facilitators. It is suggested here that this limits LMD from a theoretical, practical and research perspective. The recognition of the LMD discourses specifically the functionalist (performative), interpretive, critical and dialogic by Burgoyne and Reynolds (1997) and Alvesson and Deetz (2000) have provided an opportunity for a multi-method approach to be explored. After further reasoning throughout chapters two, three and four, this research will pay attention to the interpretive, critical and dialogic LMD discourses. This introduction has created more questions than answers, consequently this thesis will now proceed in setting the context (chapters two and three), by delving further into this complex and multi-faceted field.

Chapter Two: Setting the context

2.1 Introduction

This chapter will now review historic and contextual understandings, which encompass the field of leadership and management development (LMD). The first section (2.2) within this chapter seeks to define early key terms and definitions associated with leaders, leadership and management development. The second section (2.3) will proceed to explore leadership and management theories and discourses, with the aim understanding how leadership and management became a concept. The third section (2.4) focuses on managerialism within the context of the NHS, thus presenting a contextual backdrop for this thesis. The fourth section (2.5) delves further into the ideas presented in section 1.2.1 and begins to critique the notion of leadership and management learning. This chapter will provide a foundation before a more refined and focused search of the NHS LMD literature is presented during chapter three.

2.2 Defining the leader, leadership and management development

There is an assortment of meanings prescribed to the understanding and expressions of 'leadership' and 'leadership development'. Historically, the terms leadership and development are disconnected by nearly 100-years with the term 'development' originating much earlier in 1821 (Case *et al.*, 2011). Still, 25-years ago leadership development remained a poorly understood idea and amongst one of the most ill understood concepts of organisational studies (Appelbaum *et al.*, 1994). Because of these inconsistencies relating to definition, this thesis will apply an all-encompassing approach when utilising the term 'leadership and management development' or its abbreviation 'LMD'.

Nevertheless, in its most basic form, leadership development is regarded as a process of generating the steady advancement and progression of an individual (Mabey, 2013; Ferry, 2015). It can also represent an assembly of individuals with an aptitude to lead, chaperone, escort, guide, administer, and oversee people by the encouragement, guidance, modelling or the demonstration of certain kinds of behaviour (Day, 2001). It is argued that the art of leadership development is an interventionist one (Davis, 2014; Edwards, 2015). Most tools deployed as part of the leadership development discourse are fundamentally assertions to stimulate certain ideals, qualities, cognitive reasoning abilities, feelings, positions, actions and characteristics (Orazi *et al.*, 2004). Pont *et al.* (2008) also contend that how leadership development is implemented, can be reliant on how a person considers what leadership is and what it involves. While the composition of 'leadership development' is generally agreed upon, little

progress has been made when defining what 'leadership' is. In 1974 Stogdill and Bass claimed that:

'There are about as many definitions of leadership, and thus leadership development, as there are researchers who attempt to define the concept' (Stogdill and Bass, 1974 in: Bass and Bass, 2008, p. 259).

With a review of the various concepts linked to leadership beyond the remit of this thesis, a further selection of quotes presented below tend to view leadership as a conceptual entity, or a type of procedural intervention:

'Leaders are individuals who establish direction for a working group of individuals, who gain commitment from this group of members to this direction and then motivate these members to achieve the direction's outcomes' (Conger, 1992, p. 18).

'Leadership is that process in which one person sets the purpose or direction for one or more other persons and gets them to move along together with him or her and with each other in that direction with competence and full commitment' (Jaques and Clement, 1994, p. 4).

'The process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives' (Yukl, 2013, p. 8).

'A process whereby an individual influence a group of individuals to achieve a common goal' (Northouse, 2016, p. 3).

'Your primary responsibility is to build followership and inspire those around you to support a larger agenda under your direction and vision. You have to prioritize communications and [the] development of others. Your job is no longer about what you can accomplish, but what your entire team can achieve. Good leaders focus on 'we' not 'me'' (Hedges, 2017, p. 1).

The shared notions from these quotes relate to action, ability, quality and influence. These quotes are also pre-occupied by individual leader behaviours, characteristics and attributes, with a focus on capability and the ability to persuade others. Notwithstanding, leadership as an idea, fails to be a concept which is entirely appreciated or effectively defined throughout many institutions, regardless of sector (Ratcliffe, 2013). It is conceivable that most concepts which include both leader and managerial development lack a true collective understanding and are subsequently ill-described. Leadership development as described by Day (2001) should:

'Expand the collective capacity of the organisational members to engage effectively in leadership roles and processes... Leadership roles refer to those that come with or without formal authority.... Leadership processes

are those that generally enable groups of people to work together in meaningful ways... (2001, p. 582).

Day (2001) demonstrates how leader and managerial development can be a shared function within an organisation wishing to progress and develop its employees. Day (2001) supports the idea that regardless of employees inhabiting an endorsed leadership role, they should be sanctioned to inspire and galvanise their roles with leadership in mind. However, Winkler (2009) suggests that many employees do not preoccupy themselves with leadership, only becoming more aware of leadership when it becomes an integral part of their role. This creates an early ontological divide within the leadership field of the 'being' and 'becoming' a leader. This section will progress to explore the academic differences concerning the concepts of leader and leadership development, followed by a focus on the issues associated with LMD.

2.2.1 Exploring leader and leadership development: An academic perspective

Research involving the development of managers from the 1980s onwards has persistently focused on individual leader development (Iles and Preece, 2006). There has been a focus on the attitudinal and transformative facets of leadership development related to the growth of the participant (Day, 2001; Mabey, 2013).

In a review of leadership development, Day *et al.* (2014) distinguishes between two governing discourses namely '*leader development*' (2014, p. 63) and '*leadership development*' (2014, p. 63). Leader development focuses more on the building of intrapersonal leader skills whereas leadership development considers the development of social/interpersonal skills. Leader development focuses on internal skill building in areas related to cognitive-emotional resilience, awareness of self and motivation. Social and interpersonal skill building concentrates on the ability of the leader to shape relationships and demonstrate abilities like social responsiveness, network development and conflict resolution (Lunenburg, 2011; Algahtani, 2014). Day *et al.* (2014) continues to argue that the development of leaders is still mostly grounded in a time-honoured, traits-based leadership model. Both individual leader and leadership development models frequently focus on the idea that leaders can perform an important part in organisational progression (Bolden, 2010a).

Early commentators argued that leadership development is predominantly a social capital building exercise, which is entrenched in relationships and an asset of social networks, as opposed to something supplementary in a prevailing system (Salancik and Pfeffer, 1978). As acknowledged by Day (2001), this idea of leadership development has progressed to interpersonal skill development like social responsiveness, understanding, organisational alignment, dispute management and transformation catalyst (Goleman, 1996). Goleman (1996) emphasises the importance of mutual responsibilities and assurances

constructed on shared responsibility. Leadership consequently '*emerges when people rely on their mutual commitments, trust, and respect to create a new meaning*' (Day, 2001, p. 606) as opposed to recognised arrangements and instruments which implement control.

Though roughly defined by various authors, it can be maintained that the definitions related to leader/ship development are incoherent and overlap in many places (Martin *et al.*, 2014). This inconsistent application may leak into theoretical misunderstandings and this can be witnessed by the exploration of a range of NHS LMD currently on offer (NHS Leadership Academy, 2018). Many LMD trainings have different titles commissioned by various bodies (The Kings Fund, 2011; 2016; Portsmouth Hospitals NHS Trust, 2018 and so on), all applying inconsistent meanings, terms and structures; a lack of consistency in the use of terminology is extensive (West *et al.*, 2015). This can be further exemplified when some training providers apply the Healthcare Leadership Model (NHS Leadership Academy, 2013), with its focus on intrapersonal development, while other training focuses on more social and shared leadership development (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2013). Despite their practical differences, general labels denoting 'leadership' are applied.

Though, some researchers do incorporate features which can be deemed to be leadership development and placed under the heading of leader development. Velsor and McCauley (2004) argue that leader development should involve three dominate elements incorporating self-management, social aptitudes and work facilitation capabilities. Defined by Velsor and McCauley (2004) these elements comprise mostly of features related to social capability and can easily exist under the domain of leadership development. Drawing from the first paragraph of section 2.2, because of the inconsistencies related to leadership and management development (LMD) definitions, an all-encompassing approach will be applied when utilising the term LMD. This idea also embraces the diverse Human Resource Development (HRD) traditions which are involved in the development of leaders and managers.

To conclude, Fulop and Day (2010), Edmonstone (2013b) and West *et al.* (2015) suggest, that success related to any leader/ship development training is reliant on the people who are receiving, delivering and commissioning the training. There is a noted ideal that all three should exhibit the same expectations of the training, for all to benefit. Having alignment of expectations from all three stakeholders is arguable a complex endeavour and does draw the focus away from LMD being mostly dependent on the individual leader. This hints at the complexities involved in LMD, particularly from an NHS context.

Leadership development in both application and theory, is theoretically an ambiguous topic lacking in clear terminology and disjointed application. As theorised by Burgoyne *et al.* (2004) and Haywood and Voller (2010) this could be due to limited research, which has failed to explore the complexity of LMD

practice, theory and process. The defining of terms will continue, with a focus on managerial understandings.

2.2.2 The difference between leadership development and management development: An academic perspective

Like the ambiguity experienced when exploring the terms 'leader' and 'leadership development', comparable issues have arisen between 'leadership development' and 'management development'. This warrants acknowledgement here, as this issue is recognised within the LMD literature. Day (2001) contends that the term leadership is not paralleled to the term management; correspondingly, leadership development is markedly diverse from management development; hence confusion.

According to Zaleznik (2004), Gold *et al.* (2010) and Debebe (2017) management development commonly emphasises the teaching or coaching of managerial participants. This is a focus on explicit abilities and information which develops when managers function within their organisational position and work to their role responsibilities (Day, 2001). Leadership development, conversely, positions itself towards developing organisational and shared capabilities of participants. This can be irrespective of participants holding a recognised management or leadership role involved in leading or in a position of having to provide explanations to unidentified issues (Van Velsor and McCauley, 2004; Gold *et al.*, 2010).

Additionally, leadership development proposes to grow participants to be ready for unanticipated conditions or circumstances outside their normal role or involvement (Bolden, 2010b). Management development emphasises the development of people with experience or established answers to what is already known. Leadership development should shape organisational capability, and develop insightful methods for collective working (Day, 2001). As such, leadership development can be both behaviourally and cognitively multifaceted in comparison to management development (Day, 2001; Bolden, 2010b; Laljani and Peters, 2015).

It is reasoned that management concentrates on implementing the 'right way' and as such there is a preoccupation with being comparatively practical, functional, with a medium to short-term focus. This approach to management development is mostly developed from managerial situations, which are generally known or have been experienced before (Armstrong and Baron, 2004). Management with a leadership focus involves confronting predicaments which are deliberate and enduring and necessitate the creation of solutions that are mostly unknown and new. Though as previously acknowledged, fundamentals of both leadership development and management development do overlap and there is a mixture of both approaches to development when practiced (Zaleznik, 2004).

Furthermore, Alimo-Metcalfe and Lawler (2001) contend that many UK organisations, regardless of sector, mix the terminologies of leadership and management. As acknowledged earlier, programmes delivered by the NHS Leadership Academy based on the Healthcare Leadership Model (NHS Leadership Academy, 2013) do little to differentiate between management and leadership. Subsequently, it can be suggested that there is little clarity in the differences between leadership development and management development. Therefore, attempting to engender a pure definition of LMD, to separate between a training branded leadership development away from one branded as management development, would be futile in the context of this thesis.

2.3 A short inspection of common leadership theories

This section will briefly acknowledge a few of the classical and popular leadership theories and approaches. These leadership theories and approaches will inform this research drawn upon during the conclusion of this thesis. However, this section will still only be a fleeting visit due to the different, complex and interrelated topic areas of this thesis.

2.3.1 Physiological and behavioural leadership theories

Beginning with one of the earliest leadership theories, the '*great man theory*' (Grint, 2005, p. 29), proposes that leaders are born and not constructed. It is suggested that these leaders are mostly established in eras of need. In the 1930s and building on the '*great man theory*', the trait leadership theory became popular (Zaccaro *et al.*, 2004). This theory argued that specific personality or behavioural traits are measurable, thus meaning the facets of a '*successful leader*' are definable. Such early theories and ideas related to leadership, presumed the sovereignty of nature over nurture. This approach had many criticisms, particularly around the characteristics related to both the '*great man*' and traits theory of leadership, which frequently is regarded as masculine (Billing and Alvesson, 2002; Judge *et al.*, 2002). The idea that the characteristics of leaders can be gendered is a dubious one. A chief concern of Rosener (1995), that since it is unachievable to create a true reductive list of leadership traits appropriate for every situation; the same must apply when attempting to list gender explicit leadership traits. Later, behavioural approaches connected to leadership (Cherry, 2010) diverged away from the '*great man*' and trait approaches, by proposing that leaders can be created, and are not just born. In terms of LMD, behavioural approaches to leadership argue that leadership activities and behavioural qualities are transferrable and learnable (Muldoon, 2003; Akhavan *et al.*, 2014; Ramanathan, 2014).

As globalisation endures and developing economies continue to grow, there is a requirement for good leaders in all sectors, at all levels (George, 2014). In

developing and liberal societies, there is further dissatisfaction with the 'great man' and trait theory, particularly with the idea that nature regulates the number of effective and available leaders. Nonetheless, these reductive physiological based ideals associated to successful leadership do revive infrequently (Cawthon, 1996; Van Vugt and Roney, 2013; Van Vugt and Grabo, 2015). Some authors argue that perseverance of these ideas is due to the link between leadership and management aptitudes to transformational leadership and charisma (Mhatre and Riggio, 2014). Such leadership attributes are considered by some to be predominately inborn and subsequently anti-LMD (Van Vugt and Ahuja, 2010; Van Vugt and Grabo, 2015).

Keeping with the theme of physiological influence, neuroscience has recently contributed to the leadership literature (Rock, 2006; Waldman *et al.*, 2011; Schaufenbuel, 2014; 2015). Rock and Schwartz (2006) propose that managers should be aware of cognitive science and how this can assist in helping employees with organisational and personal change. It is proposed that biological and physiological predispositions can explain why some employees struggle with different types of change, leadership and consent in comparison to others. Yet some argue that cognitive and neuroscience research is in its infancy and at present little evidence exists regarding how this understanding can improve leader behaviour and follower experience (Swart *et al.*, 2014).

As commented on, overall there is great discontent with the 'great man' and trait theories, and as such this has encouraged the behavioural, co-operative, and contingency theories of leadership to become increasingly established (Bolden *et al.*, 2003). Leaders from both business and management, have subsequently fallen on the side that leaders are made and not born (Williams, 2013). This proposes that effective leadership and management can be fostered, cultivated, merited and learnt via approaches used in training and development. One can also argue that this has created a market place for retired senior managers to share their experience and skills with others at a cost.

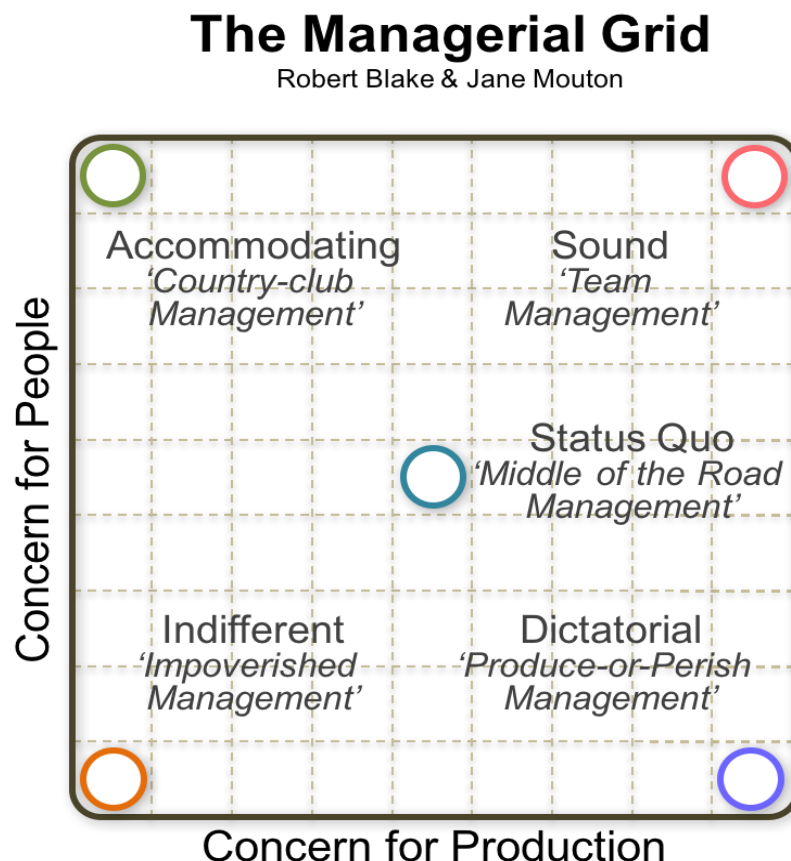
Supplementary theories of leadership consider situational approaches which focus on circumstances that bring out effective leadership (Hersey and Blanchard, 1977; Hersey, 1985; Thompson and Vecchio, 2009). Transactional and transformational leadership theories consider leadership styles and particularly how organisational leaders and managers can be effectually cultivated (Bass and Riggio, 2007). Considering the behavioural leadership approach further, Mosley (1998) suggests that this understanding contemplates the nature of Human Resource (HR) diversity occurring from the progression of globalisation and Information and Communication Technology (ICT).

Role theory asserts that people act in to the leadership position which they inhabit or have been given. This suggests that people undertake their own leadership role based on their own self-beliefs, cognitive awareness and the demands of others (Winkler, 2009). Consequently, role theory proposes that if a person is not given a leadership or management role, they have a tendency not

to occupy themselves with leadership ideas, as this does not concern them at their operational level.

Keeping with behavioural theories of leadership, managerial grid theory (Blake and Mouton, 1961 in: Clayton, 2017, p. 1), compares leaders who are more, or less concerned for people (wellbeing) against leaders who are equally more, or less task and productivity driven (see Figure 1.). This demonstration results in an interesting, yet descriptive formulation of consequences related to leadership style.

Figure 1. Blake and Mouton - The Managerial Grid



(Source: Blake and Mouton, 1961 in: Clayton, 2017, p. 1)

DeRue *et al.* (2011) incorporated both leadership behaviours and traits during their research, which sought to test the legitimacy of both behavioural and trait leadership theories. Significantly, the aim of DeRue's *et al.* (2011) study was to explore the discourse related to the deficit of theoretical assimilation in leadership and management enquiry. DeRue *et al.* (2011) quantitative research demonstrated that having certain leadership traits and behaviours only accounted for thirty-one per cent of leadership success (by utilising a trait-behaviour model to analyse success). An external issue out the control of the leaders was deemed to be the most influential factor on leader success. Interestingly, specific behaviours like meticulousness, sociability, and

extraversion were the most significant forecasters of successful leadership; characteristics linked to traits such as intellect and gender had little impact on leadership achievement (DeRue *et al.*, 2011). Over the next two sections (2.3.3 and 2.3.4) this thesis will visit the stylistic and group focused leadership theories. How these relate to the NHS workplace will also be acknowledged.

2.3.2 Participative, democratic and autocratic leadership theories

Like physiological theories of leadership, there are notable drawbacks related to the common behavioural theories of leadership. Physiological and behavioural models tend to focus solely on the leader and are therefore, limiting and restrictive, particularly within the context of complex professional matrix-based organisations. Both these theories when under scrutiny can be hierarchical, anti-collaborative and reductive when seen through the lens of professional knowledge and skills.

When initially exploring democratic leadership, it is worth observing the works of Kurt Lewin who identified three styles of common leadership nearly 80 years ago (Lewin *et al.*, 1939 in: Billig, 2015). Lewin *et al.* (1939) apportion leaders into three types being the; autocratic style in which the leader alone makes decisions in the chosen absence of consultation with others; the democratic/participative style, where others are consulted in the decision making; and the laissez-faire approach in which the leader curtails their participation in decision-making.

In the interests of definition, autocratic leadership works well when people are willing not to question and to submit to the leader or manager making the decision (this approach works when fast and decisive decisions are required). Democratic or participative approaches thrive when the ideals, opinions and intentions of all those involved are similar. Laissez-faire leadership is noted to work when stakeholders are dynamic, professionally-skilled and informed and as such are not requiring a dominant authoritative figurehead. To note, the terminology used in Kurt Lewin's leadership styles, fits well within the behavioural theories of leadership and could be the first break away from the original physiological leadership theories.

Of these three leadership styles, participative or democratic theories of leadership have particularly developed within the western world (Irby *et al.*, 2002; Bargal and Schmid, 2008). These theories innately accept that a group can make a superior decision, as opposed to just one person or leader making that decision. Such an approach asserts that a co-operative decision-making process creates a superior collective assurance towards task completion (Bass and Stogdill, 1974). Linked to participative leadership theory, distributed leadership is similar with its focus on the benefits of shared and team leadership. Timperley (2009) has noted that distributed leadership has taken hold as a common leadership approach within the UK education establishment.

Like the notions posed in participative and distributed leadership, West (2017) has recently promoted the need for collaboration along with compassion, to be integrated within the sphere of NHS leadership and management. Likewise, Bibby (2015) links collaborative and compassionate care to the nurturing of innovation and quality improvement. Though Bibby (2015) and West (2017) are linked to the agenda of The Kings Fund, they not alone with the promotion of these compassionate ideals. Elvira (2015) uses the concept of moral leadership interchangeably with compassion; with Hougaard *et al.* (2018) suggesting that a similar approach to leadership should be taken outside the NHS context.

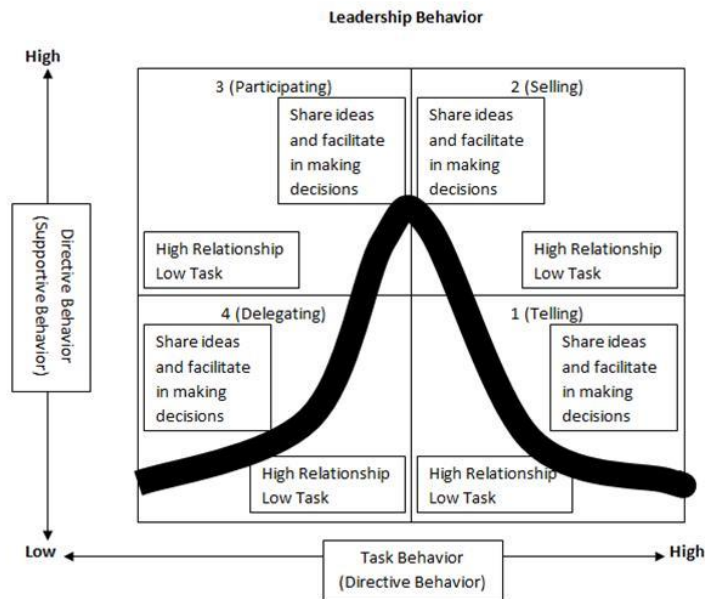
In summary, though participative leadership has the potential to be inspiring, this style can be overtly influenced by enthusiasm and conviction of its supporters and stakeholders. Huang *et al.* (2010) argues that this approach positively impacts on an employee's dedication via psychological empowerment, specifically for those with management responsibilities. Though a participative leadership style does not fit all situations appropriately; as acknowledged by Somech (2005) and Kahai *et al.* (2012) there can be a requirement to create an equilibrium concerning both participative and autocratic leadership and top-down and bottom-up approaches, by applying pliability when required.

2.3.3 Situational and contingency leadership theories

The addition of contingency and situational leadership theories aims to rationalise how successful leaders perform and operate depending on the situation they are faced with (Yukl, 2013). Yukl (2013) recognised that situational features can originate from both within the culture of the leader's internal organisation, or externally in the form of stakeholder involvement and appeasement.

Hersey and Blanchard (1982) practical version of situational leadership theory refutes ideas that there is a supreme leadership style or approach. Hersey and Blanchard (1982) argued that many styles can come in to play and this is dependent on the situational context. Hersey (1985) later summarises this understanding in to four significant leadership styles, (but also familiar to Kurt Lewin's, three leadership styles). See Figure 2. Hersey and Blanchard's (1982) Model of Situational Leadership.

Figure 2. Hersey and Blanchard's Model of Situational Leadership



(Source: Hersey and Blanchard, 1982 in Lynch *et al.*, 2011, p. 1067)

Researchers within the field of leadership suggest that there is negligible support and realistic value for Hersey and Blanchard's (1982) situational theory of leadership (Graeff, 1997; Vecchio *et al.*, 2006; Thompson and Vecchio, 2009). Butler and Reese (1991) demonstrated that applying Hersey and Blanchard's Model of Situational Leadership (Figure 2.) in a prescriptive way within a retail environment resulted in little change in performance. In fact, functioning was noted to be down, regardless of sales managers who held high competence-based roles accomplishing more sales. Nonetheless, leadership and management consultants like Gels (2018), recommend using such situational leadership approaches within healthcare to help line manage autonomous and highly skilled staff who work for long periods in isolation with limited management supervision.

The contingency theories of leadership endeavour to define the qualities, activities and approaches to leadership, which when applied may have a notable improvement on organisational effectiveness. Situational-contingency considerations include the aptitudes and capabilities of followers and recognition of assignment arrangements for the creation of developmental opportunities for followers (DeRue *et al.*, 2010).

Cognitive resource theory considers the intellect, aptitude, practice, and cognitive capabilities of leaders (Fiedler, 1986). In a study focusing on how these factors influence leadership (and like the findings of the later DeRue *et al.*, 2011) study, Fiedler (1986) found that a leader's intelligence does not have an impact on leadership effectiveness. Though situational considerations and stress did have an impact on how cognitive aptitudes influenced leadership outcomes. The cognitive capabilities of a leader were noted to only add to the functioning of an organisation particularly when the leader applied an autocratic and repressive

style. As noted during stress-based situations, the cognitive capabilities of leaders can be compromised and as such may have a direct impact on the functioning of an organisation. This can be a positive impact if the leader is familiar with the issue causing the stress or potentially negative if there are major unknown factors. Still, in circumstances where roles are not complex or where followers require minimal guidance, the intellect of a leader was noted to contribute scarcely to group effectiveness (Fiedler, 1986; DeRue *et al.*, 2011).

A key issue with situational and contingency theories of leadership is that it supposes that leaders are adaptable or can be supple in personality and style to deal with the range of different situations faced by leaders. Day (1991) argues that, leaders may struggle to change their style of leadership to match the numerous organisational or leadership circumstances. A leader may be reluctant to change, predominantly if they have a certain style which has helped them to succeed in progressing through previous organisational or managerial ranks. As Day (1991) suggests:

'There is a tendency for him or her to bunker further in the leadership approach or style he or she is most comfortable with when faced with a strong resistance' (1991, p. 12).

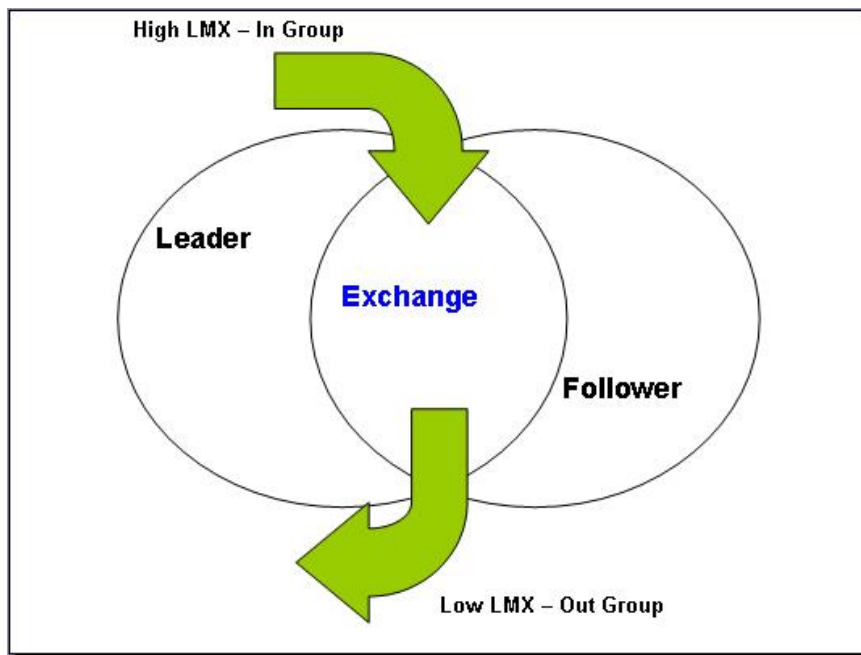
2.3.4 Transactional, leader-member exchange, transformational and systems leadership theories

Transactional leadership theory (Bass, 1990) considers that relevant to their organisational context, leaders can set up a reward and penalty regime to incentivise staff performance. This approach has its foundations in contingency theories and behaviourism; viewing humans as objects or parts in a machine, with fundamentals based on classical and operant conditioning (Pavlov, 1927; Skinner, 1938). Nevertheless, transactional leadership can be helpful in urgent situations, yet highly influenced by market conditions. For example, when employment opportunities are plentiful, employees may not be inspired by leaders who only reward when performance meets expectation. Employees may have freedom of movement between jobs and seeking just financial rewards may not be enough to keep the interest and dedication of the employee (Negussie and Demissie, 2013).

Leader-Member exchange theory (Bauer and Green, 1996; Ilies *et al.*, 2007; Nahrgang *et al.*, 2009), otherwise known as LMX or vertical dyad linkage theory, considers the give-and-take exchange amongst leaders and followers. This theory contends that leaders inspire their followers via tacit exchange agreements of fiscal reward and empowerment of the employee (see Figure 3.). This is exemplified by leaders creating an inner-circle of loyalists (in group) by fostering a distinctive relationship with reliable staff members. These staff are bestowed a special privilege with increased access to means, active involvement in managerial decisions and amplified responsibilities. As a response, these

dedicated followers subsequently have increased workloads and the out group remain distant to the leader, apathetic and can perform poorly.

Figure 3. The LMX Interplay



(Source: Ilies *et al.*, 2007, p. 271)

Opposite to transactional leadership theory but compatible with LMX is transformational leadership theory (Judge and Bono, 2000; Bass and Riggio, 2006; McCleskey, 2014). Much is written about transformational leadership and this style defines a leader as somebody who inspires and leads followers with encouragement, vision, communicable desire and charisma (Northouse, 2016). It is argued that these characteristics are what people tend to follow, or even unselfishly commit to, when they are attracted to a vision or charisma and passion of such a leader. McCleskey (2014) contends that transformational leadership is an approach which has been drawn on frequently during LMD trainings. Furthermore, followers who submit to transformational leaders may wish to be changed to be just like those they choose to follow (Eisenbach *et al.*, 1999). It can be maintained that transformative leaders are inspired and dedicated to being something more than them and as such followers and the organisation can become increasingly effective. Some authors do link the application of transformational leadership to the holding of certain physiological characteristics discussed during section 2.3.1 (Judge and Bono, 2000; Derue *et al.*, 2011; Lacerenza *et al.*, 2017). However, linked to LMX ideas, Kedsuda and Limsila (2004) consider transformational leadership to be increasingly about relationships and team work, rather than the actual performance of one person. Kedsuda and Limsila (2004) argue that a continuing method of shared arrangements amongst leaders and followers can create a heightened inspiration and ethical standing when transformative leadership is applied. In comparison to the functional and behavioural foundations of transactional leadership, it is

transformational leadership which entices the superior principles allowing the employee to move beyond the principle concern for the self (Bass, 1990). Kouzes and Posner (2002), who surveyed 75,000 people about the leadership characteristics which they appreciated and would follow; characteristics associated with transformational leadership came out on top beyond all other leadership qualities.

Still, there is room for consideration of the darker side associated with the transformational and charismatic leader. As described by Wilson (2015):

'Charisma is just an intense form of self-belief' ... 'It's closest friend can quickly become corruption, the belief that you can do anything with impunity' (2015, p. 152)

Conger (1990) considers the darker side of the transformational and charismatic leader to present in forms of unethical and damaging leadership behaviour. Conger (1990) argues that leaders can use the qualities of the charismatic style, for individual expansion and this may be applied in an abusive way which is contra to the welfare of an organisation or team. Conger (1990) focuses on four phenomena where the charismatic leader has the potential to operate in a damaging way. These being the leader's vision, approach to communication, influencing skills and their overall management practice. Conger (1990) contends that the vision the transformational leader has for an organisation, may simply reflect the internal desires of the leader, as opposed to the greater needs of the organisation. The skills which a charismatic and transformational leader may deploy to further their vision, are normally focused around communication and impression skills. Conger (1990) concludes that other possible consequences to a manipulative-transformative leader's approach may result in inadequate discipline of followers. This could present as unusual behaviour which isolates followers with frequent displays of autocratic management chiefly aimed at those followers in disagreement with their leader.

Building on Kedsuda and Limsila (2004), Timmins (2015) and Dougal *et al.* (2018) of The Kings Fund consider transformational leadership from the perspective of systems leadership. West (2017) promotes a collaborative and compassionate leadership relevant for an NHS, which has historically frequently struggled to work in a collaborative and patient centred way. Timmins (2015) and Dougal *et al.* (2018) shift the leadership focus towards the ideas of transformational change and the need for more consensus building between the complex systems of the NHS. Similar notions of the systems leader envisaged by Timmins (2015) and Dougal *et al.* (2018), Western (2013) suggests that eco-leaders promote distributed leadership styles and adaptive organisations, while maintaining ethical practice and sustainability. Western (2013) acknowledges a leadership discourse of eco-leadership to be *'a new leadership paradigm for organisations in the networked and inter-dependent global environment'* (2013, p. 28). The next section introduces the concept of social identity and discursive leadership, before drawing a summary to this short inspection of common leadership theories.

2.3.5 Social identity and discursive leadership

So far, this chapter has briefly presented a range of common and dominant approaches in leadership theory. Some authors have expressed a great concern regarding the dominance of these trait and style-based leadership approaches. These authors suggest that a greater focus is required on the socially constructed and communicative domains of understanding leadership (Tourish and Vatcha, 2005; Uhl-Bien, 2006; Fairhurst, 2008).

Social identity theory places an emphasis on social processes, whereby leadership ascends from and is applied via social relationships (Hogg, 2001). Hogg (2001) suggests that leaders are not enforced on the people they lead; leaders become applicable due to the embodying and the relational impact they have on followers. It is suggested that leaders configure collective identities, customs and principles that subsequently reinforce follower relationships.

Bolden *et al.* (2012) proposes that prescribed leadership roles within organisations are important, yet leaders who fail to notice the social situations they are in, are more likely to be excluded from the people they lead. Haslam *et al.* (2011) argue that a leader's role is predominately about moulding social identities. In this way, the leader and their vision can be viewed to be a tangible materialisation of group opinions and principles'. Haslam *et al.* (2011) also contend that a leader's role is totally interconnected to the group they lead. There is an emphasis on the leader to construct a collective identity, with leaders' fulfilling a role of '*entrepreneurs of identity*' (Besson, 1990 in: Reicher and Haslam, 2007, p. 127). Reading across the literature there is a similar recognition of identity management, purposefulness and the use of power within the wider organisational structure. An important facet of social identity theory is the recognition of how followers perceive their leader, thus resulting in the leader having to comprehend and effectively deliver leadership in line with the needs of their followers (Bolden *et al.*, 2012). The author suggests that this notion of social identity fits within the articulation of Day (2011) and Day's *et al.* (2014) LMD of interpersonal skills and the application of charismatic qualities associated with Northouse's (2016) understanding of transformational leadership.

In consideration of the communicative events which create the leadership practice discussed by Haslam *et al.* (2011); Fairhurst (2008) contends leadership to be a discursive activity which is a purely creative process, rather than a reductive process associated to the scientific study of leadership and leadership psychology. Discursive leadership places emphasis on cultural factors and communicative interplay with observance to communicative practices, which are enmeshed in the management of meaning and the communicative creation of reality (Torries and Fyke, 2013). Explored further, Fairhurst (2008) compares the differences between discursive leadership and the common psychological leadership theories (see Table 1.).

Table 1. The key differences between discursive leadership and psychological leadership lenses

	Discursive Leadership	Leadership Psychology
Object of study	Discourse	Mental theatre
Ontology	Decentred subjects	Essences
Power	Encompassing views, power and influence	Power and influence as dualisms
Agency	Reflexive agency	Untheorised/exaggerated agency
Analytic focus	Textual and contextual	Variable analytic
Communication	Primary	Secondary

(Created by Author, 2018, source: Fairhurst, 2008)

Regarding objects of study, Fairhurst (2008) suggests that distinguishing discourse can be problematic; nevertheless Fairhurst (2008) does advocate the work of Alvesson and Kärreman (2000). Alvesson and Kärreman (2000) differentiate between language and social interaction and offer a Foucauldian interpretation of historical arrangements of configurations, judgements and assumptions. Alvesson and Kärreman (2000) definition of discourse will be examined and drawn on as this thesis and research develops (chapters four, five, seven and eight).

To summarise, what is predominantly absent from the common leadership theories is the consideration of the instruments applied in the actual practice of LMD. By its nature LMD suggests a denunciation of the '*great man theory*' (Grint, 2005, p. 29) or natural traits theories of leadership. Nevertheless, neuroscience and its potential benefits to the leader/follower relationship and organisational improvement requires further investigation. Furthermore, as organisations become increasingly preoccupied with LMD (Zenger and Faulkman, 2009; Ford, 2015), current leaders and managers are increasingly accountable for the development of learning organisations. This can be defined by the idea from Senge (2006) who asserts that effective leaders should take accountability for organisational learning. Knight and Paterson (2018) furthers this by arguing that for employees to progress as emergent leaders and line managers; established leaders should be providing examples of successful and sustainable leadership themselves.

2.4 Exploring managerialism within the NHS

Throughout the development of the NHS, the management of an organisation which has become the fifth largest employer on earth (Forbes, 2010; The Economist, 2011; Nuffield Trust, 2017) has persistently been observed to be an extremely difficult and challenging plight to manage (West *et al.*, 2015). The Griffiths Report (1983) positioned ongoing concerns related to NHS management (particularly around governance and financial stability) as a priority issue, causing a great change within the NHS management discourse. A restructuring of the NHS advocated in the Working for Patients Report (DoH, 1989), promoted a post-bureaucratic age with principles of leaner thinking and an attempt to leverage power away from the medical establishment. The managerialism discourse with its complexities and contentions seemed appealing to modernisers and subsequently became embedded within the structures of the NHS. The next section (2.4.1) will begin by exploring selected discourses associated to the management and management education agendas. This will progress to recognising the influence of New Public Management (NPM) on the NHS and the torsions of the clinical/manager hybrid manager (section 2.4.3). Section 2.4.4 will refocus to discuss the disputes related efficiency and effectiveness within the NHS, along with the exploring NHS managerialism as a rational discourse (section 2.4.5). Section 2.4.6 will conclude section 2.4 by presenting a brief consideration of agent obligation and organisational culture.

2.4.1 The managerial discourses

There is a contention relating to the multiple understandings of the terms 'management' and 'leadership' that is evident throughout this study. One common discourse or understanding portrays 'the management' as the implementers of workplace control and 'the organisation' which defines management for organisational benefit. Regardless of this emphasis, the term management is still commonly defined as the scientific enhancement of the practice and purposes of organisation and organising (Olum, 2004). In isolation, this definition encompasses the notion that enquiries of efficiency and effectiveness are fundamental to both management theory and practice (Storey, 2013). Rigg (2007) describes managers as facilitators, demonstrating a procedural rationality, which endorses 'rational' resolutions and activities through the technocratic implementation of management interventions. This implies that management learning is mostly dependant on skill development and comprehension, as well as approaches which proclaim the enhancement of organisational performance. It is this understanding in both management practice and theory that defines which proficiencies, intelligences and mind sets can enrich the technocratic management endeavour.

Discussions pertaining to professional-managerialism highlight the practical elements, accrued expertise and professional understandings (Revans, 1987;

Mintzberg, 2004). Other discourses which favour scientific-managerialism, attempt to link technical and academic attainment through the intellectual demonstration of organisational improvement (Bass and Avolio, 1993; 1994). Such debates develop through the identification of management as an informal practice related to the affairs of economics and society and the imposition of worker discipline as demonstrated by the works of Taylor (1911) and Fayol (1949).

Furthermore, diverging arguments have also been played out in the form of management theory verses management practice and how management knowledge should be theorised (often characterised as a struggle amongst academic, professional and social agencies). Early 20th century notions placed management as a social practice, which placed restrictions on it as an academic field of study (De George, 2015). It was argued that management education must be managed by the profession, if accepting that knowledge is related to practice where dominant customs are involved. Raelin (2007b) comments that *'by trial and error, on the job learning and the passing of accumulated skills and abilities from one generation to another'* (2007b, p. 498) is the way management-as-practice is commonly depicted. In this understanding, management has no standard research foundation and is based on a variety of discourses and handed down traditions, a contra to scientific enquiry.

With ever increasing trade and business, management-as-an-academic discipline located itself within the realms of business education, founded upon a rational syllabus with minor importance placed on practice-based experience (Tosey *et al.*, 2013). Developing management as a scientific endeavour has strengthened it through a collective resource of commercial and administration-based curriculums, demonstrated by the functional specialisms of finance, HR and so on. The institutional nature of management development arose through similar agendas throughout the USA and Europe (Davis and Bansel, 2007). During this time, management-as-science characterised management educational-practice to be inadvertently linked to organisational and nationwide monetary improvement.

The creation of educational approaches to management along with the supremacy of scientific management becoming established through academia allowed for commercial teaching to thrive. It was contended that in the 1990s, \$37 billion dollars worldwide was spent on the development of managerial capability (Organisation for Economic Co-operation and Development, 1999). An influence Easterby-Smith (1994) noted to be associated to the idea of its function of safeguarding organisational economic existence and forthcoming competitiveness. The discursive formation of the scientific approach to manager development and declared connection to the specific manager, organisation and nationwide improvement, hastened the progress of commercial sector teaching. Academia expanded significantly in the late 20th century and awards such as the Master's in Business Administration (MBA) became especially sought after as a method of signifying managerial qualities (Williams, 2010).

The promotion of the scientific managerial approach represented a turning point where positivist or scientific realism began to integrate with the world of management professionalism (Yeung and Berman, 1997). This resulted in a joined-up curriculum, predominately so that academia and the management profession were safeguarded from the capitalization of professional knowledge and extensive occupationalism (Hyland, 2001). From this perspective, scientific managerialism was driven by the exchange of knowledge and education by accredited organisations, which contradicts the discourses which focus on learning from practice and the front line of work. As a result, managerial instinct gained from experience becomes separated from its source, while scientific management develops an honoured testimony, while relegating the value of practice-based knowledge and its variants.

Challenging this discourse, Hyland (2001) acknowledges the significance of scientific managerialism and how experience contributes to the assembling of knowledge. These challenges are supported through ontological and epistemological considerations, such as who articulates the value and the purpose of the managerial knowledge. The discourse of scientific managerialism assumes an ontological attitude of realism. The scientific managerialism discourse approves of academia being the most suitable custodians of management information (Kolsaker, 2007; Bolden *et al.*, 2015) and within this discourse, students are mostly passive receivers of extrinsic knowledge. Scientific managerialism adopts the notion that in the pursuit of knowledge, regardless of the experiences of the learner, the pursuit can be interpreted as ontologically articulate (Fenwick, 2008a). These discourses of management will now be explored further within the context of the NHS.

2.4.2 New public management and the NHS

Concurrent to the introduction of managerialism in the 1980's, NPM in the 1990's presented a philosophy of private sector practices within the NHS. This development combined with scientific managerialism, assisted managers with future organisational planning, whilst applying tools to control and monitor individual performance (Streatfield, 2001; Adcroft and Willis, 2005). More recently, and with Lansley's NHS (Health and Social Care Act 2012) reforms providing a back drop; post-NPM has increasingly looked more like a networked governance environment with clinical and managerial hybrid leaders presenting as cornerstones of this movement (Ferlie *et al.*, 2013). As mentioned in section 2.3.4, an increased push for closer collaboration, transformational change and systems leadership within the NHS is being pursued (Timmins, 2015; NHS Improvement, 2017; NHS Leadership Academy, 2018). Drawing from the Next Steps NHS Five Year Forward (NHS England, 2017) and the implementation of 44 Sustainability and Transformations Partnerships (STPs); an integration agenda has been formed with the implementation of ten Integrated Care Systems (ICSs). According to the Breaking Down Barriers to Health and Care

document (NHS England, 2018a) and a The King's Fund review of ICSs A Year On (Charles *et al.*, 2018), progress is good with four more ICSs are on the way.

Working backwards since its foundations, the NHS has mostly been governed by a mix of select and powerful stakeholder groups, with successive governments who have long delivered money and power to maintain and deliver the NHS (Harrison *et al.*, 2003; Select Committee Report on the Long-Term Viability of the NHS, 2016). Politically, it has also been acknowledged that the privileged professions, particularly the medical profession, have historically thwarted policy change by evading debate and blocking local opposition.

Historically, the government has mostly leant towards the directing of NHS provision through centralised control in Whitehall (Baker, 2000; Young, 2000). In retrospect, and as highlighted by Pollock (1995), this status echoes the original intentions of Bevan in 1944 to:

'Trade local democracy and the independence of voluntary hospitals for a national hospital service, can be seen to be based on concerns about the market and the ability of local authorities to plan for equality of treatment' (1995, p. 1583).

However, with the introduction of NPM, hospital managers have inherited increased freedoms to take control and direct care. Growth in this area has been significant over the past 30 years, with this endeavour being coupled with a meticulous focus on competition and performance indicators. This focus has inevitably led to the movement of management attention divided between local and societal concerns and the requirement of outputs, cost control and target achievement (Mannion and Goddard, 2001; Mannion *et al.*, 2008). Increased political statements associated with decentralisation, mutualism and increased NHS freedoms resulted in the movement of responsibilities regarding both (in)efficiency and governance. This responsibility transfer from Whitehall, resulted in NHS management continuing the long history of political tension associated with the NHS since its creation (Carney, 2006). Bevan's original fears of the inability of local authorities to deal with the complexities of providing responsive and equitable local healthcare are now being tested (Peckham, 2014). To note, the Balanced Scorecard is a common tool which attempts to balance local and national concerns by creating insightful and relevant indicators (NHS Improvement, 2018a).

Subsequently, a contradiction has arisen where managers motivated by merited autonomy (The Kings Fund, 2011), yet not wanting to be held responsible for failure, have created a risk-opposed and procedure-focused methodology (Rose, 2015). Pollitt (2003) argues that from the early 2000s, this approach has deterred local innovation and originality. Concerns regarding perverse incentives or wicked problems (Grint, 2010) initiated the implementation of values-based markers and quantifiable audits to try to counter this paradox (Department of Health, 2002). Still measurable features are infrequently autonomous and concentrating efforts to combat one problem have often resulted in other problems deteriorating (Hood and Bevan, 2005). Davies and Lampel (1998) offer

an analysis, signifying that such indicators demonstrate little and that the understanding they present without context is a significant drawback of performance management. Adab *et al.* (2002) propose that some indicators within healthcare can be useful if presented using the right method of presentation and feedback i.e. the use of control charts as opposed to league charts when comparing and rating hospital performance. Exworthy *et al.* (2010) considered the role of a disclosure programme in cardiac surgical practice, with the goal of disclosure being to promote transparency and improve clinical performance. Exworthy *et al.* (2010) found that a programme approach to disclosure can obscure some performance problems, while bolstering professional autonomy. Exworthy *et al.* (2010) conclude that disclosure can signify more transparency in healthcare, still it is undetermined whether it can improve clinical performance.

Ultimately, target setting urges organisations to focus, yet service transformation and innovation can be inhibited. Notably, NHS Trusts can be seen to be under-performing (irrespective of whether they are performing to the standard required), simply due to not gathering the required data effectively (Raleigh and Foot, 2010). Other concerns regarding the use of targets and the potential for them to be corrupted is recognised by Goodhart (1975, p. 53) stating that when a '*measure becomes a target, it ceases to be a good measure*'. There are indications that there are signs of improvement within the NHS, while it can be argued that this is due to increases in efficiency and accessibility (The Health Foundation, 2015; A&E Improvement Programme North Region, 2016). Some studies also pertain that performance management linked to hospital competition, has in fact resulted in reduced costs and higher clinical outcomes occurring under the right conditions (Propper *et al.*, 2010; Gaynor *et al.*, 2010). Nevertheless, the argument of Pollitt (2000) remains convincing in the contention that demonstrable improvements in organisational effectiveness can be extremely difficult to determine. Pollitt (2000) asserts that the total price of being in a constant state of reorganisation may be incomprehensible, particularly in relation to costs, time and clinical outcomes.

It is additionally acknowledged that a manager's principles may not necessarily represent the performative approach. What has developed is a disjointed, combative, splintered association between managers and professionals who attempt to meet financial obligations (Hoyle, 2011). Hence, this has encouraged an incessant cycle of schemes to increase performance through defined criteria and measurement, regulation, micro monitoring and external appraisal (Pollitt, 2003; Seddon, 2005). The consequence of this combative approach between managers and professionals, presents its self in a performative dimension (Seddon, 2005). This encourages notions of what gets measured is of value, though statistics without situational understanding is of limited worth (Krenchel and Madsberg, 2014). To alleviate this contention, the role of the hybrid-clinical manager across all professional spheres has become increasingly more wide spread within the NHS (Fitzgerald and Ferlie, 2000; Montgomery, 2001). With integration and systems leadership agendas (and the endeavour of reducing

duplication of services) dominating; it can be reasoned that the leadership abilities of the hybrid-clinical manager will be at the forefront of these endeavours.

2.4.3 The evolution of the hybrid manager

There are several arguments in favour of the amalgamation of managerial and clinical roles into one dual hybrid role. Some contend that this merger softens the impact of managerialism (McGivern *et al.*, 2015), improves patient pathways (Kirkpatrick *et al.*, 2016) and introduces more compassion back into care (Zulueta, 2016). It was originally assumed that commonality of professional role values and standards would be enough to promote an effective amalgamation of clinical and management responsibilities (Fitzgerald and Ferlie, 2000). Other ideas were understood to be that the hybrid manager represented yet another layer of unnecessary management (Hoque *et al.*, 2004) and an unnecessary distraction for clinicians (Mintzberg, 2004). Other commentators identified the potential for the hybrid manager to be highly influential within organisational settings (Grint, 2005). The Kings Fund (2014a) recognises that there are many complexities associated with the hybrid manager role or hybrids, and they can present with role conflicts and paradoxes. This potential paradox presents as conflicts between generic management demands, versus individual professional-clinical priorities. Having to deal with the loss of a clinical-professional identity and the sense of isolation from pure clinical colleagues, this appears to be a significant issue faced by hybrids. McGivern *et al.* (2015) propose that hybrids are now starting to group together and to see themselves as elite professionals within their disciplines.

In the early 2010s increased NHS LMD provision, reflected widespread understanding of the need for social capital skill building in hybrid managers (The Kings Fund, 2011). This identified the potential for a shift in the discourse of such trainings, away from the primary promotion of individual human capital skill building, to a more social/group capital building approach, which promotes networking and politicking (Fairhurst, 2007; Day, 2011; Day *et al.*, 2014). With some NHS LMD trainings still leaning more towards the ongoing promotion of transformational and heroic leadership style ideals (Tams, 2018); this may confuse hybrids who do fit this mould, but are having to operate in a more integrated, post-individual NHS workplace. However, Fulop (2012) does contend that hybrids can work effectively within these collective structures with their powerful knowledge brokerage role. These practitioners have skills to navigate structural power imbalances and the self-perception of being the hero and a jack of all trades.

More recent research has expanded the comprehension and awareness of the complexities involved in hybrid management roles. Building on Fairhurst (2007), Spehar *et al.* (2015) suggest that NHS LMD training should acknowledge the search for meaning and purpose during the transition from clinician to hybrid

manager. Spehar *et al.* (2015) explore identity transformation and provide a detailed investigation of the inner conflicts which occur during professional role development and transition. There is recognition of feelings related to loss, isolation and despair. In several studies, it was also suggested that doctors struggle with the hybrid transition more than nurses do and as such this represents a need for less uni-professional research (Currie and Croft, 2012; Clay-Williams *et al.*, 2017). Jackson *et al.* (2014) do counter this argument and suggest that doctors do not struggle with this transition as much as nurses do, due to their elite status.

Previous research exploring the impact of hybrid clinical-managerial roles on doctors focused primarily on resistance and doctors displaying behaviours which reinforce clinical integrity (Joffe and MacKenzie-Davey, 2012). Nursing dedicated research focused on how conflict and power imbalances with medical colleagues became apparent when stepping into hybrid roles. Nevertheless, Spehar *et al.* (2015) and Burgess *et al.* (2015) both assert that for nurses, adaption seemed to happen quickly, and these hybrid managers can effectively fulfil roles of knowledge broker and bearers of professional standards. Moving beyond professional background, Currie and Croft (2015) explore how the feminised nature of nursing interacts with the masculinised nature of NPM. Considering the further evolutions of the hybrid manager and subsequent contentions with NPM; Byrkjeflot and Jespersen (2014) acknowledge the existence of a third kind of hybrid manager known as the '*neo-bureaucratic manager*' (2014, p. 450), with the first type being the forced hybrid and the second kind the willing hybrid. The hybrid manager is an inconspicuous challenger to NPM and sits well within the sphere of the governance, accountability and systems leadership sort today (Timmins, 2015; West, 2017). These assumptions tentatively lead to there being limited room for the more individually commercially focused NPM hybrid. This professional may find themselves isolated, deemed too managerial or fiscally focused and crucially without the professional alliances needed to operate within an integrated environment. Understanding this role, its presentations and transitions will assist in later conceptual underpinnings linked to the purpose of LMD within the NHS.

2.4.4 Contentions of efficiency and effectiveness within the NHS

With the ongoing march of NPM, which is now accompanied with an integration agenda (NHS England, 2014; 2017), the search for efficiency and effectiveness continues. For clarity, efficiency can be defined to be the optimum use of inputs and resources. Effectiveness can be understood in terms of outcomes with the attainment of explicit objectives, presuming all objectives are explicit (Arah *et al.*, 2003). The orthodox discourse of the public-sector is linked to inefficiency or lack of effectiveness in comparison to its private sector equivalent (Curristine *et al.*, 2007; Mihaiu *et al.*, 2010). However, Pollitt (2003) maintains that

measurement of achievement within the public sector is problematic and can be viewed in many distinct ways.

The English NHS internal market directed some emphasis on efficiency utilising proportionate controls which in turn, decrease public expenditure on clinical interventions (Tynan, 2015). Notwithstanding the adoption of the philosophies of the private sector, the government presumed an effective transfer could be made (particularly discounting the public-sector notion as a 'context-dependent craft'). Burgess *et al.* (2002) contends that the transfer (public to private) has failed and has subsequently resulted in an environment of ever enduring governmental control. Even with the push for increased patient choices (NHS Choices created in 2007 from NHS England, 2018b), author's such as García-Lacalle (2008) argue that this choice is a fallacy and that the government is still fighting with the contradictions of trying to promote an internal free market through centralised control mechanisms.

The developing question envelops the political description of the term 'improvement' within the NHS and how polarised, insubstantial achievements determine progression. For example, the NHS frequently describes the notion of improvement in requisites related to reducing the wait for access to treatment and choice (NHS Constitution for England, 2015). By contrast, Fitzpatrick (2001) argues that with the ever-growing expectancy of need located within the boundaries of financial limitations. This places an enormous undertaking on managers and any achievements echo the gallant ambitions of political leaders.

The frequent obsession with performative measurement is drawn from an assertion that performative improvement connects to increased 'successes' with palpable advantages (Adcroft and Willis, 2005). Some authors believe targets are disruptive rhetorical strategies to triumph politically rather than holding any sincere relation to public interests (Adcroft and Willis, 2005). It is roundly argued that the NHS does not occur in a void. Its processes are a multifaceted mix of the noticeable and the undistinguishable, clear and distorted elements, infrequently separate and often non-linear (Adcroft and Willis, 2005). Current arguments suggest that the NHS seems trapped between performative management discourses and the practice and intuitive, context specific nature of healthcare. The use of reductionist tools of measurement being one of many representations of this discord.

2.4.5 NHS and managerialism as a logical discourse

The concept of managerialism provides the right conditions for the defining of a clear organisational vision at a strategic level. Judgements on how organisational aims can be met at policy level are also challenged (Roper and Pettit, 2002; Locke, 2011). Supporting this context echoes Weberian philosophy, in which workers succumb to executive and managerial power via bureaucratic authority, resulting in dichotomy and change (Grey, 2005). Still, Vickers and Kouzmin (2001) contend that managers are unaware of the discomfort of others under

the label of organisational efficiency. Rationality assumes that managers can continue to be detached and distinct, permitting a continuous approach to confronting their employees (Dean, 1999).

Incongruities relating to the NHS move beyond bureaucracy which rationality enforces, ultimately decreasing a subordinate's choice. Eventually this eliminates their aptitude and conceptual abilities and can contradict government's desire to promote innovation and change (Hunter and Hudson, 2000). Grey (2005) suggests that organisational life is de-humanised, empty and prejudice occurs in forms of personality and agency. Grey (2005) focuses on the fact that the supremacy of the rational approach such as scientific managerialism tends to relegate other methods which are not coherent to its methods. Boje (2006) asserts that most managers will accept the rules of others, regardless if these rules are inconsistent and illogical to them.

As previously eluded to in section 2.2, industrial development during the 18th century considered the liberal nature of humans, to be troublesome to the scientific controls of the modernist agenda. The commercial appeal of higher productivity and its associated discourses is supported by scientific management to endorse its reasoning (Whitaker, 1974). Empirical analysis and the endeavour to reveal unequivocal truths reduced agent knowledge, awareness and understanding to be scientifically inferior (Foucault, 1981; Hood, 2001). Within the NHS, the use of 'science' and its substantiation or evidence drawn from empirical investigation is frequently endorsed. This is over the professional judgement, instinct and disorganised understanding of the experience of its practitioners (Masic *et al.*, 2008).

In alliance with the scientific method, promotion to the philosophies of scientific managerialism and methods to govern worker behaviour were endorsed (Taylor, 1911; Fayol, 1949). Comprehending individual practises as narrow systems, behaving in a mechanical way, individuals were just parts in a machine. Barley and Kunda (1992) assert that it can be argued that this mechanistic symbolism became long-established within the managerial discourse in the context of the suppressed and the suppressors. Production efficiency methodology or scientific management eliminates self-sufficiency, breaking action down to constitutes, with the machine becoming the metaphor to follow (Barley and Kunda, 1992; Grey, 2005). Matthews (2009) explains that there was a belief that when agents are deprived of vigorous disciplining and surveillance instruments, thoughts invariably turn to self-interest. This subsequently fuels disorganisation and atrophy; scientific managerialism remained to be the method which can limit these shortfalls.

According to Pollitt (2003) the scientific managerialism takeover of the NHS has reduced the entitlement of the clinical specialties. This may replicate the difficulties associated with engaging clinicians, with continuous improvement mythologies such as Lean Thinking and Six Sigma (Radnor and Boaden, 2008; Deblois and Lepanto, 2016). The reluctances of various professional groupings to work with these approaches is frequently attributed to the stalling of progress.

This is persistent with the narrative of change remaining subtle in contrast to clinical work. Any change endeavour will always comprise of in-depth and time-consuming clinician negotiation, during which the motivations for the change can begin to fatigue (Waring and Bishop, 2010; Deblois and Lepanto, 2016).

In principle, the dominant feature of scientific managerialism relates to its performative function. Lyotard (1984) and more recently (Adcroft and Willis, 2005; Waring and Bishop, 2010) illuminate the fact that clinicians do not always acknowledge scientific managerialism, because fundamentally they refute that healthcare is direct and orderly. Still, one may contemplate that the categorisation and decentralisation of responsibilities to less qualified roles, undoubtedly offers itself to organisational led as opposed to consultant led care (Stuckler *et al.*, 2009). The challenge of scientific managerialism is to adjust to the precarious nature of the public sector in which boundaries are penetrable, with associations to stakeholders varying, complex and unsubstituted yet critical (Haynes, 2015). Nonetheless, this challenge is distorted, with much documented research devoted to such let-downs related to scientific managerialism. This approach still triumphs in many prescriptions of organisational performance enhancing and change models (Gourishankar and Subramaniam, 1999; Buble *et al.*, 2001; Walker *et al.*, 2011; Doppelt, 2017).

2.4.6 The concept of agent obligation and organisational culture

Opposing the efficient and focussed methods of scientific management; a subtler display of management is documented which endeavours to realise the '*purposeful self*' (Prontefract, 2016, p. 1), requesting allegiance, communal organisational beliefs and self-actualisation. This discourse recognises the disordered, fluctuating and uncertain nature of agents. It moves from the concentration on productions to the more personal features of management, such as eliminating administration with the reduction of over-observation. This approach is associated with the human relations schools of Herzberg *et al.* (1959), which considers the needs of humans (that Taylorism endeavours to eliminate) while still allowing the underlying values of performativity and command to continue. Western (2008) considers this as leader-as-therapist discourse, as such the leader embracing a therapeutic culture which concentrates on connecting with workers to encourage motivation and obligation.

Chase (1997), Martin (2002) and Manen (2015) suggest that a standardised, unified organisation can be built through commitment-orientated approaches symbolised by terminology such as, organisational culture and knowledge-based organisations. Other narratives include the philosophies of emotional intelligence (Goleman, 1996). This has assisted in the transformation in managerial representations of leadership, through the (re)defining of leadership styles (i.e. from authoritarian to more transformational and inclusive approaches). These

ideals suggest that leadership is a comprehended managerial device which can regulate activity by means of encouragement alongside knowledgeable inspiration, as opposed to regulation-founded, corrective processes (Bass and Alvolio, 1993).

However, a study by Worthington (2004) found that the advancement of a joint and inclusive NHS organisation and staff narrative which mirrored organisational problems (such as having a large staff turnover and financial difficulties) had no influence on workforce commitment. Moreover, Kurtz and Snowden (2008) believe that if an organisation cannot accomplish the development of a unified identity, a silo approach is subsequently accused of being the source of organisational problems. Some authors do argue that departmental silos can in fact function as well as most context focused teams do (Kirpal, 2004).

Schein (1984) characterises culture as an evolving occurrence, growing at will and becoming established naturally, as opposed to presenting as a set of features which are artificially imprinted on individuals. Deliberation on the ideas that actions founded through dedication to the culture can surpass the need for enforced obedience. It is argued that this approach can cultivate devotion, inspiration and assurance to the organisation (Whetton and Godfrey, 1998; Yukl, 2013; Schneider and Barbera, 2016). Subsequently, agents are subjected to the narrative of organisational values and aims. These narratives are articulated via mission statements, HR policies, organisational colours and mottos with organisational aims in mind (Shoemaker, 1996; Agyeman and Erickson (2012). Grey (2005) affirms the importance of getting organisational culture right, critically Grey (2005) asserts that this quite a difficult achievement.

2.5 Critiquing leadership and management learning

Since the early 2000s, there has been a notable critique of the management education discourse. Critics of management education have contended that inadequate theories are being promoted and as such warranting the need for a more well-defined positivist footing of knowledge (Donaldson, 2005). Other issues include the ideas that incorrect theory is being taught because it exemplifies organisations and is incapable of explaining multifaceted behavioural and political possibilities linked to them (Mintzberg, 2004). Thus, connecting the assertion that academia can have poorly qualified staff without correct degrees or experience (The Economist, 2016). Mintzberg (2004) also considers approaches to management knowledge and theorising to be insufficient in-relation to globalisation. Chia (2005) proposes that '*silo*' (2005, p. 1090) approaches to the administration of management knowledge can be obstructive when attempting to comprehend multifaceted issues.

Additionally, Ghosal (2005) suggests that speculative leadership and management models, when ideologically driven, can have a propensity to teach managers unethical practice. Ghoshal (2005) further proposes that:

'the notions of academics in the business management sector have in some ways been accountable for some of the worst excesses of recent management practices' (2005, p. 61).

Ghosal (2005) proceeds to argue that *'business schools are on the wrong track'* (2005, p. 96), mentioning the malfunction of MBA programmes to deliver managers with valuable workplace skills. Ghosal (2005) asserts that business schools do not coach them sufficiently for leadership positions and Bennis and O'Toole (2005) proposed that they fail to instil acceptable standards of ethical behaviour and conduct. Importantly and pre-2008 crash, Ferraro *et al.* (2005) summarises that the field of economics, which has delivered the foundation of business theorising, does not merit or honour the practice of successful management behaviour.

Summarised, the endorsed approach to management education under the umbrella of academia has recently taken somewhat of a beating. Furthermore, such analysis of management education in academia has been considered in relation to the understanding of pedagogical preferences and its undertaking as a manufacturer of knowledge. The question of whether academia is best placed to partake in both business and management research continues, with contentions being its obscurity, intangibility and it simply being unreachable (Alvesson and Deetz, 2000).

In 1996, the Organisation for Economic Co-operation and Development (OECD) recognised that knowledge was becoming a source of competitive advantage for organisations, thus growing the economic value of knowledge. Discursive arguments related to this have generally presented in two approaches. Approach one considers knowledge relating to the established management-as-science frameworks, whereas approach two originates knowledge from the place of work and workplace experience (Gibbons *et al.*, 1994; Bijker *et al.*, 2012). The terminology of both approaches is challenging in different ways, creating rifts between the two and generating a separation that has become entrenched, as fluctuations in research funding arrangements demonstrate (Research Councils UK, 2016). What is interesting here though is that approach two emphasises workplace knowledge and eliminates the judgemental associations which previously have accompanied it. In addition, approach two agrees with perspectives that theorise workplace learning as examples of intrinsic discovery and development.

Critique of the academic approach suggests that an all-encompassing mix of learning approaches combined with a situated management-as-practice slant to managerial development, could well be the most effective way forward within this field. Within the NHS, such endeavours to promote workplace LMD have remained relatively unclear (Powell *et al.*, 2012). LMD type endeavours such as talent management (TM), as defined by the CIPD (2017b) seek to:

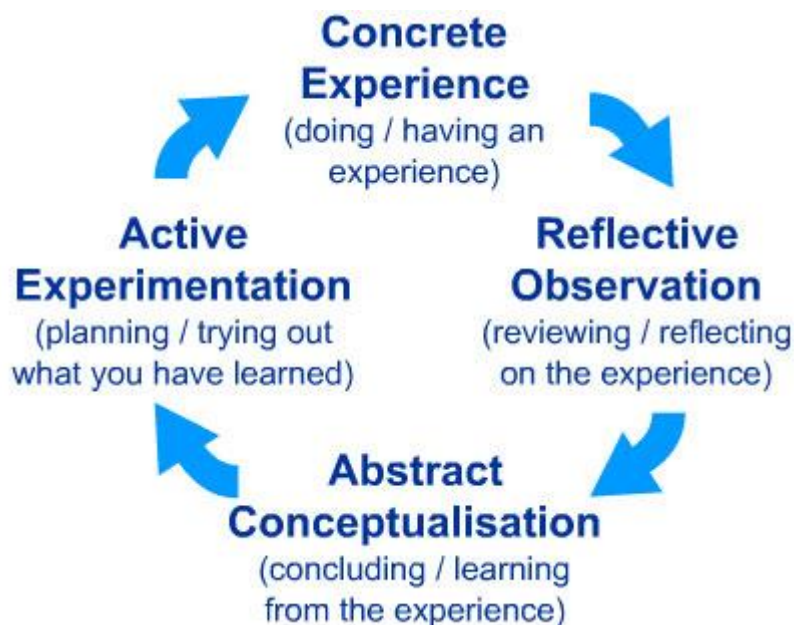
'attract, identify, develop, engage, retain and deploy individuals who are considered particularly valuable to an organisation' (2017, p.1).

Powell *et al.* (2012) suggest that having a clear and systematic TM strategy may produce individual and organisational rewards within the NHS. Key concepts surrounding leadership and management learning are further considered in the following sections (2.5.1-2.5.7).

2.5.1 Knowledge created during reflective-interaction

The re-establishment of management-as-practice as an educational force, leads to concerns relating to knowledge creation which challenges academia's function as the caretaker of knowledge. Raelin (2007b) operationalises these concerns, by recognising a rough paradigm change in perceptions of the foundations of knowledge. This change focuses on the importance credited to experience, learning as a reflective endeavour and knowledge building. This signifies an ontological and epistemological alteration in the direction of subjectivist and constructivist notions of learning (Fox, 1997). There are important considerations here. Firstly, the importance credited to the involvement of reflective practice by means of a tool for learning and its relationship to the peripheral environment. Reflective practice has progressively become integral to the process of learning, such as in Kolb's (1976; 1984 in McLeod, 2017, p. 1) Learning Cycle (Figure 4.), where both reflectivity and doing are taken to be correspondingly significant as each other during the knowledge construction process.

Figure 4. Kolb's Learning Cycle



(Source: Kolb, 1976; 1984 in McLeod, 2017, p. 1)

Certainly, when combined with effective investigation it can be considered that the experimental and reflective components are imperative, more so in contrast to the prospects of effective conceptualisation. Presented another way, this

feature of learning may not need to involve scientific theory but perceptions from somewhere else. Supporting Raelin (2007a) who considers '*epistemology of practice*' (2007a, p. 500) comprehending the involvement and doing to be a necessary part of the development of knowledge.

Echoing the notions relating to knowledge assimilation, reflecting while doing and reflecting on what has been done, has developed into fundamental narratives within the LMD field. Models such as Reg Revan's (1972; 2011) action learning, highlights between connecting reflective practice and contemporary management education. This is widely acknowledged amongst organisational studies and HRD (Reynolds and Vince, 2004; Rowland, 2014). Possibly, it is not unexpected that organisational development practitioners have demonstrated an increased appreciation of learning processes, so that they can proclaim to have an influence on organisational behaviour and improvement. It can be rightly argued that 'learning' does have an apparent link to organisational performance, which scientific managerialism does not. It can also be proposed that management-as-science and its perceived advantages for managerial conduct, organisations and communities alike is long overdue. The knowledge-based individual may bring investment potential, which can crucially be traded as a part of the knowledge economy (Popescu *et al.*, 2014).

Acknowledging the significance of reflective based learning, the consequence is its ontological and epistemological withdrawal from the management-as-science approach. In reflective based learning, knowledge and its accumulation are ontologically and epistemologically similar. In this conceptualisation, the doing and the understanding, is also the act and the learning. Hence knowledge, sense making, and learning are all linked indistinguishably to the undertaking (Elkjaer, 1999a).

Separate to formalised theory, credited training and university environments, learning can happen instead (or in addition to) in communities of inquiry (Shields, 2003) or action learning sets (Mumford, 1996; Pedler and Abbott, 2013) for example. From this standpoint, constructivist formulations incline to only consider the process of knowledge construction. They are less concerned with the imbalanced associations of organisational power within the environments where the learning occurs. This understanding is important because in constructivist management education, the workplace is mostly acknowledged to be the place where most learning occurs. To be considered further, it is first relevant to consider the dual understandings related to emancipation and dominance.

2.5.2 Humanism and the constructivist discourses: Emancipation and domination

Reflective based learning establishes ideas of disengagement from the prevailing academic epistemology of scientific managerialism; it can evade the usual,

historically dependent, predominance of power (Grieves, 2010; Manen, 2015; Mathieson, 2016). Reflecting-on-action and understanding can also alter the perception of the world and an individual's place within it. This approach exposes a tendency to reveal the continued arrangements of powerful groupings and as a result may disrupt regular discourses. Therefore, this approach may present as foundations for communities of action in understanding and the sharing of overpowering and dominating power relations (Habermas, 1984; Brookfield, 2005).

Emphasised within the prevailing humanist approach, reflection-on-practice has routes to critical theory (Elliott, 2008). Learning and knowledge can connect the individual to society, yet it can also challenge communicative misrepresentations and fabricated awareness (Alvesson and Deetz, 2000). While the terminology utilised within this thesis highlights its humanist dimensions, emancipatory potential can be noticed in the classroom or training room and learning through experience. Within the discourse of Critical Management Education (CME), there is an ambition in which autonomous learning and education and the complications of established knowledge methods from the academic empiricist environment are recognised. For example, Malcolm and Zukas (2000) highlight the departure of pedagogics, away from the professional authorities and examination. Simultaneously, the ideologies behind the humanistic discourse can be noticed outside the classroom in both feminist (Mohanty, 1988) and anti-racist movements (Sefa Dei, 2013). Some supporters do question the reflection and interrogation of experience as being the true essence of learning. As alluded to by Rodgers and Freiberg (1994), self-learning and its subsequent knowledge differs significantly from positivist constructions, concentrating on the person and their experience of learning. This conception leads the prevailing trend for the focus to be on the learner and the exploration of self, often under the heading of experiential learning. Dalton (2010) notes that there has been an increase in the awareness of this method of learning and it has been '*irresistible*' (2010, p. 181) throughout education. The application of this approach to managerial education, applied through CME academics as well as researchers, indicate a political and ethical presence within the domain of experiential learning. Suggesting, that all the problems arising from the institutional restraints of academia and the knock-on effect of empowering, allows managers permission to scrutinise each other's subjugation and their own involvement in it (Fenwick, 2005; Trehan, 2009).

2.5.3 Workplace performance and learning

Due to its proposed performative features, the curiosity related to casual as well as situational learning has significantly increased, particularly around the cultivation of the autonomous agent and national performance. Elkjaer (1999b) suggested that mainstream understandings related to organisational learning tend to take a normative stance. An awareness of the marketplace is notable with its intent to concentrate on observable and valuable tacit knowledge. This

approach can be articulated through innovative and well organised distributions and control of what is learned (Waring *et al.*, 2013).

Nonak (1995) highlights that knowledge management mixed with the notions of performance-based constructivism and autonomous learning are principally in place to ultimately assist organisational goal achievement. In this conceptualisation, the organisation governs learning and its utilisation. Learning is recognised as a vital development within the sphere of performance and competition, with the knowledge markets requiring agents who incessantly develop and in turn accelerate organisational development and improvement (Gustavs and Clegg, 2005). Yet, categorising the knowledge markets and its agents like this has been associated with concealing the deskilling propensities of the modernised reductionist workplace (Hodgson, 2005). Thompson and Smith (2010) argue that the knowledge-based marketplace largely tends to misrepresent the contemporary workplace, by disregarding how much work still adheres to the discipline of scientific managerialism and its restrictions. It is nevertheless an influential discourse resounding with concepts of organisational (Easterby-Smith *et al.*, 1999) and long-term professional development (Chartered Management Institute known as the CMI, 2018). Positioned within a consensus, these discourses represent a fundamental concept within the workplace learning field like academia. As such, understanding knowledge construction to be a result of experiential learning has exposed its tentative, performance-based intentions.

Raelin (2009) describes both action learning and experiential approaches, as action-based approaches which emphasises the situational nature of learning. This echo's Lave and Wenger's (1998) construct of work, which draws from works informal, practice-based roots. Fenwick (2008b) contends that as learning in the workplace has emerged, different characteristics related to learning have also gained momentum. There has been a notable shift from learning with achievement, to a focus on learning through the mastery of knowledge production models. This has implications regarding awareness and philosophical value, particularly regarding learning at work. Community environments have encouraged learning and communities of practice have developed using social networking applications as platforms for knowledge transfer (Gaál, 2015).

Despite these understandings, Fenwick (2008b) perceives a minimal observation in relation to the history of workplace learning and how steeped this type of learning is within the context of power and relationships. Lack of acknowledgement of the power relations related to learning within the workplace can be moderately explained through its very presence. Consideration of learning, any learning can be seen in a positive light regardless of its intentions.

Contu *et al.* (2003) noticed that situational learning and the learning organisation has been incorporated within the greater learning discourses. Such assertions contend that learning is abundant everywhere, and as such any connection made is related to an intrinsic progressivism. This reflection does not consider power and difference, which can be entrenched in academia and the

(de)constructive nature of learning itself. Correspondingly, Bolden (2010b) asserts that workplace learning has developed significantly during the past twenty years and is apparently enticing a wide-ranging collection of theorists. Still, research related to learning in the workplace has inclined to lean more towards the normative and prescriptive, as opposed to the critical stances. This has continued with the current sponsor of the Institute of Apprenticeships (2018) from the Department for Education and Department for Business, Innovation and Skills (English Apprenticeships: Our 2020 Vision, HM Government, 2015)

The workplace learning discourse has long been supported by national programmes and policies which recognise learning to be fundamental regarding national prosperity (UK Government Office of Science, 2016). Coffield (1999) argues that an agreement has arisen which establishes education as central to economic competitiveness and likewise raises human capital as a significant underlying factor in defining national accomplishment. By highlighting the responsibility of individuals to constantly develop and continue to be employable in the globalised economy; this has overridden other governmental obligations of supporting and developing workforce improvement and to tackle disparities in workforce employability.

The OECD promotes mantras of life-long learning and how continuous learning will enhance a nation's long-term economic prospect (Gustavs and Clegg, 2005). Coffield (1999) considers the life-long learning discourse to be so overwhelming that it becomes a discourse of economics. Such disconnection of learning from academia, legitimatises the importance of workplace learning, reconstituting the process as principally related to monetary advances while linking it to performative justification. Furthermore, workplace-learning acceptability has additionally nurtured a competence-based discourse; it nonetheless derives greatly through frontline learning.

2.5.4 Managerial learning and the competency-based approach

Following reports concerning inadequate management training (Beer *et al.*, 2016a), the 1980s observed improved and increasing attempts from the UK government to professionalise management development. This governmental interest in learning was expressed by the 1988 green paper named 'The Learning Age' (Department for Education and Employment, 1988) and later succeeded by the 1999 white paper 'Learning to Succeed' (Department for Education and Employment, 1999), both papers progressed the discourse of economic efficiency through life-long learning. Rainbird *et al.* (2009) recognised that there was a directing of subsidises to the Learning Skills Councils to promote competency-based training known as National Vocational Qualifications (NVQs) frameworks. The discourses of developing managers promoted the existence of a link between the commercial benefits associated with

management development and the improvement of competence by way of practice-based learning (Billett *et al.*, 2014).

By contemplating competency and national economic performance, governments and other institutions became increasingly involved in the world of learning. The pervasiveness of the competence movement demonstrates this, evolving within the USA during the 1970s and attaining eminence within the UK in the 1980s (Nodine, 2016). The competence approach centres on the principle that successful managerialism is common, as well as recognisable (CIPD, 2016). Therefore, such common proficiencies and aptitudes are measurable and can be charted on to various academic awards. These qualifications are exemplified by long-established institutions originating from within academia, however more typically from similar award structures administered through various professional bodies (CMI, 2018; Institute of Leadership and Management known as ILM, 2018).

The impact of the competent based approach in managerial development is noted to be significant. While there is acceptance of competency-based management education in academia this has not been a leading influence in pre-1992 universities (Seng-Kia *et al.*, 2010). Mabey and Finch-Lees (2008) do contend that competency methods and managerial development remain extremely popular. As Jack and Anderson (2008) asserts the capabilities of this approach to classify and instil explicit management conduct has been described as ontologically and epistemologically dubious and susceptible to performative expectations.

Furthermore, Blackman and Lee-Kelley (2006) argue that competency frameworks can be recognised as examples of disciplinary power through the methods of appraisal and the mechanics of HRD and Human Resource Management (HRM). These critiques are academic, since the competency approach is entrenched within the vocabulary of HR departments. It is also supported by government investment which encourages NVQ certification with trustworthy kite marks such as the Investors in People (IiP) endorsement (IiP Prove it! 2004). Additionally, consideration given to the notion of understanding performance as a measuring tool of management success, implies that competency through performance has taken over intrinsic understanding and awareness. This is particularly recognisable through assessment activities which place a focus on demonstrating noticeable actions and behaviours. This understanding contends that learning and experience is not as important, as the achievement of performance (Hyland, 1993).

Within the field of the NHS and UK social care field, three competency-based approaches towards the categorising of desired demonstrable leadership and management behaviours have been notable over the past eight years. Within Table 2. a cross section of where these competency frameworks can be mapped onto each other is presented, which demonstrates the similar performative functions of these frameworks.

Table 2. A cross-sectional representation of NHS and UK social care leadership and management competency frameworks desired demonstrable behaviours/similar performative functions

Notable NHS and UK social care leadership and management competency framework from the past eight years.	NHS Clinical Leadership Competency Framework (NHS Leadership Academy, 2011).	NHS Healthcare Leadership Model (NHS Leadership Academy, 2013).	The Leadership Qualities Framework (The National Skills Academy, 2016).
The leadership and management competency frameworks desired demonstrable behaviours/similar performative functions	'Demonstrating personal qualities' (p. 11)	'Leading with care' (p. 6).	'Demonstrating personal qualities' (p. 11).
	'Managing services' (p. 31)	'Holding to account' (p. 11).	'Managing services' (p. 23).
	'Working with others' (p. 21)	'Engaging the team' (p. 10) and 'Developing capability' (p. 12).	'Working with others' (p. 17).
	'Setting direction' (p. 51)	'Inspiring a shared purpose' (p. 5) and 'Sharing the vision' (p. 9).	'Creating the vision' (p. 41) and 'Setting direction' (p. 35)
		'Evaluating information' (p. 7).	'Developing the strategy' (p. 45).
		'Connecting our service' (p. 8).	
	'Improving services' (p. 41)	'Influencing for results' (p. 13).	'Improving services' (p. 29).

(Created by Author, 2018, sourced: NHS Leadership Academy, 2011; 2013; The National Skills Academy, 2016)

Antonacopoulou and Fitzgerald (1996) suggest that although there is limited agreement related to competency identification, there is a shared vocabulary between professionals who work in the management development field. Antonacopoulou (2000) and Grugulis (2002) argue that the shared intention of the competency movement and learning at work does not amount to a discursive conclusion. They continue to suggest that the competency movement linked with

learning in the workplace are sources of conflict, resistance and manipulation. Nonetheless, the competency discourse does encourage a shared vocabulary through which organisations can use the HRM/HRD function to shape performative requirements and the positioning of learning strategy.

2.5.5 The partnership between academia and the workplace in learning and knowledge

Clutterbuck (2000) contends a change has occurred in pedagogical positions, which has placed an urgent demand on LMD, while prompting further innovation in learning methods. As Clutterbuck (2000) suggests, that LMD should be of mutual benefit to every stakeholder and legitimate in meeting the needs of everybody. Yet, the expansion of the internal LMD training can be presented as an organisational workplace manipulation.

Exploring academia and commercial educational partnerships, Ryan (2009) argues that academic awards can still match the quality of programmes which are internally delivered and are of equal credibility. Academic acknowledgement can provide a valuable benchmark level of achievement which employers recognise (Basit *et al.*, 2015). Additionally, involvement with an academic learning partner propels the knowledge economy and universities to allow organisations and individuals to access an assortment of contemporary research. Academic links can also deliver a supportive level of impartial input and contribute to an organisation's approach to learning, generating an advantageous association (Dunlosky *et al.*, 2013).

Consideration should additionally be given to the construction of diverse awards which match the corresponding managerial level (Legge *et al.*, 2007). There are concerns related to the overseeing of endorsement and in the demonstration of effectiveness related to the matching of training to organisational requirements and how competencies are to be achieved (OECD, 2011). King (2015) acknowledges that there are descriptive and normative examples, citing successful best practice where academic and workplace partnerships have worked at IBM.

Other observations have focused on the shifting position to the commercial learning marketplace and the methods by which universities are reacting to these changes. Both Light (2008) and Singh *et al.* (2015) propose that corporate organisations want recognition from academia to credit workplace learning involving appropriate awards; including recognising learners who have established organisational skills and knowledge through APEL (Accreditation of Prior Experiential Learning). Likewise, Watling *et al.* (2003), remarked on the fact that some employers have repositioned themselves from university programmes and are replacing them with their purposefully designed corporate education programmes.

Consideration has additionally been given to the role of the corporate university (The Economist, 2015). These types of universities attend to the attainment of organisational achievement appearing as learning management systems and concepts related to organisational learning (King, 2015). Paton *et al.* (2004) use McDonald's as an example an early corporate university, with much further growth predominantly taking place throughout the USA (Dealtry, 2017). Critiques of this method suggest that these training programmes predominantly use case study based, descriptive approaches, frequently praising approaches rather than recognising vulnerabilities (Beaver and Prince, 2001). This approach has invited consideration of being recognised as a valid approach to workplace learning and a contra to the educational partner method (Dealtry, 2017).

Understanding the phenomena of corporate universities is mostly normative and prescriptive. The evaluation of these universities appears mostly directed towards issues related to application and incongruity directed at organisational engagement (Beaver and Prince, 2001). An exemption to this critique with a more critical stance is Antonacopoulou's (2002, p. 1) concerns regarding the '*domestication of management education*'. Antonacopoulou (2002) asserts that the motivation behind these universities is solely for the benefit of the organisation and are mostly fundamentally performative focused.

Likewise, a significant number of internal LMD training initiatives undertake a typical functionalist/performative only position. There is implication that assimilation of individual interests and broader knowledge into the greater organisational pursuits may not occur. In this context, Stansfield and Stewart (2007) maintain that even when various stakeholders are openly recognised, internal management education is presented in such a way that it beholds an assumptive type of understanding (i.e. business model, change approach, team bonding and so on) as opposed to acknowledging power contentions between stakeholders with their invested interests. Of note and of interest to this thesis is how many internal LMD trainings (which have aspects of 'situated learning' and developmental tensions between 'individual vs collective' learning), still fail to acknowledge any issues of organisational power and control related to the learner and their learning environment (Vince, 2004; Kennedy, 2007; Mabey, 2013; Bruine, 2017).

2.5.6 The 'dark side' of leadership and management development

Whereas institutes (CMI, 2018; ILM, 2018) and authors (Western, 2008; Avolio *et al.*, 2010; Mabey, 2013) promote the benefits of LMD, there are also thornier issues LMD can be associated with. In their investigation Arnulf *et al.* (2016), found a more problematic side and argued that evaluation of LMD requires much more focus than it currently receives. Arnulf *et al.* (2016) propose that LMD could not always be presented as a positive endeavour and advocated the

prospect of related risks to participants, facilitators and the organisation. Harm *et al.* (2011) suggest that organisations may fail to comprehend if LMD programmes are appropriate for the participant and the organisation. Collins (2000) alludes to the damage LMD can inflict on participants, particularly when LMD is based on managerial trends by preference, rather than experience and tested approaches. Arnulf *et al.* (2016) also suggest that the negative consequences of LMD can be time wasting and having unhelpful effects occurring both in the short or long-term on worker abilities and the mental health of the participants. When considering factors why some LMD training fails, Beer *et al.* (2016b) add that much is dependent on the promotion of a '*psychologically safe climate in which subordinates feel free to speak up in*' (2016, p. 53) to be a critical factor in the success of an LMD training. This chapter will now progress to consider a selection of the more contemporary NHS LMD related literature. Building on this chapter, the next chapter (three) will present a more refined and focused review of the NHS LMD literature.

Chapter Three: A review of the NHS leadership and management development literature

After setting the context for this thesis in chapter two, this chapter will present a more contemporaneous and focused understanding of NHS LMD. Fundamentally this will involve taking a systematic approach to organising the material found as acknowledged by Hart (1999) to be '*rearranging the elements derived from analysis to identify relationships or show main organising principles*' (1999, p. 63). As a guide from Baker (2000) advisory paper on writing literature reviews, the fundamentals of this review will be comprised of:

- Establishing a systematic framework for the review of the literature
- Describing the area to be covered (i.e. time, appropriateness and kinds of document).
- Outlining the primary periodicals, journals and publications to be considered.
- Defining the value and quality of the evidence to be incorporated in the review.

There will be a focus on any empirical and evaluative studies, with tolerance for theoretical and conceptual studies to explore common theoretical considerations related to NHS LMD. There will also be a notable acceptance of Aveyard (2010) assertion that general internet search engines do not generate evidence sufficiently specific to academic study. The initial stages of this review involved the placing of boundaries upon the search criteria by establishing certain constraints. A concerted effort was made to focus on LMD provision within the NHS, with no discrimination towards the type of providers of such programmes. This review chose to focus on the term 'leadership development' to begin with, as opposed to the broader terms of just 'leadership', 'development', 'management' and 'NHS', to principally manage the volume of data. During early scoping, the evidence was still vast regarding 'leadership development' and many items involving either public or private sector organisations from around the world (related to both receivers and providers of training) became apparent. To constrict the search, the term 'health' was included and a focus on studies of LMD trainings which had been evaluated and not based solely on one LMD training intervention such as 360-degree feedback (Hosain, 2016), one-to-one coaching (Sinclair *et al.*, 2008; Bozer *et al.*, 2014) and so on. Therefore, the focus of the search became more towards evaluative studies, which ideally included narrative accounts and descriptive exemplars (recognition of participant experience is particularly relevant to the nature of this study). Theoretical and conceptual papers were similarly considered to enable further understanding of current debates related to this topic.

3.1 Breakdown of the search

Preliminary searches suggested that most of the available research on NHS LMD dates from the past ten years. Building on an early literature search which occurred in December 2016 to create the proposal for this thesis; two UK university library searches were utilised in the form of Nottingham University (NU) search and Sheffield Hallam University (SHU) between January and April 2017. These databases include many peer reviewed journals from various countries as well as sources of grey literature. Additionally, to the reviewed articles, much material presented was in the form of book reviews, newspaper articles, conference proceedings, interviews and editorials. Working with the term 'leadership development'; even with restrictions on publication date, the number of items identified was 36,334 for NU search and 5,554,635 for the SHU search. Searching the terms 'leadership' on its own through to more progressive Boolean searches of 'management AND training' created significantly larger results but with no more informative information becoming apparent. Lengthening the search term from 'leadership development' to 'leadership AND development' did not produce any further or more useful information either. Peer review only searches using both search engines (within the past ten years), applying the terms 'leadership AND development AND health' produced a combined resource of 7,988 returns. A prolonged hand search focusing on more relevance and removing duplication between databases (i.e. NHS England and Scotland LMD trainings only), a combined 27 peer reviewed articles, six book chapters, two interviews and two reference entries were identified. This began a more refined search for evaluations; empirical results; narrative accounts related and conceptual or theoretical studies. This breakdown culminated in ten items meeting the above requirements fragmented into four evaluative summaries from well-known health related organisations and six peer reviewed articles (see Appendix 1. for an illustrative and more detailed account of the literature search strategy and Appendix 2. for a summary table of the studies reviewed).

3.2 Theme identification

Discussed below, five themes were identified through a review of the literature. These were:

- Change and the application of individual leadership skill development interventions.
- The influence of organisational culture.
- Stakeholder engagement.
- The competency framework debate.
- Participant desire to lead.

3.3 Change and the application of individual leadership skill development interventions

Sutherland and Dodd (2008) explored the impact of Scottish NHS LMD trainings on clinical practice. This paper was ranked in the top ten of the most downloaded papers in this domain of the National Library of Medicine's MEDLINE database in 2013. Qualitative research was utilised in the form of semi-structured interviews developed over several stages of a participants' journey on the LMD training. This evaluation involved 44 clinical managers with thematic analysis used to analyse the data collected and member validation substantiating the findings. Considering change during the participants' leadership training journey, Sutherland and Dodd (2008) propose that their training under review was effective in changing participants' attitude, behaviour and performance, during and post their LMD interventions. Exemplar quotes from participants throughout the paper are used to demonstrate this change. The authors highlight the power of action learning and role plays as being the most influential change techniques, though time constraints were noted to have impacted upon the effectiveness of data collection. Little is acknowledged regarding the longer-term impact of this training and if the reported changes remained. There was also very limited credit given to the influence of external workplace challenges faced by participants. No account was given by any participant who reported to not have benefited from the leadership programme, subsequently representing a gap within this evaluation.

In a similar study, Stoll *et al.* (2011) focused upon learning from the 'Darzi Fellowships' in clinical leadership for junior doctors. Both qualitative and quantitative data was iteratively used to evaluate the learning from this programme. The findings were subdivided into 'impact' and 'factors influencing impact' representing an analytical synthesis of the qualitative and quantitative data. Stoll *et al.* (2011) indicated that the Fellows demonstrated clarity of purpose and they applied ambitious but achievable projects within their workplace. The need for a supportive workplace was critical to the ultimate realisation of benefits from the Fellowship programme though an identifiable need for practical whole system engagement from all junior doctors in future NHS leadership was also acknowledged. This evaluative study considered itself to be a rarity within its field, which is surprising considering the cost of this LMD programme being £3.2m for 39 participants for the first London 2009 cohort (Stoll *et al.*, 2010). Positive outcomes from the 'Darzi Fellowship' programme appear to be ongoing with accounts such as 'a day in the life of... an NHS trainee leader' (The Guardian, 2012) appearing in the media.

3.4 The influence of organisational culture

Based on The Kings Fund Junior Doctor Project, Bagnall (2012) presents 'facilitators and barriers to leadership and quality improvement'. This paper is based on a project commissioned by The Kings Fund, concentrated on the experiences of 27 junior doctors who attended a selection of recent NHS LMD programmes. Like other studies (Sutherland and Dodd, 2008; Hewison and Morrell, 2014) one-to-one coaching and action learning were the most influential interventions within these programmes attended by the junior doctors. Like the Enterkin *et al.* (2013) study, Bagnall (2012) highlights the importance of peer networking in LMD.

Bagnall's (2012) qualitative review utilised exemplars of comments from junior doctors, which highlighted organisational cultural issues reportedly preventing junior doctors from embedding LMD learning. Examples of apathy and barriers related to networks of higher management discouraging and blocking leadership initiatives were used. Themes of traditional values, working in isolation and portfolio careers were particularly viewed as negative in the workplace. Prominent comments were:

'One junior doctor was told by his consultant 'don't rock the boat' and another consultant said to his junior doctor that he had travelled the long hard journey and had now reached a position of deserved power and control' ... 'A recurring theme throughout the study was there was a resistance and even obstruction to change at senior levels' (Bagnall, 2012, p. 14).

Bagnall (2012) recognises that a relevant limitation to this study being it is unwise to assume that every junior doctor who participated in leadership training wanted to lead. Like Edmonstone (2013a) and Phillips and Byrne (2013), Bagnall (2012) identifies the importance of stakeholder engagement in the embedding of learning from LMD trainings.

3.5 Stakeholder engagement

Presenting a general review of the literature, Edmonstone (2013a) attempted to identify learning from these as a basis for creating an evaluative framework, which focuses on recognising the impact of future NHS LMD trainings. The paper proposes that it does not seek to reach conclusions as to whether programmes were worthwhile, but to identify factors what are considered crucial to maximising efficiency (to note this includes the Stoll *et al.*, 2011, studied within this review). The range of this review of evaluations covered 1,653 participants over thirteen years. The common methods utilised by the evaluators to evaluate these eight programmes were questionnaires, interviews and focus groups. This paper generated many further enquiries regarding the consideration of basic goals and desires related to the commissioning, manufacturing and delivery of

NHS LMD training. The scope of this review is considerably large and therefore its usefulness for understanding the challenges faced by participants is limited. However, Edmonstone (2013a) did state that this was not its purpose and this piece was commissioner focused. In summary, Edmonstone (2013a) highlighted that a lack of work place support, conceptual fuzziness and difficulties with stakeholder engagement all prevented the full benefits of participant attendance on NHS LMD trainings being realised. These outcomes were very similar to a review of LMD literature by West *et al.* (2015) and a qualitative evaluation of an NHS LMD focusing on emerging leaders by Phillips and Byrne (2013).

3.6 The competency framework debate

Hewison and Morrell (2014) consider leadership development through challenging the current trend for leadership competency framework-based development programmes. Hewison and Morrell (2014) discuss this in the arrangement of a policy review informed by the concept of episteme. Utilising Foucault's notion of episteme, they offer a counter narrative to the LMD competency-based approaches. Hewison and Morrell (2014) argue that leadership can take a variety of different forms and consequently this should be reflected in NHS LMD trainings. This paper matures the argument against competency-based approaches to LMD and recognises the need for greater diversity in relation to the manufacturing of future LMD trainings. One argument against the tailoring of such trainings to an individual participant may represent an additional time and cost issue which commissioners may not wish to pay for, though there is evidence which suggests that more tailored LMD interventions are noted to have significantly longer lasting outcomes (Theeboom *et al.*, 2013; Bozer *et al.*, 2014).

A Health Foundation backed evaluation by Hardacre *et al.* (2011) titled 'What's Leadership got to do with it?' supports the idea that competency focused programmes are not capable of comprehending the complexities and nuances of leadership. This evaluation focused on six LMD trainings which the Health Foundation have been providing since 2007. The approach taken in this review is defined as seeking examples of 'leadership for quality improvement' in respect to the impact previous participants have had upon their organisations. The reviewers used an 'indicators of leadership' tool followed by mixed quantitative and qualitative design to develop into a final testing attribution stage. Like conclusions drawn by Sutherland and Dodd (2008), Bagnall (2012), Hewison and Morrell (2014) and West *et al.* (2015) this intensive evaluation concluded that one-to-one coaching, informal networking and action learning were the most relevant LMD interventions which contributed towards leadership improvement. This evaluation relied on the participants demonstrating leadership competencies (through a double-blind test method). From their findings and developing arguments like Hewison and Morrell (2014), Hardacre *et al.* (2011) establish that being able to demonstrate leadership competencies (such as engagement and

interpersonal effectiveness) are not enough to influence the complexity of healthcare quality improvement.

3.7 Participant desire to lead

Mahoon *et al.* (2015) present a 'literature review of the effectiveness of clinicians as improvement leaders following training in improvement and large-scale change'. After an extensive search of NHS clinical leadership and development literature during October 2014, Mahoon *et al.* (2015) found ten relevant studies for consideration. Four studies were one off evaluations and the other six were multiple evaluations including the Hardacre *et al.* (2011) and Stoll *et al.* (2011) studies. This literature review is extremely detailed and methodical. Mahoon *et al.* (2015) recognise that several studies were originally poorly evaluated, and questions raised regarding the vested interests of the evaluators of these studies. This is a clinician leadership training focused only review, consequently misses out on the opportunity to evaluate the valued experiences of other non-clinical and administrative staff within the NHS. This review of the literature concluded that the most useful aspects of the interventions utilised within the clinical leadership programmes studied were the use of real-world change projects, one-to-one coaching and mentoring and learning linked to achieving individual aims. Critically this review also recognises barriers such as the desire to lead and ultimately surmises that there is an apparent culture within the NHS which dissuades future leaders. These conclusions do match with the rest of the findings from this review of the literature.

3.8 Summary

Sutherland and Dodd (2008) and Stoll *et al.* (2011) evaluative studies both offer some insight into the world of the NHS LMD participant. Sutherland and Dodd (2008) suggest there is an absence in acknowledging the anxieties or difficult experiences which may have prevented LMD participants from utilising their skills within their NHS workplaces. Hewison and Morrell (2014) and Mahoon *et al.* (2015) both argue that a move away from the current trend of leadership competency frameworks is required in favour of more tailored and individualised LMD. The evidence established so far does indicate that more focused individual interventions, such as one-to-one coaching and mentoring, along with the organic nature of action learning to be the most memorable and longer lasting of the interventions. Both Edmonstone (2013a) and Phillips and Byrne (2013) highlight the need for increased stakeholder involvement in NHS LMD and workplace support for NHS LMD participants. This is echoed by Hardacre *et al.* (2011), Stoll *et al.* (2011), Bagnall (2012) and West *et al.* (2015), who additionally note the overwhelming importance of the role of supportive workplaces for the transference and implementation of skills learnt during and

post LMD training attendance. Bagnall (2012) goes further to present what an unhelpful organisational culture is observed to be. The junior doctors within this study reported multiple pockets of resistance within their hospital environments. Examples laid out by Bagnall (2012) acknowledge the existence of a problematic resistive change culture within the NHS and the need for supportive NHS workplaces (Stoll *et al.*, 2011; Mahoon *et al.*, 2015). This may be a significant factor in deterring previous participants from taking NHS management positions and further NHS leadership responsibilities.

Lack of desire to lead is commented upon (Phillips and Byrne, 2013; Mahoon *et al.*, 2015), though the theme of reluctant NHS leaders post LMD training is transiently addressed within the literature. In line with the argument against leadership competency frameworks, Willcocks (2012) contends that:

'Clinical leadership it is not just about the development of aptitudes or proficiencies; effectiveness is also about the willingness and desire of clinicians to develop into a leadership role' ... 'nurses will need to have both motivation - a set of internal forces that direct behaviour - and ability (or competence) to be effective leaders' (2012, p. 12).

West *et al.* (2015) recognises that limited evidence in this area advocates the importance of understanding controlling influences which may have an impact on team effectiveness and organisational performance. West *et al.* (2015) further suggests that these present in terms of:

'The design of the programmes, knowledge and skills of facilitators, motivation of trainees, supports in the workplace' ... 'they all impact the processes which facilitate the transfer of training' (2015, p. 13).

This emulates Grossman and Salas (2011) who identify trainee characteristics, type of training and work environment to be significant factors in the transfer of knowledge from training to the workplace.

From this brief review of the evidence, there were many identifiable gaps within the research. For example, evaluative evidence on how formal and informal participant networks established during NHS LMD trainings, which have enabled participants to lead change is minimal. Other notable gaps include the absence of accurate long-term studies with counterfactuals (which Day *et al.*, 2014 has recommended as the next stage for LMD research). Given the potential expense of these LMD trainings (Stoll *et al.*, 2010) and the noted limited research (West *et al.*, 2015); Day *et al.* (2014) suggestion for longer term LMD research are pertinent. Still, in acknowledging the drawbacks of undertaking longer term research, Mahoon *et al.* (2015) asserts that *'healthcare develops so rapidly that looking at the long-term impact of a training programme that is no longer run may seem an irrelevant activity today'* (2015, p. 13).

Taking in to consideration the evidential gaps drawn from this review (West *et al.*, 2015) and as commented on by other authors (Edmonstone, 2014; Tull, 2018); it is reasonable to suggest that research should focus on LMD

participants who have faced barriers when attempting to implement LMD learning into the NHS workplace. The research discussed during this chapter there is a link between the type of training (competency based, academic, experiential, tailored and so on), the roles of stakeholders (Edmonstone, 2013a), organisational culture (Bagnall, 2012; West *et al.*, 2015) and participant characteristics and desires (Phillips and Byrne, 2013; Mahoon *et al.*, 2015). Research aims, which intend to explore the experience of an NHS LMD participants training and the role of the NHS workplace become pertinent. The following chapters establish a theoretical framework (chapter four) and enable a viable and acceptable research design and methodology to be considered (chapter five).

Chapter Four: Establishing a theoretical framework

4.1 Introduction

Building on the previous chapters, this chapter will now distinguish how this thesis will proceed to investigate LMD within the NHS. Drawn from the works of Burgoyne and Reynolds (1997), Alvesson and Deetz (2000), Karatas-Ozkan and Murphy (2010) and Mabey (2013); several dominant discourses have been defined which summarise the role and purpose of organisational leadership and LMD. These groupings can offer a secure investigatory footing for potential research within this area. A conceptual framework such as this can also contribute to the expansion of a methodological and systematic, theoretical justification of research methods (Green, 2014). This chapter will begin with exploring Burgoyne and Reynolds (1997) and Alvesson and Deetz (2000) theories of organisational leadership and LMD discourses (section 4.2) before proceeding with a discussion of the epistemological and ontological positioning of these discourses (section 4.3). Acknowledgement of the implications and constraints of paradigms (section 4.4) and how paradigms can shift to discourses (section 4.5) are presented. Further inspection of critical theory (CT) and the dialogic domain is offered (section 4.6), before a consideration of how the theoretical framework exhibited within this chapter can lead into a viable research design and methodology (section 4.7).

4.2 The dominant leadership and management development discourses

4.2.1 The functionalist/performative discourse

To begin this consideration of the common organisational leadership/LMD discourses, this section presents the most commonly applied discourse, being the functionalist or performative discourse (Burgoyne and Reynolds, 1997, Alvesson and Deetz, 2000; Karatas-Ozkan and Murphy, 2010; Mabey, 2013). For example, functional theory represents core schemes, approaches and inferences that would encompass and provide a successful delivery of an LMD training. This approach considers how these interventions further the required development of individuals and organisations in an assumptive manner. Figure 5. Shows the current iteration of the NHS Change Model (NHS Improvement, 2018b, p. 3) which prescribes and applies a recommendation of a change-based interventions for improvement.

Figure 5. The NHS Change Model



(Source: NHS Improvement, 2018b, p. 3)

Competency frameworks (acknowledged in section 2.5.5) fit well within this discourse due to the desire to rationalise and deduce the leader, then the leader's issues can be eradicated through essentialist focused interventions (Bolden *et al.*, 2003; Mabey, 2013). Authors such as Brown and Treviño (2006) and Barends *et al.* (2014) praise the value of this approach by recognising how well formulated, planned strategic LMD can be central to enriching an organisations performance. This assumption proposes that models of action within organisations and associated actors can be enacted to increase overall performance. This discourse is result orientated and less preoccupied with explanations of why a phenomenon is the way it is. Linked to the functionalist/performative discourse, the descriptive discourse focuses on making sense of what is going on as opposed to creating a solution.

4.2.2 The descriptive discourse

The descriptive discourse within LMD attempts to characterise behaviour and tendencies, which assist in the development of theoretical frameworks and models. This approach to LMD principally analyses and classifies the state or stage of LMD within organisations (Connor *et al.*, 2012). Burgoyne's (1988, p. 41) '*descriptive six levels of maturity model*' (Figure 6.) charts with a level of

complexity how LMD is integrated within an organisations HR policies and procedures.

Figure 6. Burgoyne's Six Levels of Maturity Model

Management Development Maturity - Burgoyne (1988)	
1	Non-systematic
2	Isolated
3	Integrated and co-ordinated
4	MD strategy linked to corporate policy
5	MD strategy shapes corporate policy
6	Strategic development of the management of corporate policy

(Source: Burgoyne, 1988, p. 41)

The descriptive approaches explore the connections between LMD and HR, analyse organisational training requirements and consider how HR participate in the appraisal of staff. This approach also considers succession planning requirements and its overall interaction with organisational strategy.

Such models as Burgoyne's (1988), do not overtly advise what organisations and various actors involved in organisational training arena are to do. These models provide a conceptual framework for examining where an organisation sits within a model. Nevertheless, it can be argued that these types of models are based merely on unknown assumptions. For example, the idea that LMD is an appropriate action to take (Mintzberg, 2009), has management commitment and can be adequately assimilated (Glamuzina, 2015), are all variables which go unaccounted for. LMD approaches such as these, deduce a subtly inflexible agenda since they do not clearly recommend a schedule of activities for improvement. Yet, they do indicate that improved organisational performance can be achieved through having more devotion to, or a more united approach towards LMD. Burgoyne and Reynolds (1997) note that the descriptive discourse is mostly linked to the functional/performative discourse. This is due to the tendency for the description, followed by the development of a belief about what should be achieved or aspired.

Dalton (2010) suggests that descriptive models provide options for a convenient mode of LMD conceptualisation and provision. However, they can become mostly ideologically driven as they tend to subtly recommend a perfect state. Burgoyne and Reynolds (1997) state that both functional/performative and descriptive discourses tend to place a restrictive position or a normative understanding on social phenomenon.

Burgoyne and Reynolds (1997) proceed to argue that these approaches generally do not attempt to question the status quo or recognise issues of power. Such questions require a consideration of why LMD is respected in some

settings and not others? Why are some organisations capable of entrenching LMD in to the wider HR function and others incapable? Neglecting these considerations make these discourses unsuitable tools to be utilised within this enquiry. This is predominately due to issues of power and discord acknowledged within the NHS workplace (Bagnell, 2012; Mahoon *et al.*, 2015) and NHS LMD training provision (Lake, 2016) becoming prevalent within this thesis so far.

4.2.3 The interpretive discourse

Burgoyne and Reynolds (1997) define an interpretative stance as an approach which exemplifies social experience. This is explained by Burgoyne and Reynolds (1997) as they acknowledge the variety of accessible theories, which endeavour to disclose more in-depth levels of reality. Sociological or psychoanalytic concepts can excavate deeper insights of why phenomena occur, by investigating such fundamental reasons related to experience and meaning. Burgoyne and Reynolds (1997) acknowledge the value of interpretative theories in the sphere of LMD by uncovering what motivates behaviours and personal development. This approach can be utilised to comprehend the relationships between different personality types (Gibbons, 2013; Hazrul *et al.*, 2014), as well as appreciating the influence of emotions and thoughts related to learning within the workplace (Gill, 2015).

While interpretative theories focus on the justifications of why and how things happen, Burgoyne and Reynolds (1997) argue that this approach also imparts a normative feature in that there is a stipulation of an explanation to propose action. This may be acted upon to enhance individual and organisational receptivity and interest in LMD practice and interventions. Mabey (2013) summarises interpretive discourses as having a '*significance on development activities which arise from sense making accounts of those affected, often retrospectively*' (2013, p. 361).

4.2.4 The dialogic discourse

While the functionalist/prescriptive discourse understands LMD as a basis for growth; the dialogic discourse emphasises the socially and historically constructed way that such fundamental ideas come to fruition. According to Hassard *et al.* (2008) the dialogic discourse can be the '*embracing of an emergent and dissentive logic of research*' (2008, p. 34). Mabey (2013) places the dialogic discourse within the postmodernist, deconstructionist, dissensus/emergent domain presenting as identity or persona focused leadership. The dialogic LMD approach considers language and artefacts as providing leaders with self-meaning, status and value (Mabey, 2013). A frequent user of the term, Deetz (2003) also relates the dialogic to postmodern or poststructuralist thinking. To clarify, the dialogic symbolises a discourse which only exists in relation to a previous discourse and within the expectation of a forthcoming discourse

(Chouliaraki and Fairclough, 1992). This means that text or word is fundamentally intertextual and forms part of, or all of, the dialogue which creates the circumstances and the foundation for understanding (Elmo Raj, 2015). This approach considers the self, together with the self as leader, to be a multi-disjointed, discursive achievement, which is constantly in a condition of becoming, in comparison to something that is fixed, secure or established.

4.2.5 The critical discourse

The critical discourse is solution focused and directed by enquiry. Burgoyne and Reynolds (1997) argue that CT is the emboldening of the functional, descriptive and interpretive discourses through the examination of their weaknesses. Hence, creating challenging enquiries into LMD by searching concepts related to social control, freedom, ideology and morality. As alluded to earlier, these issues can be suppressed in LMD, yet are significant enough to require further attention. The critical discourse related to LMD predominately considers the role and influence of power. Questions include, who and what interests are served related to imposition of LMD interventions? Does LMD reinforce or challenge inequalities and system imbalances? Can LMD be understood as a humanistic endeavour or is it just repressive? (Raelin, 2007b; Bolden, 2010b; Anlulf *et al.*, 2016). In posing these questions, critical discourse veers towards investigating fundamental suppositions and connotations in LMD thinking. This approach disentangles some of the incongruities and strains which can occur amongst interested parties and the examination of social and organisational circumstances where they transpire. Ultimately exploring LMD '*programmes and activities which ensure order, predictability and control, a means to mask diversity and 'resolve' dissident voices*' (Mabey, 2013, p. 361). Comparing the critical discourse to the dialogic discourse, the dialogic discourse acknowledges a constitutive dualism between examples of free will and structural constraint. However, the critical discourse approach is clear on the epistemological distinctions between these two concepts. Thus, arguing that if taken to the extreme, the dialogic discourse view is that there is no point in struggling for a better social arrangement as emancipatory endeavour will just result in different forms of oppression.

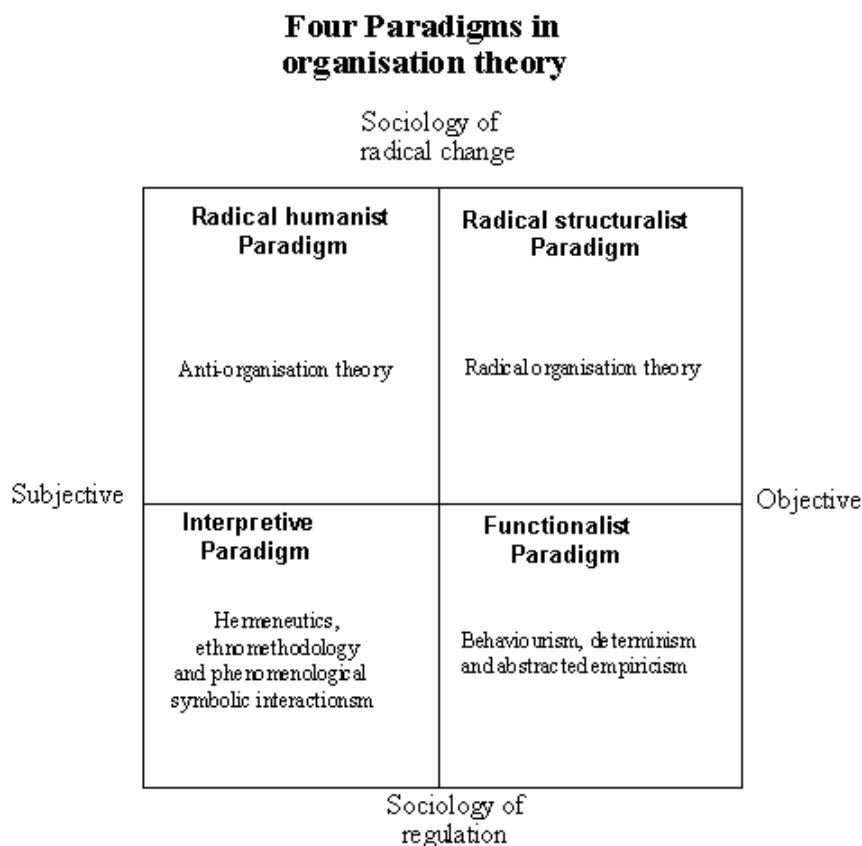
4.3 The ontological and epistemological concerns of the leadership and management development discourses

The discursive categorisations described above are descriptive and they do not present an eloquent context. Both ontological and epistemological positions related to LMD theory need to be explored before these understandings can inform any potential research endeavour. Unavoidably a conversation related to the construction of social reality at a theoretical level is required to ground the

LMD discourses into knowledge and understanding and to create a suitable foundation for the next chapter.

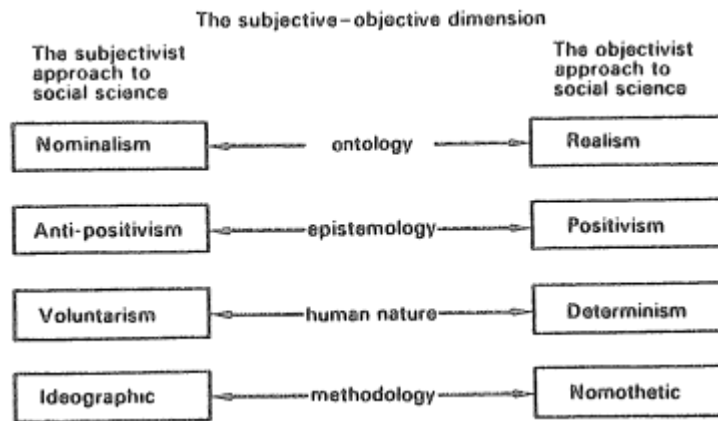
In 1979, Burrell and Morgan presented a significant expansion in organisational theory by establishing the four paradigms model of organisational theory (Figure 7.). This model demonstrated how LMD understanding can be applied to both ontological and epistemological spectrums. Alvesson and Deetz (2000) acknowledge that Burrell and Morgan's (1979) model also provided a theoretical structure for LMD research and theory.

Figure 7. Burrell and Morgan's Paradigmatic Model of Organisational Theory



(Source: Burrell and Morgan, 1979, p. 22)

The Burrell and Morgan (1979) paradigmatic model of organisational theory firstly recognises the tendency for social theorists to understand the world from their own ontological location.

Figure 8. Burrell and Morgan's Subjective-Objective Dimension

(Source: Burrell and Morgan's, 1979, p. 3)

In Figure 8. Burrell and Morgan (1979, p. 3) demonstrate both objective and subjective ontological locations as a dichotomy representing how reality is recognised (ontology). There are consequences for this understanding of knowledge of the world (epistemology) and its examination (methodology). The comprehension of this is highly relevant to LMD research and practice, and questions arise regarding how we might understand organisations and customs as real objects (and whether they have distinguishable borders and visible routines). Other questions relate to how much LMD is provided within organisations (calculated by hours and days or cost) and how this compares between different organisations, sectors and cultures? Both these questions endeavour to quantify and appraise the influence of LMD within organisations. Regarding these considerations, objectivism can offer LMD theory a range of valuable insights (Mabey and Ramirez, 2005). These insights do not communicate the experience of LMD or the motivations of those funding, facilitating or participating and whose interests these trainings serve. A subjectivist position leads to a diverse set of questions regarding LMD. This position has the potential to discover a personal and in-depth understanding of the LMD methods which individuals have participated in.

The opposing objectivist ontology emphasises more quantitative methods incorporating positivist measuring tools such as large surveys. Objectivism may ascertain patterns of behaviour and tendencies to establish causation between them. In contrast, subjectivism is more in line with an explanatory, qualitative, approach which typically involves face to face interviews. Both these understandings have repercussions for researcher preferences, options and practicalities. It also has repercussions regarding what characterises legitimate knowledge and the notional structures with which this knowledge is held. Nevertheless, the subjectivist approach in questioning the value and idiosyncratic interpretations of LMD divulge much about what is taking place (and the reasoning behind it) by principally drawing information from those involved. The subjective, qualitative stance is more in line with the critical

endeavour of this thesis and the authors own inclination and understanding of the world.

4.4 Order versus conflict

Burrell and Morgan's (1979, p. 22) Paradigmatic model of organisational theory (Figure 7.) concerns itself with the assumptions associated with societal disposition. The distinction Burrell and Morgan (1979) suggest is related to the propensity for society to lean towards either social order or social conflict (Figure 9.).

Figure 9. Burrell and Morgan's Social Order and Conflict Model

Two theories of society: 'order' and 'conflict'	
The 'order' or 'integrationist' view of society emphasises:	The 'conflict' or 'coercion' view of society emphasises:
Stability Integration Functional co-ordination Consensus	Change Conflict Disintegration Coercion

(Source: Burrell and Morgan, 1979, p. 13)

In this understanding, Burrell and Morgan (1979) endeavour to encapsulate the different foci of social theory and its conventions. It should be noted that significant amounts of social theory endeavours to appreciate the apparatus by which social order endeavours to continue. This is done by means of investigations in to the methods by which society uses education, culture, political structures and so on, as well as considering how they mix, assimilate and co-operate (Janowitz, 1975). These understandings are supported by an inherent social order view of the world. This view acknowledges the fundamentals of the social world and how it performs and functions (comparatively and commonly). There is an assumption that each of the functions play a role in maintaining the whole. For instance, structural functionalism holds a macro or worldwide interpretation regarding the operations of each of the social systems which work to preserve society (Stahelski, 2005).

A micro view of society offers a different perspective, which seeks to avoid making all-encompassing assertions regarding the whole system. Conversely, this perspective emphasises the finer points regarding individuals and the interactions between social actors. Goffman (1959) for example is open to the social order perspective, nonetheless there is an emphasis on the importance on the people who acquire and perform their individual part in the foundations of society. The conflict perspective of society provides an alternative focus which emphasises the unsolidified understanding of the social world. This argues that transformation remains pervasive, as suggested within the social order perspective. Burrell and Morgan (1979), quoting Dahrendorf (1959), recognise

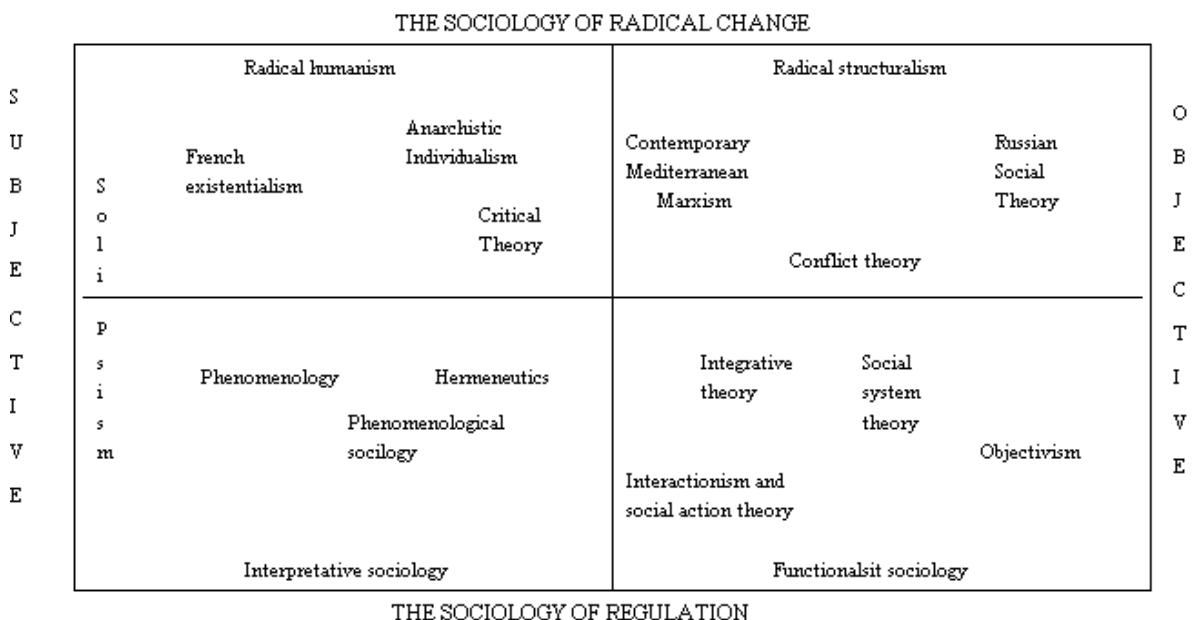
that the conflict view characterises society in relation to the developments of change, frequently demonstrating dissent or conflict. This view contends that all functions of society participate in a disassembling, a rebuilding and a transformational role.

In relation to social research positioning towards the conflict view on the continuum, there is a clear inclination to investigate such foundations related to social change. This considers such methods by which distinctive parts of society pull in various ways. Invariably this causes opposition and inconsistency concerning the way a few individuals in society possess more influence and authority regarding the control of social change than others. The social world can therefore be thought of as a sphere with numerous pursuits, perspectives and sensitivities. The function of social enquiry is to expose them and to enlighten societal change (Abbott *et al.*, 2006).

4.5 The implications and constraints of paradigms

Burrell and Morgan (1979) organise subjectivism and objectivism as applied to the sociology of radical change and regulation. These provide a foundation when creating a four-dimensional framework, which portrays the different paradigms in relation to social concepts (Figure 10.). In this way, the four paradigms assist in describing the alignment of social understandings through comparison of their ontological and epistemological expectations.

Figure 10. Burrell and Morgan's Four-Dimensional Comparative Framework



(Source: Burrell and Morgan, 1979, p. 27)

There have been many discussions and analyses about how the different limitations have been illustrated by Burrell and Morgan (1979, p. 27) in Figure

10. and what can be associated with which paradigm. Alvesson and Deetz (2000) present modifications to this framework by offering an increased post-modern focus. Thus outlining the theoretical locations amongst the two axes provided significant motivation within social theory, particularly helpful when researching organisations and management behaviour. While the framework suggests that between the four paradigms there is an even dispersal amongst them; Burrell and Morgan (1979), Karatas-Ozkan and Murphy (2010), Mabey (2013) and Popova-Nowak and Cseh (2015) all contend that most social investigation in organisational research and LMD has mostly been adherent to the functionalist/performative approach (with its realist-objectivist ontology and authoritarian concern).

Burrell and Morgan (1979) highlight how their definitive framework establishes a multi-notional context, to deliver a position which social researchers find in common when operating within boundaries. Rearticulated, every paradigm of the social world recommends a diverse interpretation. Burrell and Morgan (1979) recognise a measure of opportunity inside each retrospective paradigm related to change, nevertheless social theorists infrequently move between paradigms. Riach (2009) recognises that certain concepts within paradigms have a self-referential feature. Furthermore, an alteration can represent an '*epistemological interruption*' (Riach, 2009, p. 357) with consequences for movement within the theoretical population and theoretical standing. Riach (2009) mentions Silverman (1970) as an illustration of a shift in focus within organisational theory from a functionalist/positivist paradigm, to that of an interpretive one.

Meaningfully, the paradigms represent a diverse approach to understanding the world. They demonstrate diverse perspectives of social reality which suggests that the paradigms are distant and incompatible. It is possible for theorists to switch between them over time, but they cannot function within more than one concurrent paradigm without contradiction. Burrell and Morgan (1979) suggest that the paradigms can be thought of as being reciprocally restricted.

Tensions regarding paradigmatic incommensurability and theory development within management science have been an ongoing issue over the past 40 years (Kuhn, 1970). This issue has predominantly been between the radical labour movements (Reed, 2001) and the post-modernist, post-structuralist theorists (Alvesson and Deetz, 2006). The argument centres on the rejection of the realist ontological/epistemological position, which may suggest or be recognised as a desertion of the fundamental and radial agenda towards change. Thus, portraying social theory through a normative lens and submissively maintaining the established order and associated discriminations (Kellie, 2012). Instead, the acknowledgement of the subjectivist ontology and epistemology suggests that all social experiences can be subjectively understood. This may lead to the consideration that all discourses occupy a comparative domain and consequently none have any worthier privilege to truth than any other. The demands of incorrect consciousness to an individual's actual interests are subsequently exclusive and indiscriminate (Overgaard, 2017).

4.6 Paradigms to discourses

In relation to LMD theories, Mabey and Finch-Lees (2008) discard the notion of paradigmatic incommensurability. Alternatively, they suggest the notion of discourse to be suitable for understanding differing theoretical positions. For example, Mabey and Finch-Lees (2008) welcome the concept that functionalism produces useful theory and insights, however it does not deliver a full understanding of what is taking place. Discourse is utilised by Mabey and Finch-Lees (2008) to represent a '*meta-theory*' (2008, p. 56), which has the capability to be remote from any explicit paradigm. Discourse relates to how typically yet not inevitably via language, the social realm, people and events, are shown. Diverse discourses show the social world through diverse methods by means of symbolising social reality and shaping how people appreciate and understand it (Alvesson and Deetz, 2000; Watson, 2000). A method applied to the use of discourses when expressing LMD theories, is that diverse discourses can be used in the scrutinising of customs, accounts and meanings via reflection. Utilising the notion of discourse allows for the exploration of LMD thinking, application and experience. This concept is particularly relevant to the direction of this thesis and its later conclusions.

4.6.1 The impact on knowledge building

Moving from paradigms to discourses has important ontological and epistemological consequences, appreciated by the deliberation of modernist and postmodernist attitudes to knowledge. Modernist notions understand the enlightenment perspective of science. There is a recognition that this perspective suggests that the social world is comprehensible by using objective systematic approaches. Such concepts include the notion of objective realism and knowledge is obtained through independent examination, scientific facts and generalities; thus, deeming the researcher to be separate from what is studied and influencing how studies contribute (or not) to prevailing understandings of knowledge.

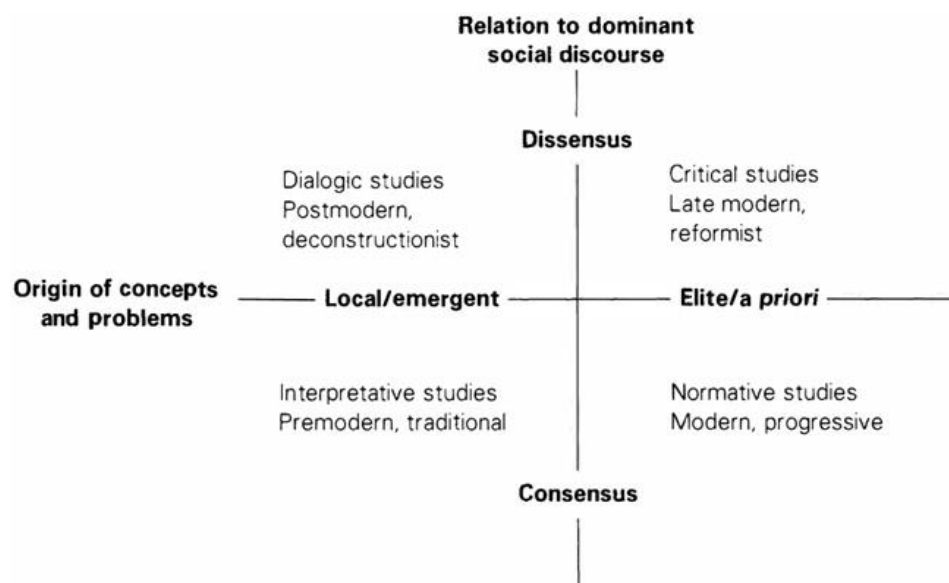
Comparatively, postmodern methodologies argue that the peripheral world is fully comprehensible. As recognised by Mabey and Finch-Lees (2008), one noteworthy influence is how language functions in depicting the social world and the human state. A person can also perform as an unbiased, detached instrument to the development of the world we see. Barratt (2003) argues that it is the depictive ability of language, which establishes our perception of what is tangible and what is not. Deetz (2003) recognises language as a method of division, which involves the categorisation of entities (through terminologies and customs, eliciting varied features of experience). However, it forgoes other features, for example, the notion that management cannot be conceivable if deprived of the concept of non-management. Consequently, each verbal manifestation also suggests what is not present. Additionally, language can

present as neutral, though this sincerity can mask the social connections to power which disguise the institutional and historic circumstances within which they occur in. Other discourses and systems are also conceivable, though they are not as influential or prevailing (Alvesson and Deetz, 2000).

4.6.2 Reframing duality

In comparison to Burrell and Morgan (1979), Alvesson and Deetz (2000) deviate in stressing the consensus/dissensus difference to the regulation/conflict duality (Figure 11.).

Figure 11. Alvesson and Deetz contrasting dimensions from the metatheory of representational practices



(Source: Alvesson and Deetz, 2000, p. 24)

Burrell and Morgan (1979) consensus/dissensus dualism attracts consideration by which societal and organisational theories incline to position themselves in either strengthening or interrupting the social order. It does not emphasise or deduce a comprehensible overriding force as the foundation of conflict. The dilemma is not understood as a class argument, but relatively the destruction of elements of the person and the occurrence of more damaging restraining processes (Alvesson and Deetz, 2000). Moreover, power is considered not through the application of supreme control, co-ordinated by groups pursuing their individual ideals, but as established societal relationships, noticeable through 'routine micro-practices in the work site itself' (Alvesson and Deetz, 2000, p. 26). The emphasis of this is on the discursive, as opposed to any grouping or class associations which permit the examination of power and the procreation of it.

As demonstrated in Figure 11., Alvesson and Deetz (2000) comprehend the consensus domain in terms of trust, the promotion of order as a natural state and the role of science as natural. There is recognition of the struggle faced by the consensus domain, in terms of dealing with inconsistencies and obscurities, labelling them as complications which require reduction.

4.6.3 The dissensus domain

Unlike the consensus domain, the dissensus domain attracts its interest from the challenging nature of social occurrence. It places emphasis on the strains, efforts and issues of control and human behaviour. The dissensus positioning undertakes a confrontation of accepted meanings, conventions and societal practices. It focuses less on the present functioning of the world, but on how the world has originated to function as it does. In terms of research, the consensus domain categorises the world rather than inspects its arrangements. From this approach fundamentally, contradictory practises are hidden.

The dissensus position within the scope of CMS, develops two significant theories, CT and postmodernism (Alvesson and Deetz, 2000). Alvesson and Deetz (2006) diverge from such notions that theory can be figurative in relation to the social world or a paradigm to be used. This supports the viewpoint that social objects can potentially be improved and understood better. This does not suggest an absolute denunciation of positivism, but a declaration that an increased, delicate comprehension and association of the different theories is required. The associations of power and relatedness of theories in to categories, the societal as well as past settings where they developed with the concerns they promote, all require further exploration. A consequence of this lens is that during research, observations are inevitably theory-loaded. Alvesson and Deetz (2000) suggest that '*theory directs attention, organises experience and enables useful responses*' (2000, p. 108), though ultimately proposing that an increased involuntary method to theory creation should occur. From this understanding the researcher presents not as an autonomous spectator but as a creator of interpretations of societal objects. These arise through detailed historic and social understandings and dialogues, trapped by the researcher's principles and boundaries of their experiences.

4.7 Critical theory

While applicable to thinking within the social sciences (Becker, 1959), the dissensus domain has a connection to the theory, research, knowledge creation and agent control presented within the study of management. CMS has presented as a medium to do this (Perriton, 2007). CMS has demonstrated to be important in disseminating an ontological and epistemological view of organisations and work, which has concentrated on the tendencies summarised

so far. Progression in this area is by means of adopting theoretical approaches which assume a critical attitude; thus, originating from CT and the dialogic method and stemming from post-modern and post-structuralism ideas. Though the historic origins show a multifaceted dimension to the understanding of the social world and management theory; there is appropriateness to this topic which enlightens the direction of the author's approach to be undertaken within this thesis.

These understandings from CT have added much to CMS in challenging the concept of work, the purpose of work and the role of organisations. CT considers the organisation in a historical and social setting made up of activities and connections related to social actors. CMS has endeavoured through investigation and presentation of social arrangements, to acknowledge the biased disposition of managerial interests (Grey and Willmott, 2007). Therefore, revealing the concealed power connections of instrumental rationality by exposing the developments that humans agree on social understandings (even though these understandings may conflict with their welfare, safety and security).

This viewpoint has a humanistic ambition which promotes the idea of a classless condition that can be made possible, by introducing more accurate communication (Habermas, 1984). In proposing this notion, Habermas (1984) suggests that a method of attaining an advanced state of rationality, is attainable through truthful communication and an acknowledgement of individuals partaking in the possibility of being free independent agents.

Alvesson and Deetz (2000) acknowledge that while post-modernism can embrace difference, it has the propensity to recognise shared themes too. Linguistics and discourse become important, as they establish a useful construct of reality, as opposed to a mere medium for the delivery of meaning. Additionally, language suggests non-attendance and attendance, and this can present as recognising language and discourse by means of endowment of power with communication. Knowledge and power can stay simultaneously connected, leading to information not ever being neutral, though presenting as insightful as well as constructive when dealing with power (Daldal, 2014). By these methods, there is a consideration to connect postmodern themes with those of CT. Discourse and its relation to power has much to provide CT's ideological stance when acknowledging different values and pursuits.

As suggested, post-modernism does comprise of dual ontological and epistemological principles which do not fit well with CT. Primarily, it theorises the person to be broadly created so there is no alternative to the essentialist concepts related to the independent mean-producing person. Subjectivity is a continuing venture in challenging developing discourses as postmodernism abandons narratives that declare advanced truths and purer knowledge.

CT, originating through the labour development theories (Bottomore, 1998) and the Frankfurt School institutions (Claudio, 2010), ideologically disguises the reality behind individual concerns and intentions. Post-modernism presents a few discourses which rival privileges to truth and knowledge. CT endeavours to

expose the interests related to humanist purposes and truth. Post-modernism follows a conceptualisation of the way some truths become more established than others and how power relationships try to replicate them. From this perspective, exposing the truth only substitutes previous deceptions with fresh versions. An understanding related to one truth gets replaced with another, and power relationships shift too, though correspondingly remain governing. Such difficulty with classification recognises the postmodern viewpoint as a perspective which is repeatedly comparative and is helpless in recognising moral and moral advantage, within the discourses. CT and its variants, who are reliant on the objectivist-realist ontology, are naturally suspect of following selective and elite alternatives related to these vested interests (Johnson and Duberley, 2000). Such variances can be viewed to be conflicting, yet Alvesson and Deetz (2000) contend that both CT and postmodernist viewpoints can be both similar as well as dissimilar. Thus, developing varied ideas from CT and post-modernism which permit freedom in relation to distinct opinions. Parker (2002) asserts that questions of influence and authority, discrimination, prejudice and moral and ethical concerns, must prevail beyond theoretical squabbling related to ontological and epistemological differences.

Differences apportioned to CT and postmodern theory in distrust of the structures relating to both power and ideological concerns is apparent; though the critiquing of these structures still goes much further than they do within the conventional normative approaches. From this viewpoint, there is an assumption to be held as anti-positivist and the promotion of the world to be held with an analytical lens is justified. Within leadership and management studies there has been some work undertaken to challenge obscure organisational arrangements, through critical and postmodernist thinking (Grey and Willmott, 2005). Postmodern involvement of exploring the punitive impact of certain organisational discourses, on the customs of ordinary working life, has encouraged much understanding. Power and conflict, and how it effects organisational discourse involving HRM have been a part of this exploration (Deetz, 2003; Barratt, 2008; Brewster and Mayrhofer, 2012).

4.8 Moving from a theoretical framework to a research methodology

In a study of 228 peer reviewed LMD related journal articles (from 2000-2011); Mabey (2013) split these studies into the four Burgoyne and Reynolds (1997) LMD discourses. These articles were Association of Business School Academic Quality Guide ranked between one and four. The splitting of these studies into distinct discourses could have been viewed as arbitrary; nevertheless Mabey (2013) established that most researchers remained within one discourse, with few presenting a multi-discourse enquiry. Of the 228 studies, Mabey (2013) identified 188 functionalists/performative, 24 interpretive, seven dialogic and nine critical discourse-based works. Though not to promote one discourse over

another, Mabey's (2013) review of the LMD literature demonstrated that there is a significant lack of LMD research from the interpretive, dialogic and critical discourses. Mabey (2013) argues that interpretive, dialogic and critical approaches are only just emerging areas of LMD study within Europe. This may have accounted for their low numbers in comparison to the functionalist/performative based studies.

Fairhurst (2008), Jepson (2009) and Edwards *et al.* (2013) have previously acknowledged the need for more alternative approaches when researching LMD. Edwards *et al.* (2013) highlights the necessity for more interpretive and dialogic discourse analysis to explore the 'becoming' part of the leader/ship journey, as opposed to the common normative stances of being a leader:

'As there appears a need for the leadership development and learning literature to appreciate the aspects of emotion, in-particular anxiety and desire in the process of becoming a leader and in being a leader' ... 'in addition, it appears that leadership learning and development should reconnect with context and community' (2013, p. 5)

Edwards *et al.* (2013) also recognise the similar issues to which Mahoon *et al.* (2015) encountered during their evaluation of LMD within the NHS. Mahoon *et al.* (2015) showed barriers such as participant desire to lead and a workplace culture of dissuading future leaders to be pertinent. As acknowledged in chapter three, issues of power and an established change resistant culture are noticeable and can have a negative effect on the NHS LMD participant experiences (Bagnell, 2012). Previous participants of NHS LMD trainings have also noted a conceptual fuzziness in the delivery of LMD (Edmonstone, 2013a) and a culture reluctance to implement LMD learning within the NHS workplace (Hewison and Morrell, 2014; Mahoon *et al.*, 2015).

Considering the NHS LMD literature drawn from chapter three and the works of Burrell and Morgan (1979), Alvesson and Deetz (2000), Mabey and Finch-Lees (2008) and Mabey (2013); using a case-based, multi-research methodology will support further enquiry into this area and assist in addressing the research aims. The reasoned view of Mabey and Finch-Lees (2008, p. 23) definition of '*meta-theory*', will allow for a multi-method analysis, as opposed to adhering to the constraints of the incommensurability of paradigms. Such a qualitative, multi-method approach will add to the limited research within this area (that of the multi LMD discourse). This will also help illuminate issues associated with LMD participant experience and the interplay of the LMD discourse within the NHS workplace. The next chapter will present a research methodology and method drawn on the understandings developed from this and the previous chapters.

Chapter Five: Methodology and method

5.1 Introduction

It is now important to define a suitable research approach to explore the experiences of NHS LMD participants. A methodology will follow establishing two research approaches that will be applied to the study of NHS LMD.

As recognised in chapter four, utilising an ideographic, multi-research methodology will support this enquiry into NHS LMD (Alvesson and Deetz, 2000; Mabey and Finch-Lees, 2008; Mabey, 2013). Building on discussion and contemplation throughout earlier chapters and as acknowledged in section 1.2.3, research aims have been formulated as follows:

- To explore how NHS leadership and management development training participants experience their training.
- To examine potential barriers which impacted upon the participant's NHS leadership and management development learning within their NHS workplace.

These research aims resulted in the articulation of four research questions:

- How did participants feel about attending their NHS leadership and management development training?
- How did the participants' organisation respond to the participant during and after their NHS leadership and management development training?
- How does the participant feel their NHS leadership and management development training influenced them?
- What, if anything, effected participants engagement with the NHS leadership and management development training and the NHS workplace?

In relation to the research aims and questions, they represent two areas of interest that require further investigation, namely the NHS LMD training experience and the NHS workplace barriers to effective LMD. As such a hermeneutic investigation could be considered appropriate in exploring how participants experienced their NHS LMD training; secondly a critical investigation of discourse to explore how participants discuss and construct their experiences of being 'in-between' NHS LMD and the NHS workplace. Considering these two perspectives would allow for a more abundant analysis of the restraints and opportunities NHS LMD participants face when linking LMD to their NHS workplace setting. Building on previous chapters, additional acknowledgement of the consequences of applying a multi-method approaches to research is required.

In summary, the first sections of this chapter (sections 5.1-5.4) will establish an appropriate and systematic methodological approach to research as acknowledged above. Section 5.5 will proceed to describe the method by which data collection was applied, the data was analysed, and the methodology was adhered too. The final sections (section 5.6 and 5.7) will conclude with a reflection on the requirements for safeguarding the integrity of this research and a summary of this chapter.

5.2 Foundations for the research design

When contemplating notions of scientific research, Guba and Lincoln (2005) consider five basic-belief systems of constructivism, critical theories, positivism, post-positivism and participatory. Both Abbott (2001) and Harvey (2009) maintain that there are many splits amongst positivist and non-positivist paradigms, which are also over shadowed by many other methodological dualisms such as rationalisation versus interpretation, realism versus constructionism, analysis versus narrative, quantitative versus qualitative and so on. Relevant to the paradigmatic tensions within organisational research (and as acknowledged in chapter four), Alvesson and Deetz (2002) as described by (Fleetwood, 2014a) acknowledge four dominant LMD discourses, these being '*dialogic (postmodern and deconstructionism), critical (late modern, reformist), normative (modern, progressive), and interpretive (premodern, traditional)*' (Fleetwood 2014a, p. 188). As previously recognised, a meta-theory approach (Mabey and Finch-Lees, 2008) would be suitable for this enquiry. There are still further considerations in terms of how any findings will be understood in relation to knowledge and value, and how this understanding will be useful and relevant to future NHS LMD.

Moving forward, Morris (2006) suggests that positivism is a principal method applied within the social sciences (and in empirical science). In social research, most paradigmatic disputes frequently result in the distinction between quantitative or qualitative methodologies (Mjoset, 2009). Quantitative methods, apply theoretical hypotheses to harvest numerical data, estimating population parameters and statistical analysis; this approach is typically connected to the positivist paradigm (Creswell, 2017). Quantitative investigations operate via applying theories and calculating statistical significance related to instances or participant behaviour (Creswell, 2017). This approach applies mostly to empirical and deductive methods of investigation. Qualitative approaches examine meanings created across language and interpretation. This method of analysis focuses on obtaining comprehensive material in relation to a small number of cases or participants, encompassing the researcher within a thematic examination of mostly text-based data. Various studies, particularly within the sphere of applied research apply a mix of both quantitative and qualitative approaches (Niglas, 2000; Fielding, 2012).

According to Fetters and Molina-Azorin (2017), the mixed methods design is becoming progressively commonplace, nevertheless Howe (2004) argues that this can place qualitative approaches into '*a largely auxiliary role in pursuit of the technocratic aim of accumulating knowledge of 'what works''*' (2004, p. 9). Still, a mixed method approach mostly presents as being coherent to the realist philosophy of scientific investigation. This contends that research must not be subdued in relation to previous conventions regarding what constitutes reality or actuality and needs to concentrate on what is in the best interests of the research (Creswell, 2017). Byrne (2009) suggests there has been an increase in the use of case-based approaches, which have generally recommended critical realism to be the preferred theoretical perspective. Critical realism and a case-based, retrospective cohort study approach will be the position taken within this study of a qualitative, multi-method approach in the exploration of the neglected LMD discourses.

Easton (2010) suggests that using critical realism allows for a degree of methodological pluralism and moves beyond the associated constraints of incommensurable paradigms. Critical realism positions itself as a complementary paradigm to positivism, but also has a robust focus on interpretivism and postmodernism; this concentrating on hermeneutics as well as account, with limited focus on causation (Bhaskar, 2008; Gorski, 2013; Janz, 2017). Theoretically speaking, it is conceivable to locate critical realism in many areas; Guba and Lincoln (2005) locates critical realism in post-positivism and Neuman (2006) places critical realism within the critical social science branch. Importantly, the critical realist investigator may contend this research approach to be explorative in that it can construct general claims and move past idiographic account, however cannot create common social laws (Byrne, 2009). Taking a critical realist stand point will inform the findings of this study as well as having consequences for study design i.e. the proposal to implement a retrospective case-based study, using two types of analysis to explore situated experience and discursive practices. To note, critical realism has no specific study method, but it does not infer a melee approach to methods either (Roberts, 2014).

5.2.1 Critical Realism

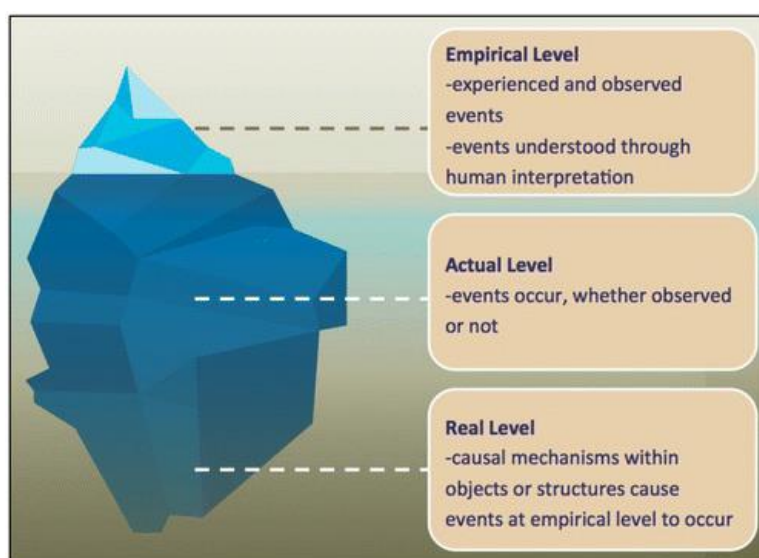
According to Bhaskar (2016) critical realism (CR) expounds the differences concerning ontology (ideas regarding the attributes of existence) and epistemology (consideration of the disposition, circumstance and the limits of understanding). The ontology of CR suggests that a certainty occurs beyond awareness, divided over three ranks of empirical, actual and real levels:

- The empirical comprises of experience related to our perceptions.
- The actual encompasses everything, irrespective of being seen or experienced.

- The real, comprising of fundamental underlying mechanisms that create events. These casual mechanisms which are not necessarily visible empirically nevertheless are real since they are the foundations for phenomena to occur (see Figure 12. An iceberg metaphor for Critical Realist ontology).

Significantly, action is conveyed through subtly organised yet undefended systems, which can cause a disruption, no matter how small (Fleetwood, 2005; 2014a; Brannan *et al.*, 2017). From this perspective, mechanisms only create propensities when challenged i.e. gravity can be (to some degree) provisionally superseded by mechanisms like the aerodynamic and thrust propensity of aeroplanes (Collier, 1994).

Figure 12. An iceberg metaphor for Critical Realist ontology



(Source: Fletcher, 2017, p. 183)

In society, human agency significantly increases the complexity of connections, and this results in difficulties in articulating causal explanations for occurrences. Along with other authors (Sayer, 1992; 2000; Collier, 2004), Danermark *et al.* (2002) recognises that to understand social phenomena, a '*double hermeneutic*' (2002, p. 32) is required to interpret other people's understandings of a phenomenon. From the perspective of social science, individuals can alter their world, since their behaviours and opinions are already determined by established social arrangements. Knowledge being abstractly intermediated, CR discards notions of scientifically controlled observance, recognising that the truths and examinations of science, are ultimately reliant on interpretation in the first instance (Bhaskar, 2008). In terms of this study, CR's understandings of the construction and description of the functioning world, fits well within IPA with its epistemological constructivism and relativism. CR also suits CDA, which moves beyond the hermeneutics of IPA into the exploration of dialectical social

practices. These approaches will assist in achieving the research aims, by investigating the real creating and maintaining mechanisms of the multi-LMD discourses (Mabey, 2013). To note, Hammersley (2009) does caution when using CR to justify research approaches:

'The simultaneous attempt both to produce knowledge and to bring about social change of some kind (or, for that matter, to preserve the status quo) is liable considerably to increase the danger of bias's' (2009, p. 8).

As an issue, counter measures attempting to address the issue of bias during the research process are acknowledged in section 5.6 and how these biases may have influenced the research findings in sections 8.3 and 8.6.

5.2.2 Methodological approach

Danermark *et al.* (2002) promotes methodological pluralism, with the intention to resolve the friction amongst quantitative and qualitative attitudes. Danermark *et al.* (2002) argues against the supposition that research methods should be influenced wholeheartedly by their research paradigm, as opposed to the topic under scrutiny. Consequently, this research will apply a qualitative methodology, with a pluralist approach related to the research aims and questions. Bearing in mind this integrative understanding, Saukko (2005) in: Hood (2015, p. 168) demonstrates how three separate considerations of the lived experience, can be merged:

'A hermeneutic emphasis on experiences, (post) structuralist critical analysis of discourses that mediate that experience and realities, and a contextualist/realist investigation of historical, social and political structures of power' (Saukko, 2005 in: Hood, 2015, p. 168).

Denzin and Lincoln (2017) additionally suggest that the understanding of lived experience can be enhanced by acknowledging the discourses and social practises which shape a life experience, and the idiosyncratic considerations which maintain that experience. Similarly, research that seeks to apply a deductive analysis of belief systems can be assisted by hermeneutic understanding of a person's individual account; thus, avoiding the reduction of *'local experiences to props for social theories'* (Denzin and Lincoln, 2017, p. 345). Furthermore, involuntary and dialogic methods of research are not autonomous, yet are positioned within the background of wider social activities and structures. As previously alluded to, this study design will focus on the hermeneutic investigation of encounter and the analytical investigation of discourse.

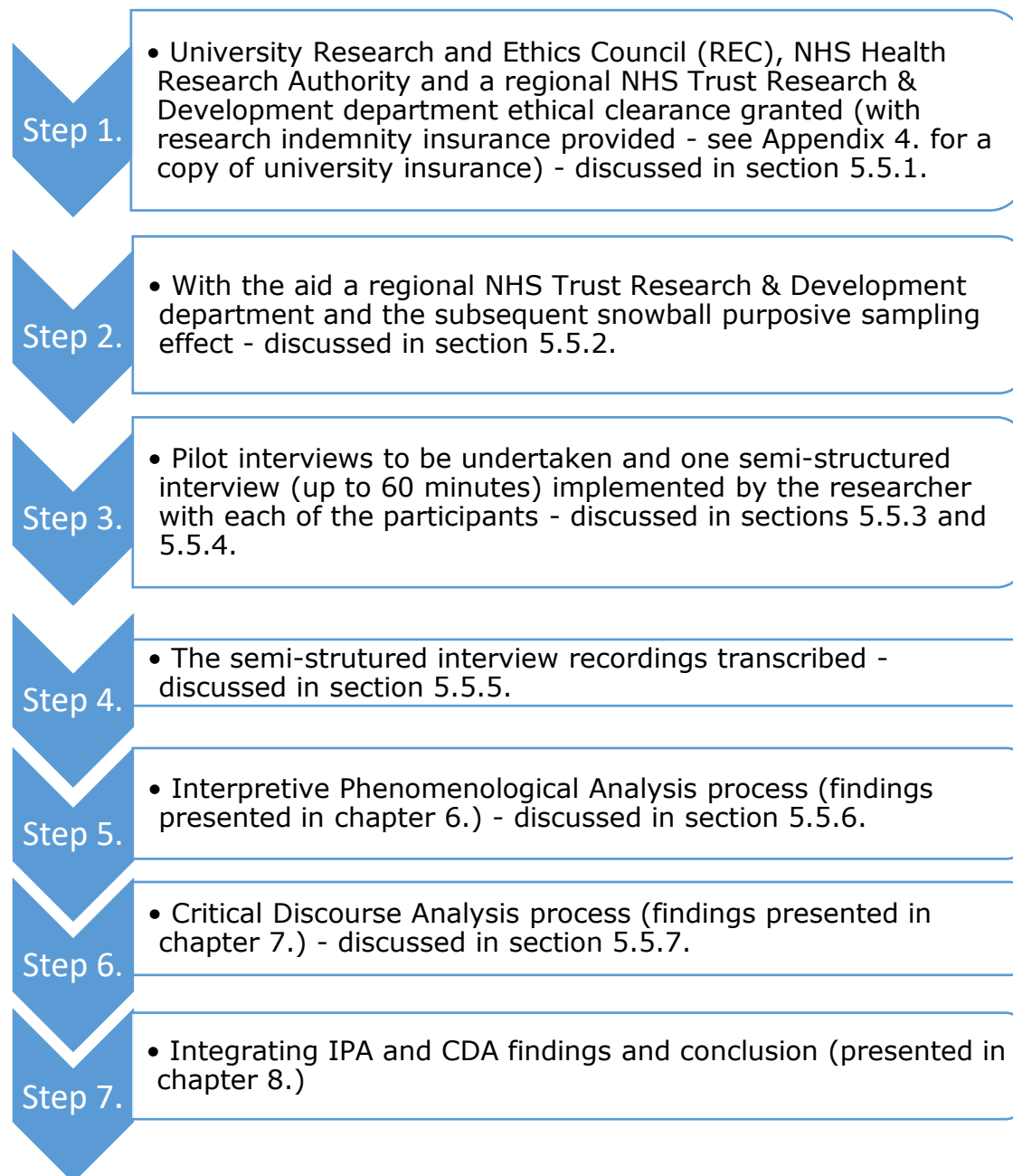
5.2.3 Design of the study

This study will be a rigorous, retrospective cohort study case-based investigation of participant experiences of LMD within the NHS. To build a contemporary understanding these cases/participants, have attended an NHS commissioned or provided LMD training within the past 10 years. In selecting research participants, it was decided that individuals who had experienced NHS LMD beyond this 10-year period would not be able to adequately recount their experience. Within the 10-year time frame, reflections on career development, work place issues and integration of learning to outcomes can also be reasonably demonstrated.

Acknowledging CR and the investigation of only NHS LMD training participants, this study will focus on exploring the social structures and organisational mechanisms which maintain their experience. This is pertinent to those who have been subjected to unique and changing workplace factors because of their NHS LMD training experience. According to Collier (1994) *'such structures can be hidden from view, but which become more visible during periods of crisis or transition'* (1994, p. 104). To add, the exploration of the research aims, and questions could have been approached in many ways i.e. an ethnographic researcher based within a cohort of LMD participants, or multiple interviews involving facilitators, commissioners, and workplace managers and their experiences of working with NHS LMD participants. These approaches could have been equally as valid, as opposed to the LMD participant only interviews. However, using a more flexible research design, such as interviewing a range of professionals involved in NHS LMD may have thinned out the emphasis on participant experience. Thus, potentially resulting in a duplication of previously recognised discoveries, which are relevant to a successful or poor NHS LMD training (such as the Hardacre *et al.*, 2011; Stoll *et al.*, 2011; Edmonstone, 2013a studies).

Yin's (2014) concept of a qualitative case study, entails the research to present as *'an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context'* (2014, p. 18) and additionally *'the intrinsic study of a valued particular'* (Denzin and Lincoln, 2017, p. 125). The study design of this research (as demonstrated by different steps in Figure 13.) is presented as a retrospective cohort 'case-based' study. Case or participant-based studies (such as this one) typically require low numbers of participants to investigate a topic. Frequently, there is a pre-occupation with conceptual construction which includes the ambition to connect situations occurring within micro level environments, with greater dimensions of social configurations and practices (Walton, 1992). Hence, creating a *'naturalistic generalisation'* (Stake, 2005 in: Denzin and Lincoln, 2017, p. 454) developed from thorough examination of a case's exceptional features and depth of analysis. Related to this study, ideas from retrospective case-based research have primed the methodological ambitions of this research. To clarify, within this thesis a case will mean a purposively, judgement sampled participant (Balnaves and Caputi, 2001).

Figure 13. IPA and CDA study design for the leadership and management development within the NHS: A phenomenological and critical account research



(Created: Author, 2018)

Figure 13. summarises' a pluralist methodological approach involving NHS LMD participants purposively sampled cases drawn from a regional NHS Trust. The process of the sampling and data gathering exercise will be clarified later within this chapter (section 5.5). Presently, the emphasis is on the theoretical foundations of the methods which will be employed to address the research aims

and questions. Applying a meta-theoretical approach, two separate approaches to the inspection of accumulated data from nine individual participant interviews will be utilised. This approach complements a hermeneutic attention to the lived experience, in conjunction with an analytic understanding of discourse. Thus, contributing to the LMD research agenda, which traditionally has delivered mostly from a functional/performative discourse, as opposed to the dialogic, critical and interpretive discourses (Alvesson and Deetz, 2000; Mabey, 2013). The research methods to be applied are IPA and CDA, which will now be considered further.

5.3 IPA

Within this section IPA will be discussed and critiqued. A foundation for IPA's application and a description of the common practices applied when employing IPA will also be contemplated. There will additionally be an acknowledgement of its conceptual and real-world limitations. Figure 14. in section 5.5.7 will relate to how IPA was administered to analyse the data collected and demonstrate how results were obtained.

5.3.1 The history of IPA

Smith (1996) originally developed IPA to be applied within the field of health psychology research. However, IPA has been applied by an assortment of health and social care researchers and its use deployed in multiple settings (Brocki and Wearden, 2006; Pringle *et al.*, 2011). Smith *et al.* (2009) specify that IPA is developed from the thinking of phenomenology, which is predominately related to the works of Husserl, Schutz and Heidegger (Elliott and Timulak, 2005; Farganis, 2011; Reiners, 2012). Phenomenology focuses upon the nature of experience from the view of human consciousness. Husserl [1900/1901] in: Moran (2001) comments on this idea as meaning to '*go back to the things themselves*' (2001, p. 168). This can be understood as the need to recognise the importance of acknowledging phenomena as it is observed and felt, as opposed to inferring to the objectivity of phenomena when consciousness is not involved (Larkin *et al.*, 2006). A phenomenological method investigates how people construct the world around them. Smith *et al.* (2009) explain phenomenological as:

'Understanding personal lived experience and thus with exploring persons relatedness to, or involvement in, a particular event or process' (2009, p. 40).

Hence, an idiographic prominence within IPA appeals to the influence of understanding, which is offered through the comprehensive analysis of the accounts of individuals.

Though aware of its phenomenological underpinnings, IPA as a research approach principally recognises the need to produce an interpretation of

experience. IPA researchers focus on the exclusive meanings that individuals ascribe to an experience, by demonstrating how such meanings can connect to an individual's life world, cultural setting, and the comparable encounters of others (Shaw, 2001). Requiring a dual procedure of experience and interpretation, representing the '*double hermeneutic*' (Smith and Osborn, 2003, p. 54). The term '*double hermeneutic*' relates to IPA researchers attempts to understand people, through the lens of their own experiences. With the integration of symbolic interactionism, IPA recognises the importance people place on their experiences through their social interactions (Blumer, 1969). It can be argued that subjective experience of the world is linked to our relationships with others, and consequently is both aided and restricted by the prospects provided through communication. Connecting the hermeneutic phenomenology of Heidegger (Smith and Osborn, 2003), the mode of being or being-there results in our experience as continuously present and personal, hence continually requiring a process of elucidation using an '*hermeneutic turn*' (Hoy, 2006, p. 170).

Importantly, Heidegger's hermeneutic phenomenology recognises the roles of internal judgments such as presumptions and prejudices, which precede occurrences, and thus require acknowledgement (Smith *et al.*, 2009; Fritzsche, 2012). The Husserlian phenomenological approach, (Husserl [1931/2008] in: Giorgi *et al.*, 2017), argues for a requirement to '*bracket out*' (2017, p. 117) or '*epoché*' (2017, p. 117) these preconceptions, with the goal of attaining an essential understanding of the phenomenon as the participant perceived it. Contra, the Heideggerian position assumes that interpretation, by its nature will summon preconceptions and assumptions which themselves be relevant and changed by the encounter with the research (Malpas, 2013). Recognising this tension and the role of potential bias, the IPA approach used within this research will not bracket. This choice recognises Bhasker's critical realist understanding of epistemic relativism which '*holds that one's social position (e.g. class, gender, race, being a researcher, being researched) influences the way one interprets the world, formulates concepts, and made claims about it*' (Fleetwood, 2014a, p. 188). With the researcher being a former NHS professional and LMD participant, it would be unrealistic to be able to ignore my influence on the interpretations of the transcripts. Nevertheless, it is noted that epistemic relativism can frequently breakdown into judgemental relativism if not kept in check (Bhaskar, 2008). Consequently (and as alluded towards the end of section 5.2.1), this will be taken into consideration throughout the IPA analysis by constant note keeping (explained further in sections 5.6.1 Reflexivity: Personal and 5.6.2 Reflexivity: Epistemological).

Though poorly defined within the literature, an interrelated principle is concerned with the '*hermeneutic circle*' (Smith *et al.*, 2009, p. 27). Drawn from Heidegger hermeneutic phenomenology, the hermeneutic circle essentially represents the interpretative interaction amongst the whole and specific elements of a text (Gadamer, 1975). Smith *et al.* (2009) employ this approach to the IPA research procedure, suggesting that there is no such thing as linear research. They

recognise that there is a changeable, reflective, almost vigorous combative relationship required for text analysis to be effective, which does suit an iterative IPA approach. This understanding can challenge theories and the presumptions of researchers, yet fundamentally sits with participants and their lived world. IPA naturally assumes a responsive and curious approach, with the endeavour of gaining an '*insider's perspective*' (Smith *et al.*, 2009, p. 36) related to the phenomena being questioned. IPA activities aim to achieve an in-depth level of analysis and consideration (Smith *et al.*, 2009).

5.3.2 Why use IPA in organisational research?

As established, IPA has been applied frequently within the remit of health-related research (Brocki and Wearden, 2006; Pringle *et al.*, 2011). As this research seeks to primarily explore LMD participants experience from an NHS context, IPA fits well here. This study is also pre-occupied with the workplace and the application of IPA in organisational and management research, which when compared to health research, can be regarded as an emerging field (Gill, 2015; Basini, 2017). Nevertheless, in relation to IPA and organisational research, Gill (2015) argues that IPA is a useful approach and delivers distinct advantages for researchers in this field. These are as follows:

The IPA approach has the capability to illuminate the role of emotions in relation to multifaceted and nuanced experiences. It is recognised in phenomenological inquiry, that feelings have different intensities. Willig (2013) argues that IPA is primarily concerned with cognition; Gill (2015) contends that IPA seeks to explain the role of emotion within a specific context. Gill (2015) proposes that understanding emotionality is significantly useful when fostering organisational insights. Such reasoning can allow researchers to describe how and why particular individuals make decisions. Fitzgerald and Howe-Walsh (2008) applied IPA to ascertain and understand the emotional issues that influenced female professional expatriate choices in seeking international work experience. By portraying the accounts of the women involved, the authors were able to deliver descriptions, acknowledging how the participants '*felt scared*' (Fitzgerald and Howe-Walsh, 2008, p. 163) and how this impacted upon their experiences of working abroad. In this example, IPA's idiographic attention empowers the researcher to explain the personal experiences and emotions that drove these employees to action. In keeping with the agenda of this study, Gill (2015) reasons that IPA studies can:

'Address a whole host of valuable questions such as what influences particular employees to leave or resign from their work or to dedicate themselves to a chosen profession. In doing so, these questions are likely to highlight the powerful role of emotions' (2015, p. 19).

The second advantage of using IPA in organisational research is that IPA can assist by explaining the role of emotions in social phenomena and processes in

what can be described as from the bottom-up (Smith and Osborn, 2003; Gill, 2015). As previously noted, IPA is valuable when examining complexity and meanings, as it can disentangle and explain these from the experiences of participants. Kupers *et al.* (2012) utilised hermeneutic and phenomenological methods to comprehend participant's lived experiences of strategy in an ICT company. They reasoned that these methods could empower researchers to come into '*closer touch with individual and social realities*' (Kupers *et al.*, 2012, p. 2). Their approach explored the lived and evolving, as opposite to the deliberate, orchestrated processes of some organisational strategy development events. Kupers *et al.* (2012) argued that they challenged the cognitive biases which are known to occur during these events, by focusing on the role of profound experiences instead. They considered how particular stories and phrases invoked strong reactions in employees, which then impacted upon their strategic reasoning.

Gill (2015) acknowledges that IPA studies are suitable for supplementing a selection of existing organisational theories. Gill (2015) additionally recognises that there is a notable lack of individual, participant accounts within numerous organisational studies. Furthering this, Gill (2015) asserts that IPA has the capacity to reassess, advance and enhance much prevailing organisational theory and research. Relevant to this research, IPA studies by Wise and Millward (2005) and Murtagh *et al.* (2012) emphasise the requirement for the incorporation of emotional and rationality perspectives into the present theory of career decision making. By examining individual's personal accounts, both these studies consider the meanings participants ascribed to their careers and development. This resulted in these studies modifying fundamental conventions of structured occupational theory development. Both studies note that at various stages, depending on the theory, neglect of the role of emotion in career decision making (Super, 1980; Holland, 1997; Dawis, 2002; 2005; Gottfredson, 2002; 2005). IPA has the potential to back further investigation into other known theories, by exploring how specific individual's experiences are felt and understood (Gill, 2015).

Both Berglund (2007) and Cope (2011) suggest that IPA is a useful approach for scrutinising entrepreneurship. It is proposed that this can be accomplished by investigating how entrepreneurs experience risk-taking and business development activities. Cope (2011) undertook an IPA study to scrutinise how entrepreneurs adapt and learn from failure. Cope (2011) discovered that '*the emotional cost of failure was emphasised by all the participants*' (Cope, 2011, p. 610). Cope (2011) contends that the existing literature fails to recognise the emotional costs that entrepreneurs suffer and how these costs are also related to loss of social status as well.

Overall, the foremost basis for utilising IPA within this research is related to its epistemological appropriateness in answering two of the research questions, specifically:

- How did participants feel about attending their NHS leadership and management development training?
- How does the participant feel their NHS leadership and management development training has influenced them?

IPA is suitable for exploratory questions like these, which endeavour to extract the exceptional and mutual fundamentals of people's experiences; this is concentrated on sense making and emotion. IPA should be reliable in terms of the critical realist social ontological considerations of this study. This is by accepting that there is one reality, but multiple interpretations of it and that reality is not entirely socially constructed (Fleetwood, 2014b). IPA places emphasis on the value related to a person's understanding, with an acceptance that even with multiple interpretations, the same meanings can still be attached to the same phenomena.

5.3.3 The methodological practises of IPA

To create a thorough idiosyncratic understanding of a phenomenon, IPA has an established, recent history of accommodating a diverse number of research designs (Pringle *et al.*, 2011). In terms of data collection, semi-structured interviews, are the typical approach utilised in IPA research, with most studies sampling between nine and twelve participants (Brocki and Wearden, 2006; Cassidy *et al.*, 2011; Pringle *et al.*, 2011). Smith *et al.* (2009) recommend nine participants to be generally appropriate for those deploying IPA as a part of a UK professional doctorate thesis, such as this.

Smith *et al.* (2009) also acknowledge that undertaking semi-structured interviews and allowing the interviewees to be the focus, in relation to the phenomenon under scrutiny, is consistent with most IPA studies. This method of interview allows participants to be able to discuss their own narrative, from their own perspective. Infrequently, encouragement can be utilised in allowing for additional admissions and discovery. Related to the fundamental values of IPA, progressive questioning can be made during the interview and the impact this has on the participant should be additionally noted.

Understanding the data through partaking in an interpretative connection with the text, is an essential part of the IPA process (Cooper *et al.*, 2012). Through this procedure, the researcher should be able to appreciate the participant's world and lived experience. The researcher can recognise the connotation's related to the participant's experiences by isolating the text into '*meaning units*' (Smith and Osborn, 2003, p. 59). Through separating parts of transcripts into meaning units, similarities, alternatives and inconsistencies amongst the participants whom depict similar experience can be identified; the primary goal being to be able to develop the foremost themes, which arose from the recognised units of meaning. Brocki and Wearden (2006) suggest that the analytic-interpretive process is not just the purification and classification of data; they specify this process should be an intimate interface between the researcher

and the data. This is due to the focus on the researcher having to make sense of the interpretation while applying their own '*interpretative resources*' (Smith *et al.*, 1999, p. 223). Smith *et al.* (1999) additionally argues that the level of personal analytical exertion accomplished during each rotation of the analytical process, will invariably result in a more valuable, in-depth conclusion.

5.3.4 IPA (a critique)

IPA is noted for its aptitude in revealing unanticipated phenomena (Hancock *et al.*, 2009). Consistent with most qualitative methods, procedures frequently applied to IPA are accommodating and unrestricted. Through exploration of the phenomena, the process allows participants to access aspects of experience, not originally thought of as relevant by the researcher or existing to any contemporary theories (Shaw, 2001; Smith, 1996). As a result, IPA can be thought of as being data-focused, as opposed to a theory-focused approach. The benefits of IPA occur when innovative data becomes apparent through interpretive analysis, and as such adjoin to establish theories which may broaden these theories. IPA can also be utilised as the foundation of novel theories, and as such is extremely valuable since these theories have been produced from the people undergoing the phenomena (Cassidy *et al.*, 2011). IPA permits the researcher to be more unprejudiced by enabling participants to express narratives, by their own means. In consideration of IPA's attitude of being slightly flexible towards data analysis, Giorgi (2011) criticises Smith's (1995; 1996) IPA for its '*hesitation to claim fixed methods, making the possibility of replication of IPA studies impossible*' (2011, p. 195).

IPA has the potential to expose phenomena which is exclusive, yet common amongst a group of participants. IPA can develop the individual, and recognise the unshared experience, with what was also common about the experience of those sampled participants. As established, IPA relies on a dynamic researcher to apply meaning to the collected data, however it is recognised that repetitive reading may be extremely time intensive for those involved in IPA research (Taylor, 2013). Within this research, this drawback has been recognised by the researcher and has been accommodated for by the utilisation of a project plan to ensure that such issues have been identified early on (see Appendix 3. DPM Project Plan – September 2015 to September 2018).

Though there are many reported positives regarding the use of IPA, Willig (2013) suggests five potential limits when applying IPA:

- Speaking about a phenomenon is not the same as recounting it.
- Use of language precedes the phenomena, and as such will taint and form part of the original phenomena.
- IPA can reject participants who lack certain language abilities, hence erroneously dismiss their worthy experiences.

- Exclusively focusing on manifestations, yet negates the underlying context, which Willig (2013) argues '*limits understanding of other phenomena*' (2013, p. 68).
- IPA is primarily concerned with cognition, which Willig (2013) reasons to be incompatible with '*some aspects of phenomenological thought*' (2013, p. 68).

Within this study, these concerns are worth bearing in mind, however most of these issues have been acknowledged earlier within this chapter i.e. Gill (2015) arguing that IPA can move beyond the cognitive and is fully capable of acknowledging emotional states. Due to the multi-disciplinary nature of the professionals (and the complexity of their roles), the lack of certain language abilities may not substantially impact on this research. Nonetheless, and bearing this concern in mind, participants will be provided with the option during the seeking of consent, to utilise a translator throughout the interview if required.

Another consideration and as acknowledged by Pringle *et al.* (2011), IPA is frequently compared to Grounded Theory (GT), and it may be difficult to meaningfully distinguish between the two approaches. Pringle *et al.* (2011) propose that IPA is distinct from GT because of its specific appropriateness when comprehending idiosyncratic understandings in comparison to the exploration of social practices. IPA's current positioning as an emerging methodology, permits researchers '*more space for imagination and freedom while evading the arguments and controversies connected with grounded theory*' (Pringle *et al.*, 2011, p. 22).

5.4 CDA

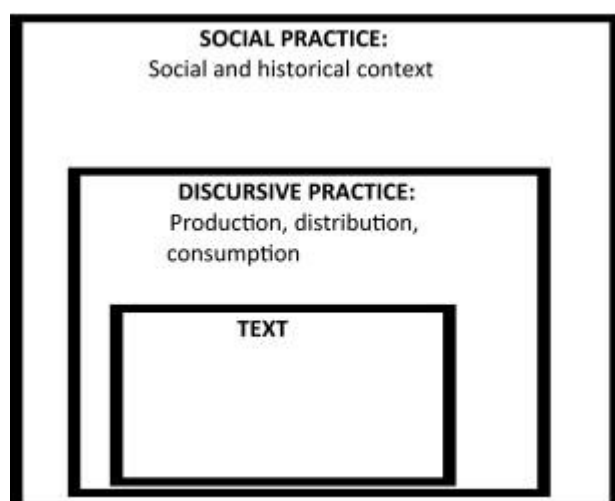
Like the 5.3 IPA section, this section will depict the fundamental foundations of Critical Discourse Analysis (CDA) and clarify its intentions for use within this study. This will involve summarising the central CDA methodological processes to acknowledge their benefits, as well as their boundaries.

5.4.1 The history of CDA

CDA has a rich-assorted history, predominantly being utilised in phonology and social research. CDA is suitable for an academic multidisciplinary method with some theoretical and methodological deviation allowed (Fairclough and Wodak, 1997; Fairclough, 2003; 2009; 2013; Weiss and Wodak, 2013). The main architect of CDA, Fairclough (2003; 2009; 2013) enlightened the link between language (and the application of language), social structures and practices, known as '*semiosis*' (Fairclough *et al.*, 2004 in: Joseph and Roberts, 2004, p. 23). CDA is focused on the features of ideology and power, entrenched in conformist, institutional or the common use of linguistics. An inspiration of CDA

is poststructuralist thinking related to information and control (Foucault, 1995). Observations of how control and associations to power operate arise from the interface of numerous interests and locations of power, which are shaped into disciplines, are considered by CDA. Foucault (1995) argues that these disciplines are demonstrated as forms of knowledge, which by their nature instruct self-regulation of conduct, individuality and thought. This meaning that power is / can be ascribed through ideological belongings transferred via directions overseeing the '*domain of statements*' (Foucault, 1995, p. 80). Language hence forth moves outside representation (of effect, or judgements) and is presented as a fundamental of social practice, such as discourse. As seen in Figure 3. Jørgensen and Phillips (2002, p. 68) representation of Fairclough's three-dimensional model of discourse analysis demonstrates this well.

Figure 14. Jørgensen and Phillips representation of Fairclough's three-dimensional model of discourse analysis



(Source: Jørgensen and Phillips, 2002, p. 68)

Fairclough (2013) notes that whilst discourse is formulated, a discrepancy between the conventional understanding related to the use of language in speech and writing (Weiss and Wodak, 2013) and the unambiguous content of sense-making can occur (Locke, 2004). In other words, stories can disseminate within society and effect how individuals relate to and observe the world. For example, the medical discourse, which mutually creates, develops and shares knowledge from interactions concerning medical professionals, may be presented by the way medics chose to offer a specific complex patient to their peers (Anspach, 1988).

Within CDA, there are several terms which require clarifying in terms of their meaning. Fairclough (2013, p. 95), terms '*discursive events*' as specific examples of language usage, which create texts (be that scribed, spoken or seen) for communicating meaning to others. Fairclough (2013) describes '*genres*' (2010, p. 67) as the consideration of language related to certain occupations or actions, as demonstrated within the medical discourse (Anspach,

1988). Transcripts for example, can be founded from the interactions between various discourses and genres, which Fairclough (2013, p. 94) names '*interdiscursivity*', or '*intertextuality*'.

Overall, CDA is primarily focused on textual analysis, investigating as well as founding the links to conversational and social activities. Transcript analysis can create an explicit occurrence of language usage, referring to '*concrete oral utterances or written documents*' (Reisigl and Wodak, 2009 in: Wodak and Meyer, 2009, p. 109). CDA offers this research an opportunity to apply socio-linguistic analysis with its foundations in linguistic theory concerning the social nature of transcripts.

The work of Halliday and Matthiessen (2004) provides several analytic groupings modified and advanced by Fairclough (2003). Halliday and Matthiessen (2004) approach consider texts as '*specimens*' and '*artefacts*' (Halliday and Mattiessen, 2004, p. 3). Texts (when considered as specimens), basically exemplifies the methods of the meaning of sources i.e. the terminology use, sentence structure and so on. This is viewed as useful data. From the position of artefacts, the environment is significant due to its ability to divulge why specific sources are chosen and used. Additionally, scripts can be versatile because speakers and authors can create meanings of individuality, function, relations, knowledge and so on. This interaction amongst the diverse purposes of texts reinforces the positioning of language, which is the focus of CDA. As Stubbs (2002) suggests texts and the use of language, exemplify what can be understood in contradiction of other texts they are associated too. Hence, discourse analysis is intended to deconstruct these options and contradictions and examine their role within the wider social practices and structures.

5.4.2 Why CDA?

The multiple opportunities accessible through the application of CDA have resulted in numerous applications within the field of organisational development and change. This has also been reluctantly applied to professional development and practice within health and social care (Pollard, 2011; Mancini, 2011; Fairclough, 2013). Viewed from an epistemological perspective, CDA is an appropriate research tool which can be utilised to examine the second element of the research questions proposed in this study:

- How did the participants' organisation respond to the participant during and after their NHS leadership and management development training?
- What, if anything, effected participants' engagement with the NHS leadership and management development training and the NHS workplace?

CDA provides a focus on the sociolinguistic analysis of texts (Luke, 2002), which for this research will enhance the hermeneutic analysis of IPA by applying a critical approach towards the discursive fundamentals of participants accounts.

According to Fleetwood (2014b) CDA suits a critical realist approach by accepting the potential for causal-explanation, by disclosing the causal mechanisms of power. Thus, accepting attempts to uncover power-knowledge and socio-political agendas, which can lend a voice to the comparatively powerless.

5.4.3 The methodological practises of CDA

CDA predominantly involves the analysis of texts and retrieving of meaning linked to specific discourses. Texts can be transcribed or be verbal and may comprise of graphic or observable data, or just transcriptions of spoken conversations. When multiple texts have been gathered for analysis they can be jointly designated as a '*corpus*' (Fairclough, 2003, p. 46). Within this research, the texts will only contain transcriptions of interviews, which have been undertaken with participants. For analytical reasons, the nine transcriptions from the participant interviews can be one single corpus or treated as nine separate texts to be analysed, known as '*corpora*' (Fairclough, 2003, p. 47). There are multiple approaches to discursive investigation, however this research will use a customised version of Fairclough's (2003; 2013) CDA approach, while treating each interview transcript as corpora. CDA is frequently applied to the analysis to the slightest level of grammatical description and meaning. In terms of time consumption, utilising that level of approach would be unrealistic for this research; as such a modified Fairclough (2003; 2013) analytic framework will be utilised. The analytical groupings to be considered for this modified CDA are presented as follows.

Described by Swales (1990), a genre is '*a class of communicative events*' (1990, p. 58). Specific texts can be classed to be a genre and placed into such a category by having been established through comparable social customs i.e. the texts scrutinised within this chapter may be contemplated as a section of the genre of the interview transcriptions. Yet, Fairclough (2003) proposes there is an ambiguity when attempting to group texts in non-specific ways, because separate texts will frequently use an assortment of sub-genres like narratives, articles and so on, which can distort and distract their original meanings.

Intertextuality denotes the integration of selected textual information, based within supplementary texts. This can be exemplified by verbal quotes taken from conversations, or parts of other text like statements. Diverse voices from text can be acknowledged, and this may encourage or challenge the voice of the speaker. Taken from Bakhtin's (1981) concept of intertextuality, Jørgensen and Phillips (2002) place an emphasis on the concept of dialogicality, in which texts can be typically deemed as dialogical and changeable to the degrees to which voices are presented and epitomised. Fairclough (2003) connects intertextuality and dialogicality by considering textual disparity. This is in terms of the divergences related to the attitudes of individuals and correspondingly the individual's appreciation and reception of deviating or opposing viewpoints.

Assumptions suggest unspoken connotations confined throughout the textual information, they are contrasting in relation to the openly specified and deliberated. Assumptions signify the slightest fragment within texts, because they are not credited or disputed (Fairclough, 2003). Specifically, intertextuality augments the likelihood of divergence by conveying supplementary voices into the text and assumptions diminish the difference i.e. certain viewpoints may represent as unbiased facts or common truths. Assumptions can consequently participate in the continuing of social practices and relationships involving power and influence on what is apparent and considered to be normal or common sense.

Depiction of events or occurrences may be embodied by many different methods and subsequently be re-contextualised by varying accounts (Fairclough, 2003). The possibility for detailed examination of established and relegated accounts are all accessible through the process of detailed analysis. This analytical category considers if estimations and value opinions are supplementary or absent, or social agents are observed to be involved or inactive, dependent on the situation.

In terms of textual style Fairclough (2003) describes '*the discursal aspect of ways of being*' (2003, p. 200), denoting the cultivation of multiple forms of distinctiveness within the texts. The analytic method of '*identification*' (Fairclough, 2003, p. 206) includes an understanding of the interactions amid the societal and characteristics related to individuality. This explores how personality can influence social situations and the investigation of these values may show how relationships can be endorsed through the style of textual information.

Interdiscursivity indicates how multiple understandings and discourses can be arranged and layered within the texts. Fairclough (2003) proposes that such discourses can be connected to a distinguishable clustering of values, viewpoints and changes. Hence, discourses are not only associated to language and understanding, but additionally concern people and their relationships, their ventures, goals, roles and standing within society. Still, Fairclough (2003) argues that there can be a cohesion or stability within discourses, as well as a mixing and evolution. Respectively a discourse itself will draw upon any quantity of additional discourses, which can be combined, embedded or reworked in different ways.

Analysis of corpus is a diagnostic category which considers a method of quantifiable investigation developed via corpus-linguistics (Baker, 2006). Fairclough (2003) proposes that this method is utilised as a way of complementing different qualitative functions, which CDA can promote. Some software platforms like WordSmith Tools version 7 (Scott, 2017) allow arithmetical data, examples of the expressions of terms and their occurrences, identification of keywords in comparison to a corpus of usual language usage to be represented. As data, this information can be limiting, without a context being recognised and acknowledged.

5.4.4 CDA and organisational change

Fairclough (2013) suggests that there are four key research issues to consider when exploring matters related to organisational change and the organisational discourse. This can be considered when analysing such interview texts as those presented within this research. These issues will be represented within the context of this research and assist in the summarising of the findings drawn from the modified CDA framework. Fairclough (2013), argues that these four research issues require recognition when effectively addressing '*discourse analysis in transdisciplinary research on organisational change*' (2013, p. 366). The first of these concerns is known as emergence, Fairclough (2013) contends that:

'The problems of emergence are approached on the principle that nothing comes out of nothing – new discourses emerge through 'reweaving' relations between existing discourse' (2013, p. 367).

Iedema *et al.* (2004) demonstrated the abilities of the medical-manager hybrid (see section 2.4.3), who could reweave themselves between multiple discourses within a hospital setting. This approach to reweaving was termed '*bricolage*' (2004, p. 20). Emergent discourses were noted to become institutionalised, as the hybrid manager-doctor navigated themselves through the complexities of healthcare change, thus altering and changing established orders of discourse as they went. Fairclough (2013) proposes that issues of emergence can be analysed in terms of social processes, texts, observations of the organisation and so. However, they also need to be context relevant to structural, strategic and environmental factors too.

Hegemony focuses on the processes of specific emergent discourses, with associated narratives becoming hegemonic in certain organisations. Fairclough (2013) suggests that the strategies used by certain groupings within organisations can create dominant and governing discourses. For example, the NPM discourse within the NHS has recently acted as an overall governing discourse (see section 2.4.2). This has in turn rearranged relations between other more basic discourses within the NHS such as performance and accountability (Jessop, 2002). In terms of research relevance, Fairclough (2013) proposes that the challenge for the critical discourse (CD) researcher is to seek out what distinctive discourses are linked to the strategies connected to certain groups. This is to be explored, while also acknowledging the incongruities and strains amongst other challenging discourses. Of note, the achievement or inability of these strategies is dependent upon the resisting forces or apathy related to the presenting organisational structures, as well as how established discourses become entrenched (Fairclough *et al.*, 2004).

Recontextualization considers how the distributions of emergent hegemonic discourses are spread amongst structural restrictions and limits. Fairclough (2013) recognises these organisational boundaries as being structural and

maintained by both local to international influences and contexts. Chouliaraki and Fairclough (1999) view recontextualization as a process where organisations see themselves as being invaded and threatened by external discourses, yet they can be actively appropriating them at the same time. This is particularly relevant to complex knowledge based networked organisations like the NHS has become i.e. The Health Foundation (2013), The Kings Fund (2014b), NHS England (2018a). Fairclough (2013) proceeds to link the issue of recontextualization to the hegemony of discourses, in which external discourses may have a substantial effect only on the *'effectiveness of flow between boundaries is subject to how they enter into the internal social relations and social struggles'* (Fairclough, 2013, p. 396).

The final concern of CDA in organisational research is related to what Fairclough (2013, p. 398) outlines as *'operationalisation'*. This considers how discourses operate and focus on their enactment and methods of interaction. This includes attention on genre and inoculation (the alteration of discourse through novel methods of presence, characteristics and style). Fairclough (2013) typifies an example of emergent hegemony, by recognising when NPM first became established within the UK public sector. This relates to the change of identities of public service managers and staff which was operationalised in new styles of communication amongst themselves and the user of services. Fairclough (2013) also highlights when discourses become materialised, for example when the introduction of new management systems include the reorganising of office space and furniture. This recognises that these forms of operationalisation resulted in changes of social practices and discourse (which are segments of them) and become observable through transformation and creation.

5.4.5 CDA (a critique)

CDA has been much criticised as a research approach, predominantly focussed on the reliability of its theoretical underpinnings (Hammersley, 2007) and its assertions of being able to create convincing knowledge (Widdowson, 1995). Hammersley (2009) has conveyed uncertainty regarding research which applies an *'honorific title'* (2009, p. 1) in the name of critical thinking and then assuming an obvious political position. Thus, ignoring the crucial duty of criticism, which Hammersley (2009) suggests is about evaluating the evidence of contesting claims to knowledge. Hammersley (2009) proceeds to examine CDA, arguing that in acknowledging the ambitious goal of social transformation, there is a propensity to go beyond the outcomes and appraise findings as political inferences as opposed to methodological soundness. Seidlhofer (2003) accuses CDA of *'replacing argument with persuasion and confusing cogency with conviction'* (2003, p. 144). Reflecting on some of these protests, Haig (2004) comments that some advocates of CDA, occasionally neglect specifics of how texts are or were sampled, do not properly describe the comprehensive nature of their textual analysis method and solely trust the skilfulness of the CD analyst to demonstrate the effectiveness of their account. In terms of this research, it is

hoped that the influence of IPA, with its interpretive but highly phenomenological focus will balance any over-political posturing of the author.

5.5 The research endeavour

Focusing on the research process, this section will demonstrate how this research was organised. To note, Figure 13. IPA and CDA study design in section 4.2.3 does show how the approvals process proceeded from the sanctioning of the research to the data analysis. However, this section will start with exploring ethics and access, before culminating in the approaches taken during data collection and analysis. The initial processes of this research included academic acceptance of proposal and ideas followed by subsequent annual academic upgrades. Running alongside the initial processes were the submission for formal university and NHS ethical and research approval, negotiation of NHS Trust access, and the attainment of informed consent from partaking NHS professionals. Starting with ethical considerations first, the following section will proceed to establish how the data was obtained and conclusions were drawn.

5.5.1 Ethical matters: The conventional moralities of research

Neuman (2006) argues that ethical research is significantly related to '*the integrity of the individual researcher and his or her values*' (2006, p. 130). The importance of being honest and open during the commitment of research and the stating of method/s and outcome/s is principally designed to deter researcher misbehaviour or deception (Komić *et al.*, 2015). Ethics in research links with the application of a suitable methodological plan which is organised, with trust worthy values and explanations which are consistent. Irrevocably, research should avoid causing harm, exploitation, oppression and dishonesty towards those who participate in it.

Upholding ethical principles, these considerations were active during in the undertaking of this research. In relation to this research, a comprehensive proposal was initially approved by various academic supervisors, before further ethical submissions to undertake this research were made. Copies of all relevant approval letters from the required bodies to undertake this research are available in Appendix 5.

Throughout the research process, frequent meetings with two academic supervisors (one of which, in NHS terms was also classed as the Chief Investigator for this research) and a third academic appraiser (in the form of an end of year academic reviewer). This academic contact and professional safeguards assured that this research was undertaken ethically with further attention provided to confidentiality and consent.

To certify that participant confidentiality was upheld during the sourcing of interview information, interview data was stored on an electronic recorder (within a locked case and within a locked room). Before being deleted shortly after the interviews, the interview data was transferred to a secure and encrypted computer server within the university. Only the author and an academic supervisor/Chief Investigator (CI) have access to this data. This was indicated within the participant consent form and that data would be securely stored on a password-protected university computer server. During the writing up of this research, caution was applied to safeguard the personal information of participants, and safeguards were applied to maintain this. The assembly and application of information accrued during this research was assured due to the Data Protection Act 1998 safeguards and The University of Nottingham Research Data Management Policy (2013). Being a relatively small-scale qualitative study, comprehensive anonymity will be restricted due to people who are research aware and able to retrieve publishable information related to this research. This needs to be acknowledged, though it can be argued that it would be almost impossible to pinpoint individual participants from publicly released data.

In terms of harm to the participant, the Participant Information Sheet (PIS), which each participant received before the interviews began, acknowledges that taking part in the interview may bring about difficult feelings. As suggested by Arnulf *et al.* (2016), this recognises that some of situations the LMD participants may have been involved in during their training could have been difficult or disturbing for them. The PIS makes clear that details of the local occupational health department will be available to the participant if requested and it was reiterated that confidentiality will always be maintained.

At the start of the interviews, participants were also provided with a verbal briefing (overview of the study) and a consent form to read and sign before the interview began. The PIS contained further study details as well as contact information for the researcher and the prime academic supervisor. Copies of the PIS and consent forms provided to participants can be found in Appendices 6 and 7. It was emphasised that participants could withdraw from the research with no reason required, at any time. This could be actioned by notifying the CI or researcher. If they chose to withdraw, participants were also able to ask for any information attained to be securely discarded or returned to them, and not included within the research.

5.5.2 Sampling

Assuming a purposive judgement sampling strategy, this research selected participants who were appropriate and revealing, in relation to the research aims and questions posed (Neuman, 2006). This involved recognising and picking individuals or groupings that are particularly knowledgeable about or who have experienced the researched phenomenon (Sargeant, 2012). The participants within this research have all experienced the similar phenomenon of NHS LMD training and present their current understandings, making this a retrospective

cohort study. Both IPA (Smith *et al.*, 2009) and CDA (Fairclough, 2003; 2013) approaches are well suited to the purposive sampling approach. The importance of using this sampling method is related to the qualitative search for theoretical richness as opposed to its representativeness. This is due to the complexity of trying to imply that one participants' experience, is going to be a representative example of others who may have also been selected for this research (Seale, 2012). Convenience and snowball sampling (Biernacki and Waldorf, 1981; Heckathorn, 2011) was utilised as a part of this endeavour. There were two stages to sampling, the first involved sending an all staff email inviting participants who had attended an NHS provided or commissioned LMD training since September 2007. No job role or gender was specified; but the participant was required to be aged 18 or over, with no upper age limit applied. It is notable that sampling could have been undertaken with a different focus to address different research aims i.e. BME participant experiences of NHS LMD, ex-NHS workers perceptions of NHS LMD etc... Nevertheless, based on the data formed from this research focus, recognising the experiences of different NHS LMD participant groupings would have presented an opportunity for rich and informative data to be harvested in future NHS LMD studies.

In total six participants responded to the initial call out for participants, and all met the sampling criteria set for this research, resulting in the sourcing of six semi-structured interviews. Four more potential participants made contact, because of recommendations made from the first-round of participants involved in the first six interviews (snowballing). Data saturation occurred after interview nine, with the tenth snowballed participant not being required. To note there are issues with sampling bias when the snowballing sampling technique is applied, which do need to be recognised here. The initial six participants which came forward obviously have an interest in NHS LMD, this is assumed by their willingness to take part in the research. The four participants who were snowballed as a result of recommendations from the first six participants may well share the same traits, interests and characteristics as the first six. Ultimately theme development may have been inhibited due to this homogeneous sampling process. Still, snowball sampling did allow for this study to take place within the research timeframes by increasing the sample number of appropriate participants. This approach did also enhance the depth and flavour of the experiences presented, spoken about by the first six participants. A data saturation point occurred during these three final interviews, culminating in a recognition that a tenth interview (who was part of the snowballed cohort) was not required. In this instance it could be argued that the snowballing technique did seem to create rich data that lead to a notable saturation point.

To explore why data saturation points can occur, O'Reilly and Parker (2012) and Walker (2012) both recognise that such positions are obtained when there is enough information to potentially replicate the research. Guest *et al.* (2006) suggest that these points happen when the capacity to acquire supplementary new information has been achieved and when additional coding is no longer viable. Fusch and Ness (2015) summarise a few universal ideas which may

indicate that data saturation has been achieved, being '*no new data, no new themes, no new coding, and ability to replicate the study*' (2015, p. 1409). Fusch and Ness (2015) contend that when and how these points of saturation occur will differ between study designs and researcher preferences. The writer does furthermore recognise that the influence of Smith *et al.* (2009) suggesting that nine participants is an ideal number for UK professional doctorates pursuing an IPA approach. The data was also viewed through a different methodological lens of CDA, so it can be asserted that 18 pieces of research data were available to the writer for analysis.

To clarify, Guest *et al.* (2006) propose that the notion of data saturation is a helpful one; though no guiding principles are available to indicate when data saturation has been achieved. Guest *et al.* (2006) goes as far as recognising that data saturation may be accomplished by as few as six interviews contingent on the sample size of the population. Crucially, both Dibley (2011) and Burmeister and Aitken (2012) assert that it could be beneficial to view qualitative data in relation to its richness and thickness, as opposed to the size of its sample. As previously established, familiarity followed by a deep level of understanding was the endeavour of the data analysis applied within this research. From the perspective of the IPA, super ordinate themes surrounding the personal motivations of the LMD participant, training experience and their relationship with their workplace LMD dominated. The final three interviews allowed for the sub-themes to become embedded or rejected as these interviews took place. The same applied while recognising the emergence of discourses, how they became arranged and reinforced, creating the conditions for a CDA too.

Table 3. presents the participant sample including a list of generic names, related profession, type of LMD attended, sampling approach and time from NHS LMD training to research interview. The addition of table 3. is to present a contextual understanding of the participants experience related to the themes they produced throughout this thesis. Including their professional background and time from their NHS LMD training to interview will add context to the complexity of the data which is presented in snippets of participants text throughout the next three chapters of this thesis. The names of the participants are non-gender specific, and this is to protect the identity and respect the confidentiality of the participants who came forward to partake in this research.

Table 3. Participant sample including list of generic names and related profession, type of LMD attended, how sampled and time from NHS LMD training to research interview

Name of Participant (and interview number)	Charlie (CA1)	Kyle (KH2)	Dale (DD3)	Reagan (RR4)	Karter (KT5)	Kai (KB6)	Logan (LC7)	Landry (LK8)	Ash (AD9)
Profession	Nursing	Nursing	Nursing	Administration	Administration	Administration	Allied Health	Nursing	Nursing
Type of LMD training attended	Non-University Accredited	Non-University Accredited	Non-University Accredited	University Accredited	University Accredited	Non-University Accredited	Non-University Accredited	University Accredited	University Accredited
Sample process	Responded to first call out for participants	Responded to first call out for participants	Responded to first call out for participants	Responded to first call out for participant	Responded to first call out for participants	Responded to first call out for participants	Snowball	Snowball	Snowball
Time from NHS LMD training to research interview	Three years	Two and a half years	Three years	Two years	One year	Two years	Two and a half years	One and a half years	Two years

(Created: Author, 2019)

5.5.3 Gathering data and pilot interviewing

The semi-structured interview was the approach of choice, in terms of data gathering. In IPA, this interview approach has been regularly favoured over other approaches like observation or survey, as interviews present an opportunity for discussion and explaining. Additionally, discretion and confidentiality can be applied in the conversation of delicate subject matters (Smith and Osborn, 2003). In CDA, interview texts are valid sources of data (Fairclough, 2003). CDA affords the same appreciation for qualitative data as IPA; as a result, no further supplementary data was gathered or required. Sampling resulted in nine participant semi-structured interviews which took place between February 2018 and April 2018, with each interview lasting between 40 and 60 minutes.

Smith *et al.* (2009) recommend that when using semi-structured interviews during IPA research, occasionally it can be worthwhile to create iterations of interview schedules. However, the interview schedule within this research remained predominantly aligned to five core questions interlinked to the four research questions. At times changes to the interviews was demonstrated in the alteration of the sub questions when following up on assertions made by participants. The principle of an interview plan ensured that fundamental topics requiring attention were applied in a consistent order of enquiry; this to contemplate complications particularly about sensitive subjects and to articulate suitable prompts. Nevertheless, the intended order of questioning is not expected to be accurately replicated for every interview (Smith and Osborn, 2003). During September 2017, pilot interviews were undertaken involving a researcher and a professional colleague and the pilots simulated the intended data collection process. Each pilot participant was asked to explain and describe their NHS LMD experience and subsequent workplace application. Due to the pilot interviews, a semi-structured dialogue was deemed suitable for this research and thus allowing LMD participants opportunities to converse and to be more open about their lived experiences. These pilot interviews were advantageous for the researcher, so that base questions and prompts relevant to the research questions were ready to use once ethical, academic and organisational approvals were formal provided. Thus, ensuring key areas are covered and to provoke participants to explore important workplace incidents extensively. The definitive copy of the semi-structured interview schedule of questions is available in Appendix 8.

5.5.4 Interview conduct

Interviews were undertaken mostly within the participant's place of work and site access was agreed with the participant and the regional NHS Trust Research and Development department. Three participants favoured not to be interviewed

within their workplace and attended The University of Nottingham instead. Subsequent efforts were made to ensure confidentiality of the interview was balanced with the comfort of the participant. Interviews were mostly 40 minutes to one hour in length, dependent upon the work obligations of the participants as well as how the interview discussions developed. Every participant agreed to having their interviews recorded and for the interviews to be transcribed afterwards. At commencement, the reasoning for the research was retold, so that participants were able to decline during interview and their recordings withdrawn post interview. The interview approach was deliberately nondirective, with the researcher's contributions limited as far as reasonable, to all but infrequent questioning and prompting. The influence of researcher individual traits and their influence on interview conduct are acknowledged in section 4.6. As suggested, the semi-structured interview approach is to navigate unclear landscapes between prescribed processes and casual conversations (Willig, 2008). Unlike most interpersonal communications, interviews comprise of a level of affinity amongst interviewer and interviewee (Keats, 2000). Still, such an underlying power disparity still exists, since the participant divulges more about themselves as opposed to the researcher, who additionally is exercising that material for their own objectives. To note, an excessively conversational approach may unintentionally expose these inequities and the participant may describe issues, which they regret having revealed.

Considering these issues, the interviews pursued equilibrium between creating an affinity with the participant yet ensuring alertness to the conventional research process. The first interview question involved asking participants to describe their NHS LMD training, before developing a richer investigation of their experiences. Attentive and empathic listening skills such as the use of non-verbal cues and reactions, including positioning, tone and facial movements were applied, as these skills allow participants to settle quickly (Sherko *et al.* 2013). Additionally, it is important that the management of the ending is completed in such away, which allows the interviewees not to depart in distress or feel they have failed in putting their points across (Edwards and Holland, 2013). As a result, participants were frequently informed that their interviews were approaching an end around the 35 and 50-minute mark. The final question was concerned with collecting any supplementary reflections participants wished to make. The interviews incorporated a component of debrief after the recorder was switched off. This was to enable the researcher to assess how participants experienced the interview and ask any further questions if they wish, about the research protocol and process.

5.5.5 Transcription

Field notes were noted, for the researcher to reflect upon early ideas and reflections in relation to the research process. This primarily allowed for any modification of interview questions or approaches to be considered throughout the nine interviews. It also acknowledged any personal reactions and bias to the

information being provided to the researcher from the participants, which may on reflection have an unhelpful impact on the analytic stage of the research (see sections 5.6.1 and 5.6.2 regarding reflexivity).

The interviews were transcribed by the researcher verbatim shortly after the interview had taken place; this included the researcher's individual interactions with the participant during the interviews (see Appendix 9. for a sample of an interview transcript). The use of a code system was employed, according to the values of Sutton and Austin (2015). Tolley *et al.* (2016) furthermore contend that there is no typical transcription method for interview recordings, yet one which sits within an appropriate scope of the research methodology and methods can be used. Throughout the IPA analysis there was a focus on the experience of participants, whereas in CDA the focus is on the application of language. Both methods do not mandate an over complex coding approach, comparatively to other approaches such as conversational analysis (Willig, 2013). Still, IPA does request an observance and the noting of non-verbal or agitated verbal expressions during interview (Smith *et al.*, 2009). None were required to be recorded during the nine interviews.

5.5.6 The case against computer software analysis

As acknowledged earlier, computer software such as ATLAS.ti 8 (2018) and Wordsmith Tools (Scott, 2017) can be used in the pursuit of useful qualitative data. However, St John and Johnson (2000) propose:

'The intelligence and integrity that a researcher brings to the research process must also be brought to the choice and use of tools and analytical processes. Researchers should be as critical of the methodological approaches to using qualitative data analysis software as they are about the fit between research question, methods, and research design' (2000, p. 393).

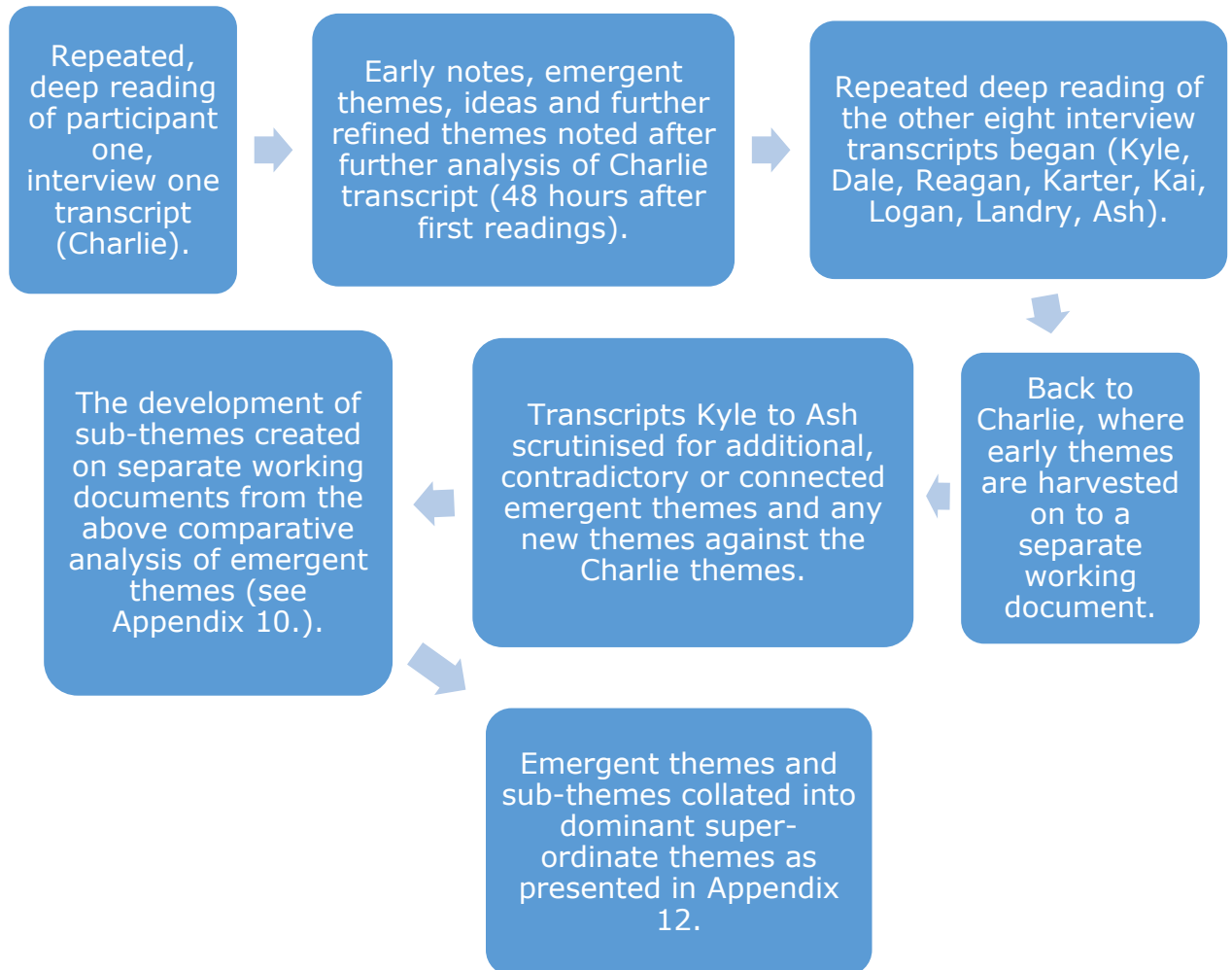
Accepting St John and Johnson (2000) opinion, this research has chosen to undertake manual analysis as opposed to computer analysis. The idea that applying computer analysis suggests that external bodies are involved in the research process i.e. the computer software programmer. Even as things currently stand in 2018, with computer software, no matter how capable, there will be a presence of intrusion in the phenomenological process. So regardless of being convenient and speedy the use of such software could be, the researcher argues that maintaining purity of the researcher and the participant is a greater endeavour. Additional apprehensions comprise of this process being an uncompromising process, which sacrifices intuition and the development of the authors' analytic abilities. This includes the tendency to generate more breath of data with computer processes, in contrast to developing depth and meaning (St John and Johnson, 2000; Gerrish and Lathlean, 2015).

5.5.7 The Interpretive Phenomenological Analytic process undertaken

Following the common Smith *et al.* (2009) protocol, IPA is primarily an inductive approach which draws from a comprehensive transcript analysis method to create sub and super-ordinate themes. IPA is idiographic, particularly during the early parts of its application where transcripts are intensely, individually scrutinised with divergences amongst interviews explored in later parts of the process.

The IPA process for this research began with each recorded semi-structured interview being transcribed verbatim and given participant codes and line numbers within the transcripts. The researcher methodically analysed each interview in order and in-depth, this required reading each transcript multiple times to achieve full awareness of the information it held (permitting the researcher to be submerged in the deep narrative of the texts). The first transcript from participant one, interview one (Charlie) was subsequently studied in detail with notes created to items of interest, initial themes and ideas that arose relating to the experience of NHS LMD. These observations were noted in the left-hand margins of the transcript paperwork. The transcript from interview one was then studied at another time and initial themes revised, established and distinguished and noted in the right-hand margin of the transcript. Additional thoughts, connections and complexities were also acknowledged here. Reading of the following transcripts from participant two, interview two (Kyle) through to participant nine, interview nine (Ash) then began. The transcript from interview one (Charlie) was subsequently utilised to harvest a list of themes on a separate sheet and the supplementary transcripts (Kyle to Ash) were scrutinised to categorise additional occurrences of these themes, contradictory or connected themes and even new themes. A detached sheet was utilised to create sub-themes and participant and line number classifiers and verbatim quotes were noted on each individual sub-theme sheet. The sub-themes were then examined with recurrent reference to the source text to safeguard the cogency of the interpretations and they were merged together to engender a list of super-ordinate themes. Appendix 10. shows a picture of the IPA workings and Figure 15. A flow chart of the IPA process applied within this research. To add, a few early themes were abandoned as the researcher's attention matured during the analytic process and these themes materialised to be remote or unrelated to the emerging sub-theme clusters under scrutiny. A table of super-ordinate themes with their associated sub-ordinate themes was subsequently created. During chapter eight of this thesis, the super-ordinate themes (from chapter six) will be augmented with the findings of the CDA (from chapter seven).

Figure 15. A flowchart of the IPA process applied within this research



(Created: Author, 2018)

5.5.8 The Critical Discourse Analytic process undertaken

A CD analytic approach was applied, utilising a procedural method modified from Fairclough (2003; 2013) CDA framework. Texts used for IPA purposes, were utilised by the CDA in this instance. Different to IPA, analytic groupings were pre-established (see section 5.4.3) and an analysis of each transcript was undertaken in order from participant one, interview one (Charlie) to participant nine, interview nine (Ash). It was particularly advantageous to use the Fairclough (2003) analytic framework to look anew at the texts that had previously been scrutinised from an alternative analytic lens. Each transcript was initially reviewed against each of the Fairclough (2003) CDA categories. Notes from the categories were assembled to identify examples of the seven CDA categories found within the texts. It was decided at this stage the CDA analytic category of analysis of corpus and intertextuality will not be proceeded with,

predominantly due to time constraints and the requirements of this research. Like the first round of CDA categorising, Fairclough (2013) four CDA research issues related to organisational discourse and change were applied (a picture of the CDA workings can be viewed in Appendix 11.). Once completed and ensuring no names or identifying material was available, a professional colleague was utilised to verify interpretation between the captured examples of the researcher and the transcripts. This was done to ensure that findings from the notes and the transcripts were properly grounded in the texts and adhering to what Mautner (2009, p. 123) calls '*checks and balances*' in terms of CDA application.

The final stage was completed by augmenting examples of Fairclough's (2003) modified CDA categories with examples of Fairclough's (2013) four research considerations for organisational change. The intention being to connect the various ways the data can be constructed to the broader social practices related to this research topic. See Figure 16. A flowchart of the CDA process applied within this research.

5.5.9 The inter-relationship between IPA and CDA in the analysis and its implications

As acknowledged in section 5.2, the consequences of undertaking a pluralist methodology as proposed within this work, has resulted in the methodical arrangement of the 'lived experience' being obtained from an IPA and 'discursive practice' through an CDA. The development and consequences of the application of this 'double lens' (Saukko, 2005; Hood, 2016) has been addressed during the formulation of chapters three, four and this chapter. However, this section will explore how the interplay of these approaches was operationalised during the analytic process; the first example of this can be seen in how the below research question was explored:

- How does the participant feel their NHS leadership and management development training influenced them?

This question considers the complexity associated with NHS LMD and its influence on the individual, nonetheless by its proposition this question places little focus on the role and complexities of LMD and its application and relevance to the NHS workplace. Moreover, associated problems of asking questions like the one above (and frequently observed in qualitative research) are connected to concerns regarding the quantity and quality of data, which is required for the question to be effectively answered.

Within this research, the asking of this question was initially contemplated by a deep and repetitive IPA to formulate the participant experience from the participants viewpoint. This resulted in a list of themes or categories, of what was considered helpful or unhelpful for NHS LMD development. The shifting of the research approach by the application of CDA allowed for a different analytical lens to be placed on to the research data. The CDA recognised the influence of structural arrangements of organisational discourse and workplace power within

the NHS workplace. This allowed for a greater level of contextual understanding to be applied to the situation the NHS LMD participants found themselves in and how this influenced their preferences for approaches to NHS LMD. This analysis was subsequently related to the complexities of the greater NHS institutional context, with observations on what originated to be the 'old' and the 'new' ways of working discourse. Thus, presenting with its multiple intricacies of discursive closure and change, it is argued that this methodical interplay between IPA and CDA, allowed for a much more in-depth exploration of this research question through the multiple analysis of texts.

Further IPA/CDA interplay is demonstrated below in the development of the IPA super-ordinate theme – the role of personality, leadership and motivation within the LMD participants context (Appendix 12.). Amongst three other sub-themes, the IPA sub-theme of leadership: show the people, lead the people was utilised to create the role of personality, leadership and motivation super-ordinate theme. This IPA super-ordinate and associated sub-theme were sourced from different initial IPA emergent themes, which included the below participant interview comment (see section 6.4.2):

"I think it's added to my clinical practice as well because it's not just about managing staff, it's about patients"

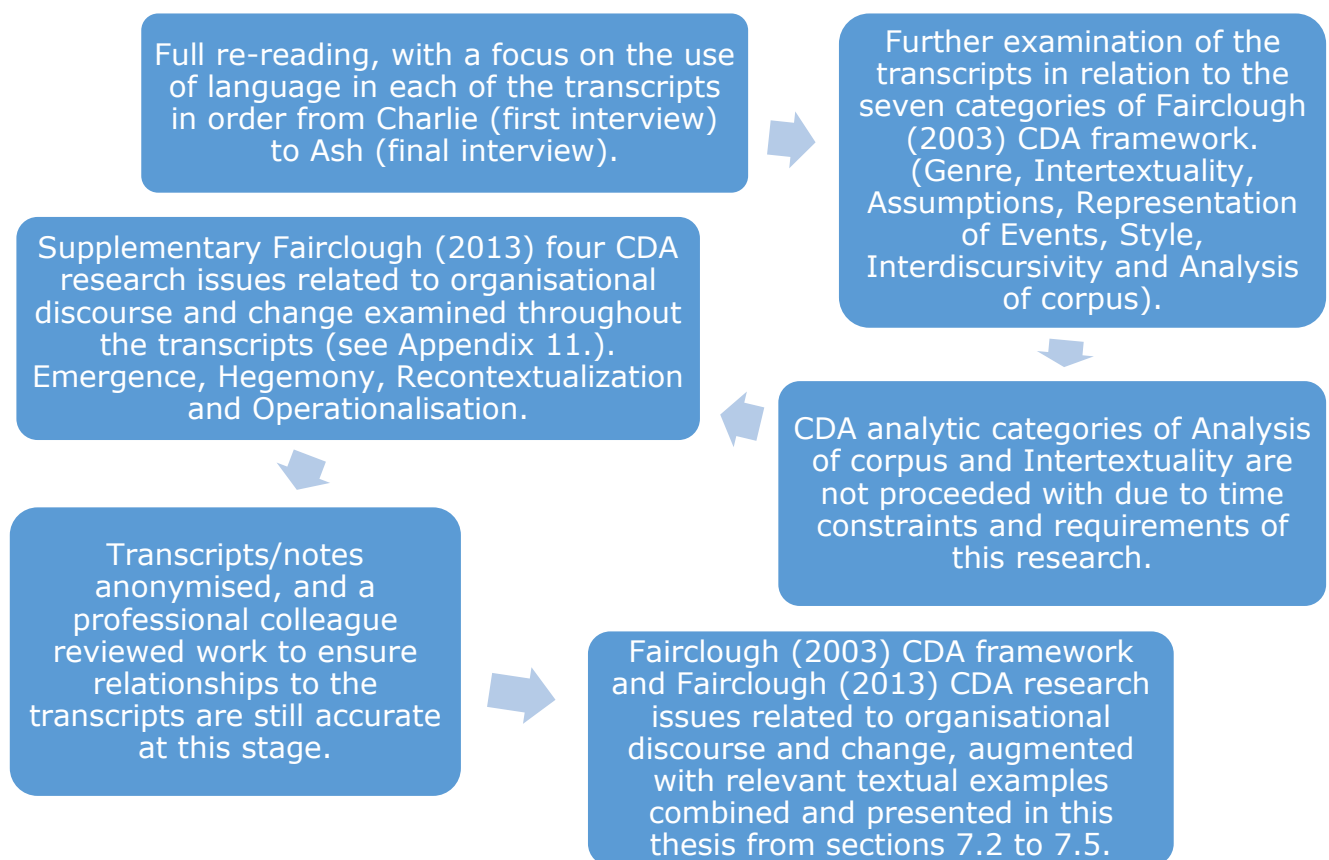
From a CDA perspective, the same interview comment is utilised as an artefact which was created from what the CDA approach considers to be the genre of the interview process. Alternative to the IPA, this text was applied to disclose a link between the application of language and the possible agendas behind NHS LMD, managerialism and the clinical-professional role (see section 7.2). Ultimately examples of inter-discourse and interdiscursivity were created from the same text, which collectively allowed for the formulation of factors which the IPA indicated (when pulled together) create a positive LMD participant experience and promote the importance of greater the integration of NHS LMD actors.

To summarise the implications of this interplay and the subsequent outcomes of this research can be utilised as a tool of critical reflection to what has already been established within the NHS LMD literature (chapter three). Consequently, such critical endeavour can contribute to theoretical debates, policy considerations and the experiences of NHS workers. This is important for the future of NHS LMD, as established earlier LMD and subsequently NHS LMD would benefit from being more evidence based (Jasper and Juma, 2005; Yukl, 2013; West *et al.*, 2015). The promotion of methodological pluralism, which attempts to combine quantitative with qualitative data, may yield similar multifaceted results as those produced from the IPA/CDA interplay. Viewed from a critical realist position, these forms of evidence may create a glimpse of how and why certain LMD interventions are effective. A quantitative method could consider evidence of causal effectiveness and the qualitative approach considering the idiographic features.

Still, the significance of using critical methodologies such as CDA when used in evaluative research is a contentious one that may require greater exploration

(Pawson, 2013). The promotion for pluralism promoted here may ask, can a research approach like CDA produce applicable knowledge regarding a phenomenon, while depriving the need for explicit political or emancipatory ambition (Hammersley, 2005; Pawson, 2013). It is argued that during the analytic process the assistance of CDA, provided a finer contextual understanding of the NHS workplace where the LMD participants applied their LMD training. Nevertheless, it is asserted here that what is important is that the research was carried out in a methodical and transparent manner, set within a defined agenda of investigation.

Figure 16. A flowchart of the CDA process applied within this research



(Created: Author, 2018)

Like the IPA approach, the final part of this CDA process required the greatest investigative action (augmenting the initial CDA categories into four research issues related to organisational discourse and change). A significant reference position here was the analysis of the barriers and allowances which permitted LMD learning to be applied within the NHS workplace. This was acknowledged throughout chapter three and assisted in the developing a foundation of

selecting CDA over other methodological approaches presented within chapter four and this chapter. The results of the CDA textual analysis will follow in chapter seven, after first consideration of the IPA findings in chapter six.

5.6 Qualitative research and quality

This section will explore why creating good quality qualitative research is important and how it was adopted throughout the application of this research. Initial considerations were given to the ethical tenets firstly depicted in section 5.5.1. A variety of researchers have provided strategies for the undertaking of a good qualitative method, through the arrangement of high standards (for example Yardley, 2000; Yin, 2014; Sanjari *et al.*, 2014 and so on). However, one argument is that there is no one framework that can consider the diversity of epistemological and ontological research issues. Nevertheless, pluralist studies and doctorate theses such as this one, share a dedication in attending to quality research. This to be considered in the following sections:

5.6.1 Reflexivity (personal)

Willig (2013) acknowledges that personal reflexivity necessitates researchers to reflect upon their interests, ideals and prejudices. Through personal reflections and as alluded to during section 1.2, I will expand on how my past experiences have influenced this research.

As an early career NHS manager, I was encouraged to attend NHS LMD trainings by my line managers. I found these trainings helpful and the disparity of agendas between those involved in these trainings to be fascinating. My early exposure and preoccupation with leadership began around 15 years ago within an NHS secure forensic mental health setting. Here the promotion of 'the team', with respect for time served and management titles were all endorsed, and this culture appeared to be handed down from one team member to the next. The reasoning for this approach was the promotion of adherence to rules, policies and procedures which were perceived to promote the consistent care of patients and safety. An authoritative and paternal approach to leadership was frequently applied, nevertheless I would personally question who benefited from the reinforcement of this culture i.e. power and control of the ward seem to be handed down through consistently renewing workplace discourses, with words like 'safety' and 'security' reinforcing control and maintaining this culture as something good or desired. I questioned how much of it was for 'everybody's safety' versus keeping the more dominant members of staff in charge of the ward routine. Invariably, these early experiences of working in forensic mental health services raised more questions regarding leadership and its function, than it offered answers. Later reflections only resorted to understanding what I witnessed to be symptomatic of what Gabel (2012, p. 489) defines as '*demoralization*' relating to a stress reaction after prolonged exposure to working in mental health care.

I later trained as a Cognitive Behavioural Therapist, and after a short spell of working in the prison service I obtained my first management role leading a team of nurses, psychologists and psychotherapists in 2010. This is where I was first introduced to the notion that trainings can enable leadership to be developed, as opposed to something you just get to do when you have been in the job long enough. Firstly, I attended a ten-day non-academic based LMD training funded by the NHS which was provided by a private training organisation. This was followed by a PGCert in Healthcare Leadership (also known as the Mary Seacole Programme). I later undertook a Master's in Public Administration to further my academic interest and it could be argued that it was at this point, I attempted to build on those early experiences of leadership and I was introduced to the concepts of complexity theory and organisational reality (Stacy, 2010).

In 2015 I was fortunate enough to find myself in a position where I was able to leave the NHS to focus on pursuing this professional doctorate as a full-time post-graduate researcher. Knowing that leadership development was something which was of interest to me, particularly as a sufficient amount of my time working within NHS management was in conjunction with the undertaking of LMD trainings. Leaving the NHS to undertake the professional doctorate journey was a difficult decision to make, yet I knew that it was one which I had to do to complete my own LMD journey. By becoming a full-time self-funded researcher and removing myself from the NHS, I believe this opportunity provided me with some degree of critical distance and freedom in terms of what I was learning in the early modules related to this professional doctorate, but more importantly how the data I would eventually collect would be interpreted. As Meyrick (2006, p. 802) acknowledges '*some sociological approaches to rigour put greater emphasis on establishing critical distance of the researcher from data*'; hence no longer being a part of the organisation, I was intending to critically explore. Still, I feel that the usefulness of this distance from the NHS did not really start to truly occur until the second year of my doctorate journey. Deeper reflections suggest that this leaning towards greater criticality towards myself as researcher of the NHS, was developed through the intensive doctorate supervisions and my end of year assessments. This encouragement and wide reading helped me go back to my earlier experiences of leadership and how I noticed the use of language and ritual was applied to create epicentres of organisational power and control.

This personal and academic development changed the direction of this thesis and allowed me to explore my criticality towards aspects of the NHS workplace in an informed way. Drawn from early reading, my approach to qualitative investigation was going to be an IPA approach only. Though my prior experiences and the doctoral journey (as well as the select LMD literature lending itself to the recognition of the neglected LMD research approaches), the application of a CDA permitted me to push myself and this thesis further. This personal growth did ultimately influence the chosen methodological approaches

and the way I undertook and subsequently viewed the data collected. This is explored further in the next section (5.6.2).

As acknowledged in section 1.2, during the final year of this thesis I began working as a Lecturer within the field of NHS leadership development and undertaking this role inevitably altered how I viewed the research data. Within my current working environment there is a notion that universities providing LMD is considered to be more credible than non-university LMD providers, with academic qualifications, governance procedures and publications being artefacts of this assumed superiority. As a result, this may have impacted on how I reflected a desire for participants to have their LMD 'rubber stamped' by an academic institution and thus acknowledging how working in this environment may have inadvertently favoured certain LMD trainings. It can still be argued that this influence was present anyway, by the amount of LMD trainings I have previously attended and the fact that I am seeking academic validation from the undertaking of this thesis.

While undertaking this role, I am aware that I have started to develop favoured LMD interventions which I prefer to be facilitated in my LMD classrooms i.e. action learning groups and the application and discussion around TED talk topics. Again, these preferences of certain LMD interventions over others, may have influenced how I interpreted the interview data. The preference and make-up of the modules I deliver of the academic institution I belong to will also have played a bias in this too. It can be summarised that this could have altered the way I consciously or unconsciously sanctioned some LMD interventions, while closing down other LMD interventions which I view as not as effective. I argue that this is where my two years as neither an NHS worker, manager or LMD facilitator but as a self-funded full-time researcher assisted me. That time allowed my earlier literature review to be robust enough to support assertions regarding some of these interventions (see Appendices 1. and 2.).

To add my previous experience as a Psychotherapist and associated self-reflective practice has helped my research abilities to grow and to further consolidate strategies which created and maintained some critical distance during this research. In summary my previous experience has informed and tainted this research and subsequent thesis, nevertheless I bring my own intrigue and passion to this topic. This will have impacted on the knowledge construction processes and this will be discussed in the next section (5.6.2).

5.6.2 Reflexivity (epistemological)

Considering epistemological reflexivity and the double hermeneutic related to qualitative research, this research process creates an understanding regarding society and social process in its self (Danermark *et al.*, 2002). The limitations of explanation and description are recognised through the refining of a research focus, articulating a research approach as well as determining a method of study. The IPA approach targeted an idiosyncratic viewpoint of LMD training, as

experienced through participants, though understanding was ultimately directed through researcher likings and interests (as acknowledged in within the previous section 5.6.1). Similarly, the CDA section attempts to investigate LMD integration into the NHS workplace, and was assembled in texts credited to participants, yet conversely, they have still been produced by the research process. While the interviews mostly consisted of the participant talking, the interviewer led on the enquiring, turn-taking, which queries remained relevant or not, which topics were expressed further and so on. This resulted in the researcher being a veiled co-author of the text, regardless of attempts to avoid becoming involved. These processes are observable throughout parts of all the interviews and undeniably through the entire sequence of knowledge creation.

What also requires attention is the power disparity which can occur during the undertaking of research interviews. Karnieli-Miller *et al.* (2009) do recognise that power imbalances and associated connotations can occur particularly during interviews taken by the method applied within this research. Karnieli-Miller *et al.* (2009, p. 281) state that *'relationships are affected by the content of the inquiry, and equally by the institutional context in which the study is carried out and by researcher and participants' personal motivation's'*. As mentioned in section 5.5.4 (interview conduct), mindful of wanting the participant to feel relaxed, I was conscious of providing participants with an option of venues (either within their workplace or at The University of Nottingham). Using the same reasoning I did not disclose to the participants that I was a previous NHS manager or worker, I just confirmed that I was a doctoral researcher based within The University of Nottingham. This was a conscious choice, I believed that disclosing my previous role may have impacted on the participants willingness to be open about their feelings towards NHS management and the LMD process. This power disparity within the interview may have inhibited rapport building and the potential for a natural flow within the interview to occur, which Qu and Dumay (2011) recognise to be important when gleaning additional insights. As an addition, throughout the interviews it did become noticeable that had I still been working within the NHS, the power disparity between myself and the participant could have been turned on its head. Relevant to this LMD research, with its questions invariably opening opportunities for critical responses towards senior NHS management and actors; it could have been the participant who may have asserted a political agenda on to the researcher. The researcher being leant on to promote more favourable and less critical attitudes towards the conduct of those involved in NHS leadership and as such this would have run the risk of maintaining the position of the powerful managerial discourse. Both Alvesson and Deetz (2000) and Bryman and Bell (2015) do recognise how this alternative power disparity might occur during this type of organisational focused research and this is summarised in section 8.7.

Further issues to consider are how trustworthy and valued knowledge taken from approaches such as the one applied within this research can be. Willig (2013, p. 10) acknowledges reflexivity as *'an awareness of the researcher's own contribution to the construction of meanings throughout the research process'*,

thus recognising the hopelessness of continuing to be external to one's topic, whilst researching it at the same time (alluded to in section 4.6.3). Willig (2013) argues that to differentiate amongst the personal and the researched, it is highly challenging for any researcher to achieve an effective balance. Epistemological reflexivity acknowledges the research process and the influence this process can have on knowledge creation.

Researchers apply personal ideas during the research process, from articulating the research aims and questions through to recognising the outcomes of the research. The critical realist paradigm identifies such involvement through the notion of the double hermeneutic, as researchers attempt to understand how other people construct their world (Danermark *et al.*, 2002). CDA flexibly accepts the posture of critique i.e. '*a social wrong in its semiotic aspect*' (Fairclough, 2013, p. 235). Thus, acknowledging that qualitative researchers operate in a reflective way, and as such accepts their influence on the findings of the research. Within this study, contemplations and reflections relating to the undertaking of a professional doctorate and this thesis were made on my smart phone using its note function. These notations, reflections of the process and deliberations would occur at any time and location, day or night, but are not aligned to the transcripts.

As acknowledged earlier I was aware how I could have been permitting and denying certain LMD interventions just by my own preferences as a facilitator; I was conscious of analysing just the functional/performative interventions, mechanics and tools of the NHS LMD training approach and its many different methods, after attending such trainings myself. It became clear through this process that this focus was not required (as this tended to miss the more nuances of participants whole LMD experience). I would spend much time studying the interview transcripts to separate the functional accounts from the subtler reports of friendships and networks made during NHS LMD. Similarly, this also made me reflect upon what participants said about their NHS LMD experiences, and its influence on my own LMD facilitatory practice. This provided me with new understandings of the content I use in my LMD training sessions (by applying more criticality towards the delivery of some LMD topics). I have also become aware of how I plan an LMD related module in such a way, which does not ignore the opportunities for personal growth and networking between the participants.

5.6.3 Credibility

The expression 'credibility' refers to the reliability, validity and dependability of the material offered, and the knowledge declarations made within the study (Guba and Lincoln, 2005; Neuman, 2006; Guest *et al.*, 2014). In consideration of this, some authors distinguish amongst the notions of reliability, suggesting the reliability of methods is employed to make assertions of validity, relating to the precision of how what has been observed, has been reached (Noble and Smith, 2015; Leung, 2015).

Debatably, this concept is from the quantitative understanding with its focus on empirical measures and is naturally challenging for the qualitative researcher. Although the qualitative approach exerts to scrutinise and construe the social world, the analytic process is less definitive and is ultimately an ongoing developmental and co-operative endeavour. This is naturally dependent to an exceptional combination of occurrence, background and explanation. The critical realist ontology and epistemology does indicate an approach to research, which promotes a positivist concept of validity. However, matters related to legitimacy and impartiality are vital for research invested in the heuristic features of human existence, like the notions related to reliability of research assuming a critical approach (Fleetwood, 2014b). Acknowledging Smith *et al.* (2009) appreciation of credibility, it is reasoned that it can originate from research exhibiting three qualities. These being the general philosophies of reliable research practice, objective audit, respondent validation and triangulation.

A reasonable set of values to hold when appraising research conduct can be the understanding of situation, assurance with thoroughness, clarity and consistency (Yardley, 2000). These values consider not just dependability and legitimacy, but how the research is undertaken and the use of subsequent data. Within this research, understanding the context was shown by acquisition of a thorough identification of the research subject and the appropriateness of the research participants. Attention was also shown by the effective preparation for interviews and performing them with discretion, identification and dexterity. Attention to detail was applied when substantiating analytic declarations from the raw data, including verbatim excerpts provided by the participants in the finished thesis. Assurance of study validity was established by three years of dedication to the research project by the researcher. The research was applied in a meticulous manner, which resulted in gaining the necessary approvals, the undertaking of the interviews to a good benchmark and analysing the presentation of the data. Completion of this work will demonstrate a reasoning and arrangement of themes through an apparent and comprehensible way within this thesis. Vague and inconsistent outcomes will be emphasised and acknowledged as required. Lastly, it is recognised that under examination of study, its conclusions are considered thought-provoking, significant or valuable, though this will be something which will be only be demonstrable in the future.

Regarding the audit process, Yin (2014) proposes the use of a case study database, which can arrange material concerning the research into a system where material can be easily recovered. Thus, improving reliability as research related work can be tracked and substantiated by others. Within this study, research material was ordered into documents saved on to a university secure server via a password-protected computer. This created a virtual trail, connecting the different facets of the study to each other and encouraging systematic and controlled conditions. This has allowed the academic supervisors of this research to understand the progress of this thesis upon request and to view the theoretical reasoning and methods at first-hand. Smith *et al.* (2009), consider such inspections as an independent audit of research. Nevertheless,

they do acknowledge the need for more credibility as opposed to immediacy to actuality. They summarise that feasible entitlements to truth can exist, yet the trustworthiness of entitlements will be adjudicated through the demonstration of a credible research process. To add, the use of research and professional colleagues to support the creation of the semi-structured interview schedule and theme verification during the CDA process has reinforced the transparency of this work.

Lastly and relevant to this research approach is the concept of triangulation. Mertens and Hesse-Biber (2012) define triangulation as:

'A measurement technique often used by surveyors to locate an object in space by relying on two known points in order to 'triangulate' on an unknown fixed point in that same space' (2014, p. 74).

When applied to research and the application of multiple methods, approaches or theoretical styles; the concept of triangulation is best placed to recognise these type of research endeavours (Denzin and Lincoln, 2017). In terms of issues associated with the incompatibility of paradigms (see section 4.4); Mertens and Hesse-Biber (2012) assert that Denzin argues that some mixed methods approaches support the methodological hierarchy in which quantitative methods govern over qualitative methods. Yet, Cohan *et al.* (2017) do back the idea of triangulation by identifying, for example, that qualitative research is more assured by the application of alternative quantitative or other qualitative techniques; from this perspective, compensation of the shortcomings of each method can be applied. The deficiencies of each method can subsequently even out, revealing a more reliable estimation of the results (Brinberg and Hirschman, 1986). Hence, triangulation produces a more supplementary precise and endorsed approximation of a result, when the methods of measurement congregate (Williams, 1999). Within this study, a twofold qualitative approach to triangulation has been constructed into the research design. This multi-method, retrospective case-based approach of using IPA and CDA to permit the exploration of situated experiences and discursive practices. Consequently, conveying a varied explanatory view of the research aims and questions and studying nine participants regarding their own experiences permitted the application of two qualitative approaches. Undertaking the IPA first invariable influenced the CDA and this is an inevitable side of undertaking a multi-method approach. This view is acknowledged as consistent by Karatas-Ozkan and Murphy (2010) and Popova-Nowak and Cseh (2015) when applying these types of approaches to organisational research. However, using academic and professional support to validate theme analysis as well as the maintenance of research diary has helped monitor these concerns.

As remarked previously (in section 5.2.1), research in relation to the development of social understanding from a critical realist viewpoint can only attempt to create simple assertions (by slightly moving away from just idiographic explanations). This movement is only slight, because there is recognition of the unfeasibility of being able to establish common social laws

(Byrne, 2009; Fleetwood, 2014b). As acknowledged, descriptions of social occurrences understood in one study may also be pertinent to other situations; this can be known as transferability (Morris, 2006). Undeniably and as suggested above, research should offer circumstances for transferability by offering a research description that has adequate, has relative evidence and a comprehensive demonstration of methodological process. A research design may additionally present a triangulation of research approaches and a reliable selection of participants which can deliver a foundation related to the research outcomes. In relation to this research, practical transferability to the NHS workplace and LMD teaching approaches are a notable opportunity with is associated with this work. However, it will be the reader who will appraise this overall thesis donation to the foundation of knowledge related to the NHS LMD arena.

5.7 Summary

The intentions of this research and its methodological attitude with which the research aims, and questions will be addressed have now been acknowledged (section 5.1). The undertaking of a pluralist, multi-qualitative method, utilising a participant, retrospective case-based research project approach has been presented (section 5.2 to 5.4). Procedures have been defined, together with the recognition of ethical implications, sampling and data gathering methods (section 5.5 and Figure 13.). In section 4.5, approaches to analysis have been displayed in relation to IPA and CDA, with a flowchart's (Figures 15. and 16.) demonstrating how data was engendered from the transcriptions related to both approaches. To conclude, section 5.6 addressed the concerns regarding the value of research, concentrating on the three main apprehensions related to research quality. The subsequent chapters will demonstrate the findings from the multiple analyses of the interview transcripts, considering first the IPA in chapter six, followed by the CDA in chapter seven. Conclusions will be drawn in chapter eight.

Chapter Six: IPA findings

6.1 Introduction

This chapter will present the findings of the Interpretive Phenomenological Analysis (IPA), by showing the in-depth examination of interview transcripts from nine semi-structured interviews. As reasoned in section 5.1, this approach can assist in addressing the research aim of exploring how NHS LMD training participants experienced their training. It has been asserted that it is the duty of the researcher to reflexively collect and analyse the data; as a result, from participating in the in-depth analysis of the interview texts, three compelling super-ordinate themes have become apparent. These super-ordinate themes presenting as the NHS LMD training experience, the experience of being an NHS LMD participant in the NHS workplace and the role of personality, leadership and motivation from the LMD participants perspective. These comprehensive super-ordinate themes and their related sub and emergent themes are summarised in Appendix 12. All these themes became apparent by their frequent occurrences within the interview texts, together with specific explanations which encapsulate both the exceptional and the exhaustive perspectives of participants. All themes are exhibited individually yet arose during wider interpretation. This wider interpretation comprehended the intricacy between the connections and relations amongst each theme. How each super-ordinate theme, with its related sub and emergent themes were acknowledged and created, will now be presented in the form of commentary.

While exhibiting the verbatim excerpts some slight changes have been made to enhance readability. For example, negligible hesitations, word duplications and words such as “erm”, have been removed. Absent material is specified by dotted lines. Dotted lines during the beginning, middle or end of an excerpt specify that the participant was speaking before or after the excerpt. Identifying information has been removed or altered and this can be seen by the application of X's. None gender specific names have been used to maintain consistency for the reader as well as anonymity for the participant.

6.2 The NHS LMD training experience

The most prominent super-ordinate theme throughout the analysis was the theme of the NHS LMD training experience. The sub-themes which established this super-ordinate theme, were founded on the participant experience of accessing LMD and a recognition of factors which improved (or not) their LMD experience. The sub-theme of post-NHS LMD, supported the concept of a recognisable NHS LMD journey undertaken by the participants, summed up here as a whole training experience.

6.2.1 Access to NHS LMD

Both Kyle and Landry reported an enforced approach to LMD attendance, with Kyle commenting that LMD attendance was insisted upon due to a post-clinical incident recommendation:

"It was a blanket, there's an error on your ward, go on a leadership course. That's how it felt" ... "felt initially as though we were sat in detention with other managers, other leaders from the Trust who had similar incidents" – Kyle

"I was sent on the training, by my ward" – Landry

However, most participants felt supported on to their NHS LMD by endorsement from senior management:

"...saw something in me that could be developed, so I applied and was signed up" – Reagan

"So, I went through the course requirements and everything and it said you had to be Band 6 and above. This is not the level for me, I can't get it and then I thought, well, you know what, you have nothing to lose! I'll just give it a shot and see what happens!" – Kai

With Karter identifying LMD to be linked to career progression:

"Something good for the CV, I didn't mind doing them" – Karter

Kyle and Landry who felt forced in to LMD attendance from their organisation, both ultimately reported that:

"Very interesting, very useful" – Kyle

"I would recommend it to anyone, you learn so much about yourself" – Landry

In summary, how the participants accessed LMD ranged from being sent, recommended or they were just interested and applied. Those participants who were sent or felt *"press-ganged into a leadership development course"* as participant Kyle expressed it, still found LMD to be a motivating and useful experience.

During the interview process for admission on to their LMD training, one participant reported to have had a torrid time:

"The interview process was one of the worse days of my life!" ... "I was totally, totally oblivious to what I was walking into and really just thought it was going to be an average sort of interview process that would be straightforward, and I didn't find it straightforward at all. I thought it was horrendous! I think afterwards, that night, I drank a neat gin when I got home!" – Logan

This experience was created from the assessment interview process being competitive and trying to make sense of the associated behaviours of other candidates. However, not all participants reflected on the interview for LMD access as a difficult process:

"The interview, I thought it was quite a good process. The team exercise, it was almost an apprentice kind of thing where you get yourselves to be the best and then have a one-to-one interview, so you've already built up that tension with your competitors. So, I think the interview process was quite fun, if I'm be honest. I liked that..." – Reagan

Contra to the above experiences, most participants just had to turn up or complete a form, do a written piece or complete a questionnaire to gain access to LMD:

"You had to write about it and say why it would benefit your role to go on it, and that kind of thing" – Landry

With Ash also reporting a precondition of access to LMD being:

"We had to be managing somebody at that time" – Ash

6.2.2 During the NHS LMD training: Coaching, diversity, interaction and the learning environment

Of the interventions used in NHS LMD, one-to-one coaching (regardless of the coach experience, style and background) was a highly praised intervention by those who received it:

"I think anyone who went on the course came out thinking that was by far the best part of it and I think it was also possibly helped by the fact that he had no clinical experience" – Charlie

"The coaching side of it as well helped sort of get some perspective on what you can change, what you can't change. You know, the push-pull type thing. It was really beneficial at that particular time" – Dale

No style of coaching was noted to be better than any other type, however of notable distinction were coaching methods, which focused on empowering the coached participant:

"Coaching learned, me what I could do" – Kyle

"I just needed someone to help me realise you've got everything, you just need to probably sit back, take yourself out of the scenario and evaluate everything again" – Kai

In consideration of self-care, using innovative approaches to understand the effects of stress all proved to be a very useful coaching approach for Kyle:

"... I say look at dashboard because at the sessions we did physically draw a dashboard like you have on a car, so we had a dial for perceived workload. We had a dial for 'felt stress'. We had a dial for perception of others and I became, through that coaching quite adept to being very honest with myself, where I could go and where I couldn't go" – Kyle

For Kyle, coaching was also viewed as being a scaffold, while they experimented with a project linked to LMD:

"You're not going to put yourself out there and do something that you're going to completely regret. You've got that kind of scaffold. So, the coaching really sort of allowed me to do that" – Kyle

In line with the discussions about background of the LMD coach, much was made of the benefits of diverse facilitators who presented as external to the NHS:

"The guest speakers, they were interesting, they were external, so we had the Chief Exec of Boots come in and we would kind of see how he developed his team, how his sort of leadership strategy and style progressed and that was interesting" – Kyle

"The stuff from external facilitators, really, really interesting, really useful in how they manage people so the one that was really interesting" – Kyle

"...and I also think it's good simply because they're not NHS" – Karter

"...one of them was very, very good and she obviously had a lot of knowledge and a lot of experience" ... "worked for the local council and across education as well" – Ash

With Karter pronouncing an active desire for more external facilitators from outside the NHS to attend NHS LMD:

"...get me someone like a policeman or something who's done something different, I think I'll listen!" – Karter

There seemed to be resentment against LMD facilitators or speakers who held NHS positions (both managerial and senior clinical roles) with them seen as not worthy of their LMD facilitating role:

"They side step vital XXXX XXXXXXXX experience or XXXXXX experience and all the gritty parts of the role and start delivering that training to people who are obviously XXXX XXXXXXXX and XXXXXXXX without having had that experience" – Charlie

"...and I think, you've got here because you've probably been here long enough! But the idea that you somehow are someone that we all look up to and we all sit there wrapped because a director come to talk to us! Fuck off!" – Karter

This willingness to look outwards and to be able to engage beyond that of the participants own circle of professional peers and workplace associates, seemed to enhance the LMD learning experience:

"I think the main benefit was the links with other people and seeing it from different perspectives" – Dale

"I think the beauty of having this course was because you had people from diverse backgrounds" – Kai

This desire to promote cross disciplinary learning during LMD was noted to be important for Ash and Reagan:

"It would have been interesting to maybe have OTs, physios, maybe some doctors involved. Maybe some admin staff and things like that to get that wider perspective" – Ash

"The commissioners of the training could have been involved a little bit more" – Reagan

It was also reported when a facilitator spoke too much, this resulted in subdued group sharing opportunities (which would have been of value to Ash). Landry highlighted an issue when a group of colleagues who work together would tend to dominate group discussions. This lack of diversity was noted to inhibit LMD learning:

"How they taught it wasn't necessarily the best way. Some of them would just talk at you rather than doing lots and lots of group work" - Ash

"So, because they were a group from the same background, sometimes they quite often dominated, and you almost felt as if you worked where she worked because she shared so much" – Landry

Having a previous LMD participant attending (who attended the same LMD training previously to Logan's LMD cohort), Logan found this to be inspiring:

"There was a girl who stood up, who'd previously been on the course like a year or whatever before and she'd done brilliantly. I can't remember what she'd done but she'd done brilliantly developing something on the back of the course and that was really inspiring for me, shows some sort of level of achievement..." – Logan

Logan cross referenced this visit from a previous LMD participant to other LMD activities:

"...whereas people dancing on a stage, I'm not getting it" – Logan

The more elaborate, experiential LMD interventions, which included the use of Lego building or singing and dancing activities to encourage team building, storytelling and demonstrations; received limited appreciation from some participants:

"I struggled with the sentiment of the 'games', could have done without the final show" – Logan

"I think sometimes they baulked on add-ons to justify it" ... "You're there about learning about management, why do you have to build a Lego wall, or something like that?" – Karter

"We had to do all the silly taking things off, putting things on and altering how you looked and things like that, I did start to think, I'm not sure where this is going!" – Dale

Yet, Dale did mature into these exercises with Kai finding them as an opportunity to explore and grow:

"...but I just thought, you know what? I'm just going to embrace this and see what happens at the end of it! And I think that I did notice that there was a point to all of the things, although they did seem a bit daft at the time!" – Dale

"On the exhibition day, I would never have, in my entire world, have ever thought that I would ever dress up like a XXXXXX and go on stage! So, I went from being shy, introverted, into myself..." – Kai

Other approaches used in NHS LMD appeared to enhance the participatory experience, including the use of TED type talks and seeking out inspiring leaders to learn from:

"We watched some TED talk videos and things like that, that I've since gone on to watch more of from an inspiring point of view, that I found interesting" – Logan

"There are a couple of the TED talks that I've often gone back to, Simon Sinek, amazing! They ask not what you can do, it's not what you do, it's why you do it! I look at that very often" – Reagan

"One of the pieces of homework was to find someone who you think is an inspirational leader and talk to them... Now I'm a XXXXXX, and she's still there and she was my inspirational leader" – Logan

There were also mixed results for those who participated in action learning sets, which seemed reliant on the skills and attributes of the action learning set facilitator:

"Action learning, when you're leading a group, is very much about ensuring everybody speaks and is comfortable speaking in their own words... It's more about XXXX teaching style in the fact that XXXX had a set dialogue that XXXX needed to use, and XXXX wasn't very dynamic when things didn't go to plan" – Reagan

"...I mean the action learning sets as well, dependent on who was leading them. They were a bit hit and miss" – Dale

The learning environment was also reported to play an important role in the enhancement of learning, with an emphasis on the promotion of interaction and group work:

"I thought the environment they had was quite conducive to the learning because it was light; it was airy; the sound carried well; we were able to see each other and see the lectures and interact with each other. It was a comfortable learning environment" – Ash

"A conference suite environment, so physicality was very nice, comfortable, very different from your daily work" – Reagan

6.2.3 Post-NHS LMD

Several participants commented on life after their LMD course, with Kai wishing the LMD had gone on for longer with an academic reward at the end:

"I think I would have wanted the course to have gone on for a bit longer, something that would lead to more qualifications" ... "I would have loved it to have carried on, probably for a year, and get a diploma, or something from it" – Kai

Reagan and Karter were left asking for follow-ups or refreshers related to their LMD experience:

"Follow-ups could have been better, and I think just to abandon people, to put them out the door, tick box exercise. I would change that bit, we've done our bit, you now do yours!" – Reagan

"A lot of it is about your habits and behaviours which can slip, and I think that would probably be an idea to have refreshers just to reiterate those points" – Karter

On a similar line to Reagan, both Charlie and Logan observed a political agenda behind LMD:

"It could be argued that it would look very good on people's CV to say that they had developed, implemented and presented a development programme for XXXXXX and these people might have been the same people, for arguments sake, pushing the course, it could be argued!" – Charlie

"I was one of those successes that were appointed. They took the responsibility of, look what we've achieved! So yes, I was appointed during it" – Logan

Overall many participants reported that their NHS LMD training experience was a valued one:

"It was certainly one of the best courses I've been on in the end and one that I've used probably the most out of any other qualifications" – Logan

"It did meet my expectations. I think I benefitted a lot more than I thought I would do from it" – Dale

"It's made me think about going into a leadership position, perhaps the university teaching about leadership or in a more senior manager's position in my clinical role as well. I think it's certainly opened my eyes to that" – Ash

6.2.4 Summary

Considering the first notable sub-theme, enforced attendance on to LMD was quite distinctive in comparison to the experiences of the other participants who felt supported on to NHS LMD. Interestingly both Kyle and Landry did report that they enjoyed their LMD experience even having felt forced on to it at first. Logan found the competitive interview process for LMD highly challenging, with Reagan finding it challenging too, but also rewarding. The process to access LMD was a disjointed experience for most participants, with Ash reporting an additional requirement of line managing somebody.

Throughout the LMD process, one-to-one coaching was reported to be an effective intervention for those who received it (this was regardless of the experience, style or background of the coach). Kyle saw coaching as a scaffold type intervention, which can be used to support the participant through other developmental activities. The idea of diversity, in terms of both speakers and facilitators not belonging to the NHS, was highly appreciated and reported to aid learning experiences. Desired LMD commissioner involvement was also noted to be important. There was a mixed reaction towards action learning sets, with their helpfulness appearing reliant on the skills of the action learning set facilitator. Creative, more elaborate experiential LMD type interventions which included the use of props (like Lego) or singing and dancing, received limited appreciation, yet showing TED type talks (such as Sinek, 2009; Torres, 2013), external facilitators and previous LMD participants were deemed helpful. Having an open, clean and airy learning environment, which allowed sound to carry, reported to significantly assist LMD learning as well.

After LMD training, a few participants reported feeling abandoned or that the LMD training was too short or could have been accredited by a university. This left a few participants commenting on a possible political agenda behind their LMD training and questioning, who really benefits from their attendance. In general, the shared experience of the participants was that NHS LMD training was a valued and appreciated training experience.

6.3 The experience of being in the NHS LMD participants workplace

Reflecting on their NHS LMD journeys, participants spoke with degrees of separation between the LMD classroom learning and their NHS workplace. This developed into four notable sub-themes around line manager support, organisational culture, communication, and time poverty.

6.3.1 Line manager support

Many participants spoke positively about line manager support they received within the workplace, throughout their NHS LMD training:

"...yes, yes. She was very supportive. The management, I've always found they've been quite supportive, even the senior nurses..." – Charlie

"There was support from my line manager every single step of the way. She asked me, we had a catch up every single time I'd been on a day classroom session" – Kai

"Fab! No issues no bother. No, you can't have the time, none of that. Very supportive, yes" – Logan

With other participants reporting a more ambivalent response from their line manager and pondering how such support would have assisted them during their LMD experience:

"I'm not sure whether any management support would have made much of a difference, but even just having the time freed up to go and speak to suppliers or to attend specific training courses that I needed, just wasn't an option. So, there was I, almost a set up to fail before it even started" – Reagan

"...as far as they were concerned, it was just another course that I was doing, and I think that they treated it in that way" – Karter

"I don't think they were particularly supportive about the amount of time it took but after it, when it came to interviews at the end of it, there was a restructure..." – Dale

With Dale further suggesting that management only realised the benefits of participant LMD attendance, when it was seen during an internal interview process:

"When it came to interviews, I think that they then saw that I had picked up skills from that. That I could demonstrate what I needed to do" – Dale

Logan suggested that having consolidation opportunities to build on the LMD experience would have benefited Logan's learning experience:

"It would have been good if they had said, oh, we're doing this today. This might benefit you. We're planning a meeting. Would you like to help organise it? Or, we're interviewing people today. Would you like to be involved?" – Logan

With Kai experiencing significant difficulties with line management support:

"I had a line manager who was really horrible, who was a bit of a bully as well. XXXX manager, XXXX didn't really know what was happening each day, even if XXXX did, I think XXXX just allowed XXXX line manager do XXXX own stuff" – Kai

Dale summarises the importance of line management support and how a positive culture can assist during LMD:

"Not from the training point of view but depending on what your managers are like; will depend on what sort of experience you have. I mean, I'm lucky with the line manager that I've got now, and the one above XXXX, there's a different sort of cultural feel over it and it's more supportive and not punitive and it's a different kind of feel" – Dale

A mixed appreciation for line management support during NHS LMD is presented with many participants reporting the value of receiving it and wanting more support. Other participants felt ambivalent towards the usefulness of line manager support, yet this seems to be a response to the feeling of being treated with ambivalence by their management.

6.3.2 Organisational culture: Control, conflict and innovation

Building on line management support, a sub-theme developed recognising various challenging organisational cultures associated with the participants NHS workplace. Presenting in a variety of different forms and examples, such cultures were frequently observed and commented on:

"I guess it was more a cultural thing than anything else. It's all a cultural thing. As soon as they were able to go past that level of a culture of non-trust..." – Kai

"Absolutely. It was just a very bad culture within that team but, as I said, I just sucked it in and sucked it up" – Kai

"...you dare not make mistakes and that's not a culture you really want to be in. Because people have got to make mistakes to learn because that's the best way" – Charlie

Organisational team and group factors mixed with conflict, blame and difference, were also experienced by participants:

"...they've ultimately ended up blaming each other for the failure to deliver this thing because they've run out of ideas why this has gone wrong. They're like, well, we've done everything!" – Karter

"...they reported me to the Chief Exec and said how you dare employ someone who's not a XXXXX over us! And they were absolutely evil, but you know, I kept going there even though in my hearts of hearts I was like, why am I going to go for another beating up?!" – Dale

"It's a very hierarchical area. It can be very click and groups form, hostilities form and things like that" – Landry

"...it would be interesting wouldn't it, to know what makes the difference between, XXXXXXX and XXXXXXX? Is that a culture thing? Is it a lack of staff? Is it a financial thing? Is it a leadership thing? Is it a mixture of all of that? I don't know" – Logan

When attempting to understand this tension and challenging team dynamics, participants often spoke about organisational anxiety. This would present as organisational over-responses, team anguish or apathy:

"...so, the knee jerk reaction to that was, everyone now must go on observation training, everyone must partake in an observation audit, everyone has to do the same observation policy regardless of where they work" – Kyle

"...and actually, that team, when I first went to them, they were so angry. They were angry that no one listened to them. They were angry that no one agreed they were short of staff. They were angry that they were being put at risk and really, really lots of anger going on. They were angry that they'd told this story to so many people before..." – Dale

"Yes, I think we are, because I think we are reactive rather than proactive. We're more reactive, so we'll react to situations" – Ash

Several LMD participants recognised resistance and possible jealousy within their workplace, particularly when it came to the implementation of LMD workplace projects. These workplace projects were frequently associated with most participants LMD training:

"So then in terms of the projects I had to implement, I probably still looked at the people I knew, rather than trying to expand it out because, in some ways, it was quite intimidating because there were quite a large group of people and they'd all worked together for a very long time and it was quite difficult to infiltrate" – Ash

"It was just the offhand comments really and I think some of it was a little bit of jealousy from another couple of the Band X's that hadn't applied, and they were like, why's she doing a project?" – Dale

Echoing Karter's previous criticisms of some of the more elaborate LMD experiential activities (section 6.2.2), they also suggested that LMD workplace projects do not necessarily belong within the LMD process:

"...you see, these courses are about self-reflection and about changing how you do things whereas projects are about doing something new and different and all the rest of it and I think that's a different field, period" – Karter

Yet Kyle, Dale and Kai all reported to have benefited from LMD related projects:

"...so, for me, it was an excellent project to have. In six months, you completely re-imagined recovery and that pathway was adopted by the whole of the XXXXX, so a really huge impact and we got additional staff and additional resources as well!" – Kyle

"I probably wouldn't have got this role if I wasn't able to do a project which is what I ran on the course from end to end. I wouldn't have probably been a XXXXXXXX manager" – Kai

Like the challenging line management relationship previously reported by Kai, other participants also reported troubling instances of workplace management control and toxic cultures being prevalent:

"...so, I think they're being found out and stamping their authority was just one of the tactics that they used, I am in charge! Do as I say! This is how I do it! Not a very good leadership skill!" – Reagan

"There were some very odd decisions talked about. I believe that that part of the organisation was quite toxic. There were lots of things that were said at management meetings about people on a personal level that shouldn't have been shared and it was just not a very healthy environment to be working in" – Dale

"There was me and one of my colleagues from the XXXX XXXXXX and we were sat in a room with some of the GPs and one of the GPs said to us, I don't know why you've come here! You're not wanted! You're not needed and you're a waste of space!" – Ash

Even with these reports of troubling workplace conduct, the LMD participants recognised and spoke about innovation consistently. Views were split regarding how innovation and change could be understood and applied:

"...don't get me talking about that because one of my views is that innovation is not always a good thing. Innovation takes you forwards. Innovation forced me backwards and I think that people think of innovation always in a positive context, but it's not" – Charlie

"It's sort of like when you talk about the old ways and the new ways. The old ways of doing things is that anyone seen as wanting to make change, or lead, or do service improvement were a rebel, really, weren't they?"

That's not your job! That's not what you do! That's the old way of thinking" – Landry

"...that's what defines their success is their ability to hit those targets which is fine, but I don't necessarily think that innovation, new ways of doing it, is necessarily a huge part of their roles" – Karter

Dale draws a relevant point, recognising the cultural domain of progression or protection:

"So, your kind of saying the cultural aspect really is a big one whereby you let progression happen or innovation, you will withdraw from that and protect that, or not?" – Dale

Linked with both LMD workplace projects, innovation and change was the interplay of patient involvement and co-production:

"There was a lot of fear there and I think a lot of that was tackled by re-education. A lot of it was done very well by feedback from the patients with what we had... "we made a decision early that we will split the team" – Kyle

"I came on the ward and it's who's deciding on what we're spending the money on then? You haven't got any representative of any patients or any relatives who use this service and yet you're raising money to do something when you don't know if that's what's wanted" – Dale

"...made me think about the different ways in which I need to communicate with patients as well and how I manage their consultation and how direct do I need to be or how fluffy, I suppose, do I need to be?" – Ash

With Karter being critical of the organisational dialogue used during such initiatives:

"...if it becomes too eulogised, like patient opinion, or patient... It becomes meaningless. It's something you say, like good leadership or, you know. When you look at patient care, what the hell does that mean? Have you proven that? It's just one of those terms that people throw in there..." – Karter

6.3.3 Communication

Many LMD participants reported the role of communication within their workplace to be influential. Both Dale and Landry found issues related to communication being an important part of forming and maintaining relationships with colleagues:

"...why do we need a communications book when I'm sat next to you? We can just talk? And because I'd said I didn't want the communications

book, she said, well do you want things to be shared?" ... "I know, but I don't want 66 emails either! It's a tricky situation" – Dale

"I learned how to stand up to her and how to be more concise in what I was saying, more assertive and deal with her differently than I would have done before. I think she respected me more for it because I'd changed the way I communicated with her" – Landry

Karter found the issue of communication to be largely ignored and a source of difficulty when observing a relationship between two teams within their workplace:

"There is relatively little stress on good communication, but you can see the elephant in the room is that they're poor at communicating. They're pleasant. They're objective in all the good things but actually, a lot of the things you'd expect them to do like keep a record, work to certain agreed points, they're not doing and they're not communicating with this other department to achieve something they both have to do" – Karter

Building on Karter observations, Dale and Landry recognise the importance of good communication and contend that using effective communication can help strengthen teams:

"I suppose it's about not always emailing, it's about picking up the phone, isn't it? It's about being visible and having those physical connections with people" – Dale

"Yes completely. It's like human factors. Its hierarchy and communication and all those types of things, it completely ties into it" – Landry

"...listening to people more, so communication skills and things like that. Thinking about playing to people's strengths in a team and how best to utilise the team that you've got" – Landry

Ash found miscommunication and misunderstandings to be a real barrier to effective communication within the workplace:

"...why can't you just do this because that is part of our role? And them understanding our role could be quite difficult, in terms of just communication" – Ash

"...because it wasn't communicated that we would be coming across and what our role would be. So, because they didn't have that information, I think they jumped to conclusions that they were going to be replaced by us, which wasn't the case" – Ash

Viewing poor management as a source of communicative disruption, both Karter and Ash noticed how their LMD training highlighted management failures on others:

"I wouldn't have necessarily paid so much attention to it otherwise, but you realise, as I say, how much of it is down to communication" – Karter

"...so, I think a big part of it was down to the communication possibly from the management team to the rest of the staff, which it seemed didn't happen" – Ash

"...so, I think the communication side of things probably fell down and actually during the leadership and management course, at that time, made me think about how I would have managed that situation, under those circumstances" – Ash

Ash reflected further in relation to communication with patients and adapting communication strategies when motivating colleagues:

"...which is a massive thing and it's made me think about the different ways in which I need to communicate with patients as well" ... "they've not done this; they're doing that; I've asked them this and they've not done it! But if you think about the reasons why that might not have happened or maybe I haven't communicated that in the right way for them" – Ash

6.3.4 Time poverty

Like communication, the concept of time presents as a constant issue in the workplace for the LMD participant. Some participants were given time to attend their training away from their NHS workplaces:

"Time was given for the course, so it wasn't in your own time. You could have the time off the ward to have your one-to-one sessions with the coach and obviously the training sessions were in work time. Concessions were made. Time was given" – Charlie

"Time out from my usual job, I suppose and time to think and get a different perspective on things" – Dale

With Dale reporting that by attending LMD, there was a judgment about having the time and Ash having to fight for the time to continue LMD attendance:

"...when I was doing it, it was just a bit of an inconvenience, I think that I was going out to do this training again, you're off again, are you? Sort of thing!" – Dale

"The manager and myself had to sign a contract to say that I would be given the time to attend the course and obviously, I would be given some time to carry out homework as well. I did get that time... but I had to have quite a few conversations with people to say, you know, you've agreed for me to continue this" – Ash

Some participants did LMD work within their own time with some LMD projects failing due to a reported lack of organisational support. This links to earlier emergent themes related to the crucial role line managers can play in the journey of the LMD participant:

"You did things, in your own time outside of work, there were a lot of writing to do" – Landry

"I found it very difficult to get the time, or be given the time, to put the time aside to actually engage with the individuals I needed, and the potential cost involved, they weren't interested in spending. So, the project work was very much a tick box exercise for the course and I didn't get any value out of that" – Reagan

With Reagan and Landry both reporting despondency due to a lack of management support, interest and related time poverty:

"So physically getting it to write the reports for us would have been labour-saving, getting the reports would have been less time-consuming, so there's all those administrative functions that weren't being used, but they just weren't interested" – Reagan

"I wasn't able to do a lot of the programming side of it, so it required time from other people that I just couldn't get" – Reagan

"It was just like; one day a month we'll give you time to go and do this, but they didn't ask me about it or it was like something separate. They weren't really interested" – Landry

Kyle and Karter suggested ways in which time could be best spent by the LMD participants within the workplace:

"...who's ultimately responsible for that in the Trust? So, I would contact that person, I would spend time with them, I'd shadow them, I'd watch what they were doing and how they went about it, bringing back all is more learning" – Kyle

"...you're not going to get all the solutions in your job just by sitting there and banging away in the same way" – Karter

Nevertheless, a culture of time poverty within the NHS was reported by many participants as a real disruption to their LMD learning:

"They don't have it, they don't have the time, the resource, the expertise and so we generally tend to fall back on what are easily measurable indicators" – Karter

"...you can imagine, you've put all that time and effort into something, it's quite demanding and you don't really do anything with it afterwards..." – Landry

"...on the ward, time was such a limitation. It was such a barrier..." – Landry

Logan concludes with a critical eye applied to the NHS in terms of bureaucracy and process, by presenting a culture of limited urgency:

"...and in the NHS, it is very suppressing in that way. Let's jump through a million hoops! And go through finance! And go through this manager and that manager! Let's not make a hasty decision! Let's think about it for six months! I'll put you in my diary in two years' time!" – Logan

6.3.5 Summary

This super-ordinate theme recognised the many emergent themes which encapsulated the LMD participant's relationship with the NHS workplace. As mentioned previously, participants frequently spoke of their LMD training and their workplace as separate entities. Identified earlier, the importance of a supportive line manager was emphasised by most participants. The fragility of this relationship seemed critical and dependant on the successful consolidation of LMD learning, with time shadowing senior NHS leaders being suggested as a good LMD strategy.

Organisational workplace culture was often commented on as being important in the consolidation of LMD learning. These presented as examples of workplace conflict, blame and division. Other notable, difficult organisational behaviours could be described as over-reactions, team anguish and apathy. Some participants suggested that their workplace is prevalent with over-controlling management and toxicity. Resistance, with essence of jealous colleagues was also acknowledged when LMD participants applied LMD projects within their NHS workplace. The philosophy of innovation and co-production was challenged, with a mixture of it having both positive and negative connotations linked to the complexities of organisational culture, management application and dialogue.

Communication was noted to be a common issue of contention for the LMD participant within the NHS workplace. Many participants spoke of how communication sustained interpersonal relationships with colleagues yet could hinder project success and be a potent source of misunderstanding. Ash commented on an example when management had not communicated a change properly, and this resulted in unnecessary stress. Frequently LMD participants reported that LMD training allowed them to highlight the skill deficits of others.

Linked to the sub-themes of communication and line manager support, lack of time dedicated to LMD was reported to have a significant impact on LMD participant experience. Some participants had more time support than others,

with all reporting a direct link between time given to the training and their ability to consolidate LMD learning. As Karter and Landry acknowledge, limited time impacted on their ability to innovate and promote change in their workplace. Logan concludes that the NHS has a culture of limited urgency in some areas, yet this is contradicted by examples of limited time given for LMD developmental activities and innovative practices.

6.4 The role of personality, leadership and motivation within the LMD participants' context

The final super-ordinate theme relates to a collection of more nuanced sub-themes, which examined the role of personality, perceptions of leadership, values and motivation from the LMD participants' perspective. Sub-themes were developed from the observations made by the LMD participants relating to their experiences, relationships and understandings of these topic areas.

6.4.1 Ability, ambition and personality propensity

A consistent theme amongst many LMD participants was an observation of how colleagues progressed within NHS leadership and management. Charlie, Karter and Ash suggested that colleagues can progress to senior levels of NHS management quickly, without having mastered the lower level roles which they feel to be important:

"Unfortunately, sometimes individuals get into clinical roles and they don't necessarily have the skills and its driven sometimes more by ambition and personality rather than ability and sometimes I think people view steps away from the XXXX as an easier role, they may struggle in their role and they've been quite good and eloquent to find themselves a job, but it doesn't mean that they have the ability" – Charlie

"There's a cycle, so people go off sick so then there's less staff and they have to promote other staff so I think there's a big thing, especially in A&E where a lot of junior staff have been promoted really quickly to senior positions and actually don't have that experience behind them to be effective leaders and managers and to effectively do that position" – Ash

"I think often it is the case that there is the presumption of competence by having reached that level. It is as presumption. Not only is it a presumption that you can bypass what would be the normal expectations of interchange, you wouldn't be able to get away with it" – Karter

Logan recognises how some colleagues can progress, but places a more serendipitous perspective on things:

"There are the odd people that seem to do well, and everybody will comment on that particular person and how have they got their blah de blah de blah! And you think, what? Is that just a, who knows, right time, wrong place, whatever situation? What page are we on?" – Logan

Slightly contra to Charlie and Ash proposal of the need for experience to be associated with the requirements for progression, Dale separates clinical experience away from the role of being a leader:

"...I haven't actually been physically on a ward since 1986 so it's been a long, long time and I know that my clinical skills are quite outdated but I'm not there as a clinical person. I'm there as a leader" – Dale

Personality traits with a focus on the ability to play politics, as opposed to having observable ability which comes with time served, seem to play heavy on Charlie's mind. Particularly with the impact this may have on colleagues who have ability, but limited ambition:

"...so, for me, I would suggest that, you got ability, ambition and personal properties. In each one of these, there's always going to be sub-sections, personal qualities you've got and the ability to develop others, personal insight, awareness, that kind of thing. Then, there's ambition, a burning ambition that some people have!" – Charlie

"There are people whose ability is down here, but their ambition and drive are up here which counters out this and they also been able to learn the pattern, the right words, and develop the networks and potentially raise that, but actual ability is still down here. They can superficially appear to be up here" – Charlie

Reagan observes that there can be a "float or sink" (Reagan) culture, where managers are left to survive or be deemed unsuitable, with Charlie reporting having experienced this. Both Reagan and Ash argue that leadership and management training should be cultivated early on in careers, before new managers are appointed:

"...you're a manager and no one shows you what to do. No one shows you all the bits of paperwork that you need to complete all the time or It's expected. You're the manager, get on with it!" – Charlie

"...individuals who are put in a management position without any management experience and left to find their way 'float or sink', kind of thing, which I do think is unfair. I think you should be training staff as succession planning rather than get them a job and see if they can do it" – Reagan

"...I certainly think that even qualifying from a band X; I think there needs to be some leadership and management training throughout your undergraduate training through to post-graduate" – Ash

Reagan proposes an interesting solution, which fits with an earlier emergent theme regarding the appreciation and practices of professionals who are external to the NHS:

"You have to have promotional exams in the police and the army, you train people to do the job and you then you sit the promotion. Once you've got the promotion qualification, you are eligible to apply for a role"
– Reagan

Charlie and Dale are critical of the environments which support a cultural notion of *"looking after their own"* (Dale) as opposed to the recognition of ability:

"It was very incestuous and if you weren't within that department, nobody from the outside was going to come in and get promoted unless someone got sacked and made a role for you" – Charlie

"It was all about ticking boxes and there were very much people looking after their own. Oh, you don't need to bother to apply because you not actually going to get that job because it's already been given to somebody else" – Dale

With Kyle commenting which behaviour that promotes one's goals over the goal of the team can be harmful towards the greater endeavours of that team and society:

"It's all about self. It's all about meeting your own goals before the goals of others and things like that, and that sort of thinking, when we're trying to achieve what we're trying to achieve, it can be quite harmful to a project" – Kyle

"...essentially you're doing things for society. You're completely aware of everyone else's perception but you do what's right for society and I know that you can continue to climb the corporate ladder and I never have been about that at all" – Kyle

Karter, Kai and Logan do contemplate about being more proactive in applying LMD learning for personal and career development:

"Silo working and how much I've been in them and things like group think, I've been exposed to that and doing the course made me step back from it and, to some extent, pushed me to get more involved off my own back with other people" – Karter

"After the course, I realised how much I was hungry for it. I was hungry to progress and to take what I'd learned somewhere else and help other teams develop as well" – Kai

"I'm not a huge climb the ladder person, I have started to think that maybe, like there's a seed in the back of your head, is there other opportunities that I could do" – Logan

6.4.2 Leadership: Show the people, lead the people

Interlinked, though notably different to the emergent themes which created the previous sub-theme, were attitudes towards the concept of NHS leadership and what it means to be a leader. Some LMD participants spoke of how their experience of LMD has altered the way they see their leaders and managers. For example, Karter comments on a tension between those who have done LMD type training and those who are leading and managing, but for whatever reason do not demonstrate the same LMD skills:

"This runs counter to the sort of training you are putting us through, which is about bottlenecks for instance, or good communication, and I'm thinking, I can't believe you've done that course!" – Karter

"...highlights what's a good manager and you are surrounded by not good managers, shall we say. It makes you think, really! I can't work with this! He should really go on this course!" – Reagan

Several LMD participants had a strong sense of what being a leader is, what comes under the umbrella of leadership or as Karter suggests effective leadership is not NHS title dependant:

"To me being a good leader would be, as a manager, you initially go in, you show the people, you lead the people, you show people what you want them to do. You challenge. You go in, you do it, this is how you do it, you challenge an individual" – Charlie

"...so often, when you talk about good leadership, it's about needing to think outside those hierarchies because it's not necessarily what your title is" – Karter

"...what I think was great about the leadership thing was ultimately they stress it's nothing to do with how many stripes you've got on your arm" – Karter

"In leadership, it's about leading and sharing an example of what you do. So, actually mentoring and training people to attain the best at what they do" – Kai

"Leadership and management; both as separate entities and about your own behaviour and how you interact with people, whether they be junior members of staff or more senior, because actually sometimes you still need to be a leader for someone more senior than yourself" – Ash

Many examples of when the LMD participants have undertaken leadership demonstrations in the name of development and leading heroically from the front were presented:

"...you then go, you go and do that; I'll stand with you; I'll show you how it's done. If you need a blanket, I'll take over and you'll stand behind them and you'll let them go and do it but you're there in the background ready to help them if required" – Charlie

"...for the team to see me in a role where I'm back on the shop floor and I'm taking a much more hands on approach and a doing approach. I think something I learned from that is that I really enjoyed that, and I saw the positive of doing that and I've kept that going as well" – Kyle

"...I get the essence of the leadership ethos ... leaders eat last, and that sort of thing" – Dale

"...so, in a way, when this initially kicked in, I needed to be the leader and get everyone on board" – Kai

LMD participants' self-awareness of leadership approaches, and reflections played an important part too:

"I think I've developed a leadership style. I've become more aware of leadership styles. I think that the clear majority of that is by accident, by trial and error, by being there and making mistakes and I think some of it is by more formal learning" – Kyle

"So, it was interesting thinking about situations where you need to decide, am I a leader? Or am I a manager? Am I both? And thinking about it as separate parts, not just a whole" – Ash

Dale's relationship with leadership was linked with the concept of leaving a leadership legacy behind:

"...because they were going to employ a lot more band X's and so they wanted that information of what this leadership should look like in the new structure" – Dale

"There were two XXXX XXXXX that I sponsored that were band X's but then went onto be band X's, so that's really good. Good on them!" – Dale

Kai, Logan and Ash all acknowledged the role of dealing with people and changing behaviours (of staff and their own) through leadership:

"...manage staff members so I think it's having that strategic role as a leader, as a manager..." ... "...dealing with people, how to deal with people, I think is really key to leadership" – Kai

"I think I perhaps looked at leadership from more of an academic point of view, it's more about the people than anything that's academic, isn't it?" – Logan

"...managing and changing behaviours and mind set and I find that serves me in this job" – Logan

"I think it's you have to adapt your leadership and management style to suit the person that you're leading or managing because actually, people won't change their style and the person being managed or led shouldn't have to change their style as such, it should be you" – Ash

Though Landry comments on how the staff group which Landry works with can be reluctant to take the lead at times. Landry reports that they say things like:

"...that's nothing to do with me! I don't know about leadership! I know about clinical skills and being kind and caring, that kind of thing" – Landry

Further commenting:

"I was in the first cohort for that and a FAB Change Ambassador for FAB Change Week ... Encouraging staff to implement change at grass roots level and saying that anyone can make change, and anyone can lead change. You just need the skills and the support" – Landry

Ash recognises the link between leadership and patient management:

"I think it's added to my clinical practice as well because it's not just about managing staff, it's about patients, it's patient management" – Ash

6.4.3 Values and motivations

Kai reported that they had a lot to give back to the NHS:

"...because of the skills and experience I've gotten so far, I think giving back to the NHS to help the NHS develop or to help better the outcome for patients, which is why we do what we do in the NHS, it's for the patients" – Kai

With Ash not wanting to work for another organisation which was perceived not to have the same ethics as the NHS:

"...you'll be sent across to the new company. They didn't engage through this; the new company and I didn't want to work for them. I looked at the ethics of this company, it just wasn't where I wanted to work" – Ash

Charlie, Kyle and Ash had perceptions regarding the positives associated with private sector reward mechanisms:

"If you look at private companies, for example, you reward the good people for doing good work. In the public sector that reward isn't there, so the ability does not float to the top. The ambition floats to the top rather than the ability" – Charlie

"...how Boots manage, and they have a very different way of managing. It's all positive goal setting. It's all reward. It's all a bit of Pavlov's dogs really. If you do well as a manager, you get whisked off on one of these fantastic getaways and stuff like that! So, you sit there, and you think, you've just rewarded them for doing good! And you think, well, why not?" – Kyle

"...what is the point of me working for you? I'll just go and stack shelves in Tesco because I'll be better off. I'll go and be a manager in the middle who's on double what I'm getting. It's a fairly easy job and there's none of the hassle" – Ash

Karter suggesting that there is a difference in attitude between private and public-sector worker dedication:

"People just simply do not feel that secure in a lot of organisations outside the NHS to entertain the idea that you can go off for weeks and weeks and weeks on end, and some of the individuals I've known who've done it, have done it more about their relationship with their boss or the office dynamics than anything to do with workloads" – Karter

Comparative to Karter, Ash suggests that this issue runs deeper than the type of behaviours Karter observes:

"...they'd have that resilience and good will because they think, you know what? I can retire at 55. So, in those years, I am working for that Trust, say from 21 to 55, whatever, I will give my all! I will go above and beyond and help that service because I've got benefits here" ... "Whereas now, you can't. They've changed that. They've taken a lot of the benefits that the NHS had in terms of the pension and things have now gone so people think, why am I doing this?" – Ash

Some participants reported that a simple acknowledgement from a manager when a job is undertaken well would help them with motivation:

"...ridiculously simple as saying, job well done! To people which can get massively overlooked, I think. I'm in a role, I don't need it, but I can't remember the last time someone said, well done XXXXXX! That was amazing! That was a brilliant piece of work!" – Kyle

"You get to a point where you've done all you can as an individual and there was no well done after it. There was no acknowledgement that you'd done it. It was just the same old, same old!" – Reagan

6.4.4 Summary

The role of perceived ability and how this combined with ambition and personality is very pertinent to Charlie, Karter and Ash. For Ash this idea is conceptually based around earning your role and doing your clinical time. Charlie adds to Ash's understanding, and really emphasises the influence of ambition and personality within this, yet Dale is content with the role of leader regardless of the concept of clinical ability. Agreement is based on the need to cultivate LMD early on in NHS careers, which may help avoid problematic management cultures of "*float or sink*" (Reagan) and "*looking after their own*" (Dale) LMD participants Karter, Kai and Logan all reported that LMD has made them contemplate their own personal and future career development.

Tensions were noted by LMD participants towards managers who it is surmised may have not done LMD training, due to the management behaviours they exhibited. LMD participants reported to have a strong sense of what a leader is and how they exhibit leader behaviours. Ideas of leadership were heroic, front facing, staff developmental focused (i.e. creating safety and learning when mistakes occur) with a limited emphasis on NHS management position or title. Reflections on LMD participant leadership style and leadership legacy interacted with this too, with a respect for people and the role of interpersonal effectiveness.

The final sub-theme recognised the values and motivations LMD participants held towards the NHS, with both Kai and Ash feeling intrinsically linked to the higher ideals of the NHS. Charlie, Kyle, Karter and Ash all toyed with an idyllic perception of how the private sector rewards staff in comparison to the methods currently used in the NHS. Karter even suggests that the NHS dis-incentivises people, possibly due to a softer sickness regime, in comparison to private sector approaches. Nonetheless, Ash does critically observe that a wasting away of NHS staff benefits has played a part in eroding the values and resilience of some staff. Both Kyle and Reagan recognise simple appreciations from management when a job is done well to be motivating.

6.5 Conclusion

This IPA has explored the experiences of NHS LMD participants, who have attended LMD trainings and have worked within their NHS workplace. Frequent considerations were represented in the presentation of three super-ordinate themes, which created a comprehensive IPA of the interview texts. Each of these super-ordinate themes were created from the grouping of ten sub-themes, developed from 27 emergent themes.

To summarise, the first super-ordinate theme established what the LMD training experience was like for the LMD participants. Several participants initially reported that they were forced on to an LMD training programme, yet this made

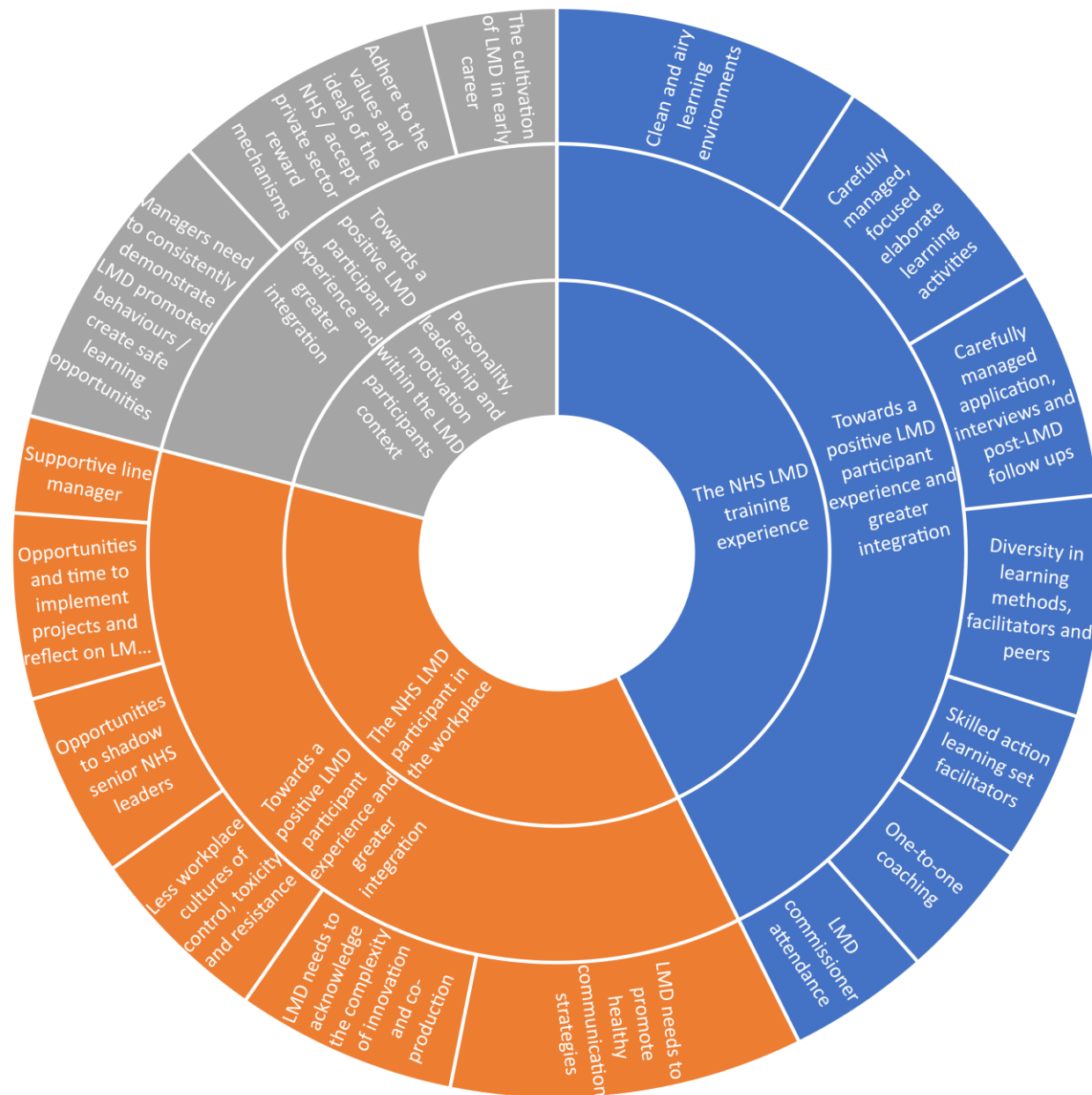
little difference to their reported enjoyment of LMD. It was noted that the process to access LMD does need to be carefully managed. Influencers which enhanced the LMD experience for participants were distinguished to be around the diversity of learning methods, facilitators and peers (coming from all backgrounds and areas). This application of diversity was acknowledged by the reported effectiveness of TED type talk presentations (such as Sinek, 2009 and Torres, 2013), external speakers (not belonging to the NHS) and a visit from a graduate LMD participant (for Logan). In addition, active LMD commissioner involvement was noted to enhance LMD training in the Edmonstone (2013a) study, which was also desired by Reagan. Within this context, open, clean and airy learning environments which allowed sound to carry, reported to significantly enhance the learning experience too. Experiential interventions like overly elaborate learning activities received mixed reactions and successful action learning sets were deemed dependant on the skills of the facilitator, though one-to-one coaching was highly praised. Post-LMD follow ups or refreshers were reported to be a desire of the participants and may also avoid the political tick box feeling experienced by some participants (Charlie, Reagan and Logan). On the whole NHS LMD training was highly valued by most participants.

The second super-ordinate theme acknowledged the workplace experiences of the LMD participant, with the role of the line manager being established as highly influential in the consolidation of LMD learning. Increased engagement and opportunities to practice LMD learning were sort after. Organisational cultural issues such as conflict, blame, over-reaction, apathy and division were disruptors in the eyes of many LMD participants. However, these disruptors also provided LMD participants with an opportunity to reflect on their own LMD learning, project development and practice. More unhelpful issues such as controlling management behaviour, toxicity and resistance, particularly when applying LMD related projects, did hinder LMD learning (similar issues occurred in the Bagnall, 2012 study). Both innovation and co-production were perceived in both positive and negative terms linked to management interest, application and the use of dialogue. Within the workplace context, the role and use of communication (at all levels) was frequently acknowledged as important. Many participants framed communication as a crucial factor in maintaining effective interpersonal relationships with colleagues. Communication was also linked to project failure and regarded as a potent source of misunderstandings. Time poverty additionally impacted on the LMD participant's ability to innovate and produce change, with examples of frontline work pressures getting in the way of LMD consolidation. There were NHS workplace examples of limited urgency and vested interests, mixed with a resistance to innovate or change experienced by Charlie, Reagan and Logan. These participants are not alone in this perception (Turnbull, 2011; Aldrick, 2018), though time shadowing senior NHS leaders as suggested by Kyle may potentially be a good LMD learning strategy to help with understanding the complexities of senior management roles.

The final of the three super-ordinate themes related to the role of personality, leadership and motivation within the LMD participants context. This theme considered the other, more nuanced and subtler sub-themes during analysis. The role of perceived ability, ambition, experience and personality were all considered pertinent issues to the LMD participant. The role of personality and its influence on future leadership desire is mentioned as a major influencer of willingness to lead within the Mahoon *et al.* (2015) study. Within this research, this idea focused on the general notion that you must earn your management position, rather than achieving it through what was vaguely seen as a manipulation of the system. A need to cultivate LMD at an early point in people's careers (which may help avoid problematic leadership and management cultures from forming) became evident during participants accounts. Disgruntlement was exhibited from the LMD participants towards those managers who do not present with the leadership behaviours promoted in LMD. Ideas of leadership were predominately based on the concept of the heroic leader, front facing, staff developmental focused with a limited emphasis on actual NHS management position. This is an interesting contrast to the more distributed, systems healthcare leadership styles promoted by the likes of The Kings Fund (Timmins, 2015; Dougal *et al.*, 2018) and discussed in section 2.3.4 within this thesis. Reflections on LMD participants own leadership style and leadership legacy was important.

Some participants felt intrinsically connected to the ideals and values of the NHS, while others held a perception that private sector reward systems motivate more effectively than the NHS offer. There was an understanding that some NHS staff have low resilience by Karter and Ash, with Ash attributing this to an erosion of NHS pay and benefits. Other participants noted that simple verbal acknowledgements for work done, would help them in terms of reward and feeling valued. This issue may well link to participants becoming aware of managers who do not exhibit LMD promoted leadership type behaviours like those highlighted in Table 2. by the NHS leadership Academy (2011; 2013) and The National Skills Academy (2016).

Figure 17. IPA identified factors which may promote positive NHS LMD participant experience and greater integration of the NHS LMD training, NHS workplace and the NHS LMD participant



(Created: Author, 2018)

The super-ordinate themes created from this IPA are now accessible in the form of a conceptual model presented in Figure 17. This model demonstrates how the three super-ordinate themes can be linked and how the identifying factors or sub-themes on the outer ring creating them could be organised. This IPA likewise suggests that when the super-ordinate themes are pushed closer together by adherence to those identified factors, the LMD participant may well have a more positive NHS LMD training experience. It could also be contended that these identified factors may influence these themes, by pushing and pulling them away or towards each other dependant on adherence to the identified factors. Thus, creating or disrupting the goal of producing a positive NHS LMD participant experience. When the NHS LMD training, the NHS workplace and the values and motivations of the participant are pushed closer together due to adherence of the identified factors, it could also be suggested that these themes become more integrated and aligned too. This IPA additionally proposes that closer integration could functionally be represented by the development of closer working relationships between the LMD training, the NHS workplace and the LMD participant.

This conceptual model (Figure 17.) allows for a quick access and understanding of the IPA findings and will assist in responding to the research aims and questions. Regarding these IPA findings and where they sit within NHS LMD theory and research as well as their future implications for LMD knowledge and practice; these considerations will be addressed further within chapter eight (conclusion).

Chapter Seven: CDA findings

7.1 Introduction

This chapter will describe the findings from a modified Critical Discourse Analysis (Fairclough 2003; 2013) of the same nine qualitative semi-structured interview transcripts utilised in chapter six. As reasoned in section 5.1, a critical investigation of discourse will now assist in addressing the research aim of examining potential barriers which impact upon an NHS LMD participant's learning within their NHS workplace. This modified CDA will endeavour to critique the transcripts by considering what was verbalised and what was not during their accounts of NHS LMD. This approach to textual analysis implies that what is external or inferred i.e. sources of power, influence and assumptions can be as pertinent to what is articulated through the transcripts. The notion that multiple discourses will be uncovered, entwined and contested, as participants discuss their experiences will also be prominent throughout this chapter.

The CDA findings will be presented in four sections, as the analytical arrangements from Figure 16. in section 5.5.8 are presented. Throughout this chapter, acknowledgement of the themes and understandings developed from the IPA will also be accredited. The first section (7.2) will recognise the genre of the transcripts created by the nine semi-structured qualitative research interviews. Consideration will also be given to the emergence and interdiscursivity of certain organisational discourses, which are explained, developed and explored. This examination of organisational discourses continues while their interdiscursive nature becomes further revealed as this chapter develops.

The next section of this chapter (7.3) will explore assumptions and organisational hegemony by contemplating what is being implied or omitted from the transcripts, and how this provides further understanding of the identified discourses and social practices. The penultimate analysis section (7.4) will discuss how events are represented and recontextualized in the language utilised by the LMD participants. The final analytic section (7.5) will relate to how personality, styles and identities are operationalised. As indicated, the analysis from the final sections (7.4 and 7.5) unearths two further discourses or social practices, relevant to this thesis. Finally, a conclusion (section 7.6) will be formed and presented as a conceptualisation using Fairclough's (2013, p. 28) '*orders of discourse*' to assist with the summary of this chapter. Figure 18. presents a conceptual model which acknowledges the dominant discourses drawn from this analysis and how they interact with each other throughout the interview transcripts. A final assertion is made from this critical analysis of the discourses, that the LMD discourse is a relatively vulnerable discourse (in comparison to other identified discourses). This assertion and why it has been made, will contribute towards the next and final chapter of this thesis.

7.2 Genre, emergence and interdiscursivity

As established in the CDA methodology (throughout chapter five), the transcripts can be treated as a genre within themselves (by being created by the same social practices of a repeated research interview). Through exploration of this genre of interview transcripts; discourses and the methods by which they emerged will be explored.

Firstly, there must be a reason to examine a genre, and this is to be understood by the rationale for the social routines involved during the creation of a genre. Habermas (1984) splits a genre into those of communicative action and that of strategic action. Through a strategic social action, Habermas (1984) argues that people attempt to achieve a joint understanding through collaboration and compromise of communicative action, with a focus on goal achievement. Debatably, qualitative interviews such as the ones utilised within this research, are also a mixture of communicative and strategic action. They are managed to achieve a goal, while also reaching an understanding.

For the purposes of this chapter, a discourse is a type of socio-linguistic custom; a method of signifying the world which may be connected to a recognisable collection of values, perceptions, and social practices (Fairclough, 2003). It is asserted that discourses can develop from other discourses and during this process, they can be reworked, adapted and re-contextualised (Rayner, 2003).

Significance will also be given to Fairclough's (2013) concept of the emergence of discourse from an organisational perspective. This will assist in understanding the context of discourses relevant to structural, strategic and environmental factors. The interdiscursivity of these discourses will be acknowledged throughout this section.

Frequently recognised within the research interview transcripts was the application of LMD terminology promoted by LMD facilitators and trainings or the managerial professional language of the NHS workplace. For example, participants would often utilise this shared terminology associated with the LMD discourse and managerialism, by applying terms like 'leadership', 'managing' and 'changing people':

"...that's why selling your why and all of that has been important and people managing, changing thoughts and behaviours" – Logan

A clinical-professional shared terminology is regularly applied and this is prominent to the field of contemporary NHS patient care and medical language. Shared terms like 'clinical practice', 'care pathways', 'assessment' and 'patient safety' were regularly used throughout the transcripts. It was noticeable that no matter the terminologies being employed, LMD participants tended to communicate the managerial language of responsibility, change and power. These notions start to disclose a link between the application of language and possible agendas behind LMD, managerialism and the clinical-professional role:

"It used to be rehabilitation whereas now it's got various care pathways which involves some longer-term patients, assessment pathways and things so basically, we'll take anybody" ... "they come to us for the assessment and the sorting out of the funding and we get rehabilitation" – Dale

"...about patient safety and service improvement and stuff and they always say, that's not my job! I'm not important enough! It's them up there that deal with that! Our Chief Executives!" – Landry

"I think it's added to my clinical practice as well because it's not just about managing staff, it's about patients. It's patient management" – Ash

Karter relates the issues associated with the general usage and the application of certain NHS professional terminology. Karter's commentary opens a critical exploration of this type of language, and implies that it is an influential tool which can embed power to users:

"It becomes too eulogised, like 'patient opinion', or 'patient...' it becomes meaningless-in-itself. It's something you say, 'good leadership', or, you know. When you look at 'patient care', what the hell does that mean? Have you proven that? It's just one of those terms that people throw in there. Like about leadership, or equality; no one can really define what the hell they mean..." – Karter

Building on the "eulogised" comment, Karter continues to propose that these terms empower ongoing arrangements of roles and structures within Karter's organisation. Karter alludes that since terms can be poorly defined or shared amongst a select grouping, they can assist in empowering organisational routines, structures and centres of power (for example administrative functions, governance departments and so on); a critical appreciation of these terms such as *"patient opinion"* (Karter) do fit the functional endeavour of key performance measurement and subsequent funding to monitor what is being measured. As previously commented in section 2.4 of this thesis, this terminology does fit within the emergence of increased governance, administration and managerialism of the NHS. The following caption from the Dale transcript emphasises Karter's point regarding the use of phrases and what can occur with poorly defined terms and understandings:

"...but they haven't got patient involvement and I came on the ward and it's who's deciding on what we're spending the money on then? You haven't got any representative of any patients or any relatives who use this service and yet you're raising money to do something when you don't know if that's what's wanted" – Dale

Later, Dale shows how poor management practices can be associated to unprofessionalism and cronyism. The textual example below shows how Dale makes sense of this association:

"I believe that that particular part of the organisation was quite toxic. There were lots of things that were said at management meetings about people on a personal level that shouldn't have been shared" – Dale

"It was all about ticking boxes and there were very much people looking after their own 'Oh, you don't need to bother to apply because you not actually going to get that job because it's already been given to somebody else'" – Dale

As well as questioning the professionalism and conduct of Dale's colleagues, Dale later highlights the existence of a "*ticking boxes*") culture which connects to Karter's critical appreciation of professional terminologies used within the NHS. The author contends that this terminology can be operated to assert institutional agendas and additionally be a potent source of misunderstandings, both honourable and disruptive. The role of mis/communication was emphasised in section 6.3.3, with an appreciation that LMD participants associate poor management with frequent ineffective communicative strategies.

Exploring the concept of the LMD discourse, officialdom of the academy in the application of LMD learning is desired by some participants. Still, participants Charlie, Kyle and Ash also talk fondly of their leadership development taking place within the workplace, with other participants representing a more conflicted approach towards this. For example, Logan initially represents the idea of leadership as something more academic, followed by an assertion of Logan's workplace experience of leadership:

"...I think I perhaps looked at leadership from a different perspective from more of an academic point of view and actually when you're working in the NHS with loads of different people; it's more about the people than anything that's academic, isn't it?"

Charlie splits LMD into theory and practical domains, with Charlie expressing a desire for a more practical relevance regarding the LMD training Charlie attended:

Interviewer: *"You say you were looking for a bit more practical?"*

Charlie: *"Yes, it wasn't practical at all. It was very theoretical, so it wouldn't have been about talking about what qualities make a good leader but not necessarily how to implement those and what it actually means in practice"*

Though influenced by the interviewer, Kai does move towards a desire for an academic approval of the LMD award Kai achieved:

Kai: *"...something that would lead to more qualifications, does that make sense? Because of how intensive it was and how broad it was. I would have loved it to have carried on, probably for a year, and get a diploma or something from it"*

Interviewer: *"So a bit more of an award? Academic?"*

Kai: *"Absolutely..."*

Dale similarly deems coaching which Dale received as *"not official leadership training"*) by discrediting it as not being official, but praising the benefits of it at the same time:

"I worked very closely with my manager who was a coach and would coach me, so I think, although that wasn't official leadership training, I think some of her ways that she handled things probably" – Dale

The influence of the clinical-professional/medical discourse became apparent as the participants verbalised seeking approval from other organisations associated with this discourse. For example, Kyle demonstrates:

"...that in turn has kind if made me apply for a job in the CQC. I've got an interview for that in a couple of weeks, the power of it is massive"

The Care Quality Commission (CQC) is a powerful UK health and social care quality enforcement agency linked to the monitoring of health care organisations and their staff. Kyle uses the term *"the power of it is massive"* (Kyle), while verbalising the opportunity of an interview as well.

Linking the social practice of the clinical-professional and medical professionals to an LMD situation, Landry explains the below occurrence:

"...was mainly nurses in our group and one doctor and we had to do the spaghetti and marshmallow challenge, and without it being discussed or agreed at the beginning, the doctor took the lead..." – Landry

The *"doctor took the lead"* (Landry.138) could be a representation of how this LMD intervention represented the power disparities between the different clinical-professional and medical professions. The actions of the doctor also demonstrated how LMD can be influenced by these organisational arrangements; a similar analysis is presented in the next section (7.3).

As the transcripts were analysed from an interdiscursive perspective, NHS LMD appears to be a vulnerable and disjointed organisational discourse. For example, terms like *"add-on thing"* (Dale), with reference to certain planned LMD interventions, while Karter referred to the reactions of fellow LMD participants towards some LMD interventions as *"I think sometimes they baulked at add-ons"* (Karter). The term 'add-on' here suggests that some LMD interventions can be deemed unnecessary and this links to certain experiential type interventions receiving limited appreciation (as noted in section 6.2.2).

The LMD as a discourse is uncertain and lacks influence or power which the clinical-professional and medical discourse or the managerialism discourse seems to hold. The social practice of management development is represented within the interview transcripts as being described as a 'ladder' to climb or something *"you get up"* (Charlie); LMD participants frequently focus on an organisational hierarchy:

"I have like a good name that I've built up and that's just by being me. I'm not trying to climb the ladder or be anything fabulous, I'm just trying to do my job really" – Logan

"It's the ladder, what can I change about it? Is it my responsibility? Am I blaming them for how I'm feeling? Actually, no I can move forward" – Reagan

"I felt I deteriorated after three or four years and I started looking for other jobs. The further you get up, the harder it is to get up there" – Charlie

Summarising this section, the genre of the qualitative research interview has been recognised as the social contact which led to the creation of the transcripts utilised within this research. The transcripts comprised of LMD participants contact with the interviewer and co-creator of the transcripts. Interactions primarily concerned the forming of equilibrium between strategic action, the interviewer prompting for responses and the participants, with the communicative action to achieve an understanding. Through this approach, the LMD participants have begun to present discourses or ways of summarising their assertions related to a common understanding of organisational issues and social practices.

Examples of a shared LMD terminology were frequently entwined with the use of a general NHS professional language. Thus, highlighting how two discourses of the clinical-professional and senior manager/managerialism emerge. The interdiscursivity and emergent description of these discourses show the LMD discourse as being mostly situated between them. The LMD discourse as a social practice seems torn between how LMD participants construct its value and inconsistency related to the appropriateness of some of the LMD interventions reported by participants. Nevertheless, this summary is restrictive and limits understanding of the complexity between the competing agendas within the NHS workplace and the role of LMD.

7.3 Assumptions and hegemony

Fairclough (2003) distinguishes three forms of assumption which can present in texts or transcripts like the ones presented here; these being existential assumptions, propositional assumptions and value assumptions. Existential assumptions concern what is presumed to occur or exist, propositional assumptions proclaim that something is, or will be happening, and value assumptions consider what is good or wanted. As noted in section 5.4.3, assumptions can lessen the dialogical options of a transcript by indirectly representing viewpoints as contradictory, common-sensical and vague. The hegemony of discourses can also be demonstrated as some of these assumptions are applied.

Within the transcripts, LMD participants frequently provide examples of assumptive attitudes towards their senior managers within the transcripts. For instance, Charlie suggests that senior managers have ulterior motives in relation to the application of LMD training:

"It's beneficial to the management but they say, you've actually been put on that course, you should be able to do that now. But the course has not told you what you need to do, it benefits them not you, so they can say that it will benefit you putting you on a course"

Charlie continues to apply a presumptive approach towards the motives of the LMD facilitators:

Interviewer: *"Do you think the course gave the facilitators something to do?"*

Charlie: *"It could be argued that it would look very good on people's CV to say that they had developed, implemented and presented a development programme for XXXX XXXXXXXX and these people might have been the same people, for arguments sake, pushing the course to be implemented"*

Charlie was not alone in acknowledging an assumed ulterior motive of senior management and LMD facilitators (frequently alluded to throughout section 6.4). These assumptions distance the senior management and the LMD facilitator away from the experience of the LMD participant. Significant to this assumption was the notion that senior management and LMD facilitators were mostly focused on their own career growth and utilising the LMD participants and their training as vehicles and tools of this endeavour. Thus, suggesting that LMD training is not just a CV building or developmental opportunity for the LMD participant, but also a growth opportunity for the senior managers and facilitators involved. Critically, it could be proposed that the assumption being presented here is that senior managers and LMD facilitators are applying a strategy of power consolidation through developing their own apprentice managers; commissioners showing that they can build capacity through return on investments; and facilitators trumpeting the success of their approach to LMD. This assumption by Charlie reduces the LMD discourse to a tool, which is principally utilised by the agendas of the actors involved in its delivery.

These assumed motives are frequently linked to other propositional and value assumptions regarding the role and abilities of senior management. A distinctive theme being that senior managers are deemed to be mostly successful politicians and networkers, a skill promoted frequently within NHS LMD trainings (section 2.3.4). Nonetheless, LMD participants such as Karter struggle to associate the politicking manager, as anything good or useful:

"...oh, I did this, and I think they're talking about politics, as if they're one of us and what they don't understand is, you're a politician to us, and you don't even see it! You're an arbitrary decision-making person whose closer to those people that we see on the television than you are to us"

Further propositional assumption's (proclaiming that something is or will be happening) were frequently made regarding the role of senior managers within the participants' workplace. For example, Reagan pinpoints the restrictive behaviour of two directors new to their role:

Reagan: *"The two new directors basically did a lock down on the whole team. You only if you weren't Head of XXXXXX, you didn't have contact with them..."*

Interviewer: *"Sounds quite protective and restrictive really?"*

Reagan: *"Quite hierarchical as in we're up here, you're down there, you'll do as we say! I don't think they knew the difference between leading and managing. So, I could still lead but they were restricting my management practice"*

The proposed assumption suggests that the new directors are consolidating their position by enforcing organisational hierarchical power and status. This led to Reagan feeling that their management practice is now restricted (in comparison to how they practiced previously). Reagan earlier suggests, what can happen to managers when they are first placed into complex managerial roles, but does not acknowledge that this may have happened to these directors:

"I have knowledge of individuals who are put in a management position ... and left to find their way 'float or sink', kind of thing"

Propositional and value assumptions are made by Reagan, who succinctly identifies the overt behaviours and defences used by the directors. Reagan asserts that they do not know the difference between leadership and management and acknowledges a vast power differential between the directors, head of XXXXXX and Reagan. Reagan suggests that the previous directors were the standard bearers of supportive senior management. Reagan does not explicitly acknowledge the role of knowledge (what the directors are aware of accounting for their behaviour), anxiety (how they feel within their new role) and contradiction (all managers are people and can struggle). The role of Reagan's personality and style in relation to this situation will be explored in section 7.5.

Working in a new area after being subjected to an organisational change, Ash reported the following:

"...one of the GPs said to us, I don't know why you've come here! You're not wanted! You're not needed and you're a waste of space!"

It can be argued that the General Practitioner (GP) assumed that Ash's specialist health practitioner role represented significant misunderstandings. Ash later suggests that the antagonism by the GP was down to senior management not communicating the nature of their role effectively enough to the team. The above description was followed by this further comment:

"...funnily enough, that same GP now, because he'd got to know me and my level of working, he's actually one of the nicest people!"

Ash does normalise the GPs behaviour and shifts the blame on to a non-specific problem of poor communication by the senior management. A degree of impunity was given to the GP regardless of their behaviour, by forwarding the blame and misunderstandings towards senior management.

In summary, selected assumptions have been examined. These were recognised as perceived threats to professional roles (existential and propositional), ulterior motives of senior management and LMD facilitators (existential and propositional) and leadership and the management skill deficits in senior managers (propositional and value). It can be seen, how the social practices of the clinical-professional and senior management can become hegemonic due to the discursive strategies they apply to assert their agendas. Both informal and formal communication was noted frequently as a tool to accuse, defend and contradict. Senior management frequently fulfilled the role of being the supporter, the antagonist and scapegoat, with the LMD facilitator also fulfilling part of this role for Charlie and Karter. The GP was presented as the misunderstood professional during a verbal lashing out at Ash. Ash passed over this issue by indicating that senior management were responsible for any misunderstandings (it seemed safer to accuse the 'senior management' then address this further with the GP). The discourses associated with the senior management and managerialism and the clinical-professional (combined with the medical discourse) have acknowledged to be hegemonic here. The power of the medical discourse has also been previously acclaimed by others including Shaw (2002), Waring (2007), Sartori (2013) and Sheaff *et al.* (2017). Overall the participants expressed critical, defensive, normalising and contradictory opinions which have helped grasp some of the tensions which exist between the professions and agents of the NHS workplace.

7.4 Representation and recontextualization of events

It can be proposed that the interview transcripts utilised within this research are not typical examples of a continuous narrative, particularly in comparison to a book or a blog (Van Dijk, 2001; Fairclough, 2003). Nonetheless, they are still transcripts regarding recollections of social occurrences or incidents. Through the transcripts, examples varied from recounting events like the LMD interview process or NHS organisational change endeavours relevant to leading and managing people. This section will also explore these events through a "*representation of recontextualization*" (Faircough, 2003, p. 139). From an organisational perspective, Fairclough (2013) argues that a process of recontextualization becomes prominent when embedded organisational hegemonic discourses clash with external emergent discourses. Fairclough (2013) asserts that this is identifiable by claims or denials that hegemonic organisational discourses are not changing, when in fact they are discreetly being appropriated by external discourses.

The first event to be represented is Dale's recollection about taking over the line management of a challenging NHS community team (Dale was also attending LMD training during this process). Dale presents the following:

"One of the teams, when I was first their manager, after their first meeting with me, they reported me to the Chief Exec and said, 'how dare you employ someone who's not a XXXXX over us!'"

Here Dale represents the presence of 'the new manager' who the team find fault with, due to Dale not having the same professional background as them. Dale is also an external manager and as such the team struggle to accept Dale interference with their way of working. Dale describes contact with this team as being subjected to a "beating up"), recognising that "they were so angry") and it "took my hearts of hearts to keep going"). Later in the text, Dale explains the organisational difficulties this team experienced, of being short-staffed, not heard and a history of being disowned by different managers. Dale intuitively noticed that they had developed a narrative of martyrdom, which by operation protected and reinforced certain behaviours towards external entities:

"...and nothing changed because they carried on working extra hours, they just stopped moaning about it! Because I think at the end of it there was a culture of wanting to be a bit of a martyr" – Dale

Re-contextualizing the language employed by Dale to represent the event/s of taking over the management of this team, there is an emphasis on physical and emotional trauma. Dale represented senior management and change, which created distress for a team fighting to maintain its narrative against external influences. Dale later comments on how the LMD training Dale attended supported Dale during this experience. To note, Kyle highlighted how LMD coaching provided a scaffold for development, while Kyle tested new approaches to leadership.

The second event to be represented will be when Kai recalled the implementation of a new ICT system in to an NHS community care team, as a part of an LMD project. Kai recollects:

"...because the patients are older, it's hard for you to get that culture change, not just for the patients but actually with the staff members as well because the staff members are actually used to having to go in every single time to get patient's vital signs, observations and everything"

Kai explains an event of organisational change, by describing a project to implement a mobile phone-based system to monitor patients in the community. Kai explains that this system is principally designed to empower patients and reduce staff workloads. Still, as they clarify the process of implementation, Kai uses language such as; "kickback") as representing frontline resistance to the project; and "defensive") with further reference to how the staff behaved towards Kai's LMD project. This can be summarised by Kai suggesting that the workplace in question has "a culture of non-trust"). Like the situation faced by

Dale, the event or practice of changing established organisational practices or implementing an external managerialist agenda called 'improvement' caused anxiety. The clash of discourses is apparent and the language re-contextualized can be that of resistance, as old, established discourses clash with new emergent ones external to the structures of that team. Kai recognises how attachment and emotions presented by the staff, overtly represented a commitment to patients too:

"...especially with elderly patients, they have that emotional attachment to patients as well. It's about them being able to trust what you've been given and it's going to have better effects and better outcomes for this patient..." – Kai

Kai can rationalise the agenda of the project and place it within the narrative of improvement and rationality. Charlie has a contra understanding of the improvement and innovation agenda, which was recognised in section 6.3.2:

"Innovation takes you forwards. Innovation forced me backwards and I think that people think of innovation always in a positive context, but it's not" – Charlie

Kai addresses the practice of improvement as an organisational cost saving endeavour which Kai names "*quick savings*"). The language of LMD in terms of leader-ism (a term used by O'Reilly and Reed, 2010, during a discursive appraisal of NHS leadership) and inclusivity also helps sustain this agenda:

"...I needed to be the leader and get everyone on board" – Kai

What is emerging within this section is a complex tension between the social practices of NHS community teams and the senior management/managerialism agenda. As eluded in the previous sections, the LMD discourse seems situated in the middle of these dominant discourses. On occasions the LMD participants are utilised as a tool by the senior management to impose change. The language of Dale and Kai reflects the emotional conflict they experienced, as defences became entrenched and resistance was verbalised towards them. The LMD participants are empowered to implement organisational changes such as integration, cost savings, efficiency and innovation. The LMD participants also report active resistance by some senior managers who rebuff the LMD discourse (and its associated narratives). Maybe the LMD discourse and the newer ways of working or the flattening organisational structures is a change too far for some senior managers. They may over identify with the more historic transactional and bureaucratic leadership approaches and reject other leadership approaches.

Moving forward, the third event to be represented is Logan's LMD interview assessment incident, which was acknowledged in section 6.2.1 (determining that these processes should be handled with care). Logan describes the interview assessment as "*absolute hell!*" (Logan), commenting "*My God! What have I just put myself through?*" (Logan) with a "*God! What the hell have I come to!?*" (Logan). The shock related to the language used by Logan is connected to an

event which took place during one of the LMD interview assessment exercises. Logan explains:

"...the lady who was sat next to me started in this secret way, but not secret, because we're surrounded by people watching us, writing on my piece of paper ... a secret message so I was already like screaming inside with anxiety ... this woman is writing this secret message on my piece of paper that I just then had to look at and read, which said something along the lines of, this was a mistake! We shouldn't have split up! La! La! La!"

To place further context on this event, Logan labelled the person involved in this scenario as *"...one of those inappropriate people, that did inappropriate things"* – Logan. Logan later acknowledges that they had led:

"...quite a sheltered life in that my nursing career had basically been on one ward where everyone got along and there was not that much animosity, so I had not really come across people who could be so sort of 'I AM!', particularly before at work..."

The use of the term "I AM" (Logan) expresses a negative impression of the managerialism and change. This may additionally explain the reactions of the NHS community teams to Dale and Kai's presence and the change agenda (which accompanies them). As previously indicated, the appropriation and conflict of the discourses may encourage difference and defensive behaviours by the actors involved. In relation to Logan's situation it is worth considering Arnulf *et al.* (2016) recognition of the dark side of LMD. They propose that LMD participants can be significantly traumatised by the application of certain LMD activities.

In summary, there is a tension between the managerialism and innovation agendas and teams and staff maintaining their professional identities and values. The language Dale utilised to represent being caught in this tension was both physically and emotionally troubling. Kai faced a similar situation when implementing a modernisation project. Several assertions became apparent during this part of the CDA. Dale and Kai represent the management agenda and subsequently tools of the senior management to enforce the control of rogue teams. Terms associated with power affirmation appear cloaked under the banner of modernisation, innovation and efficiency which all propel the management endeavour. This suggests that LMD (which also promotes these terms and topics) is a tool of senior management to further its cause, regardless of the wellbeing of the LMD participants. This same assertion may well be applicable to how clinical-professionals or hybrid managers also apply LMD training. Within this, Logan may represent a voice to the teams and individuals, which Dale and Kai are faced with. Logan's shock of dealing with "I AM" type people, may help understand the contentions, misunderstandings and anxieties, as the senior management/managerialism discourse challenges the established social practices of these types of teams. This may also explain why Charlie is reluctant to praise and provide credit to the improvement and innovation agenda.

7.5 Operationalisation of personality, styles and identities

This section will explore how interviewees operationalise their identities as LMD participants, managers, professionals and staff members of an NHS organisation. A focus on the personality of the LMD participant and associated discursive features of the style and identity related to this will additionally be acknowledged.

The first example to be considered is the experience of Kyle and how Kyle changed and adapted to the demands of NHS leadership and management. Kyle's leadership journey began from being: *"...a qualified nurse... I think I spent 5 years doing my time on the front line"*) to *"...becoming non-clinical..."* and then back to a *"...much more hands on approach and a doing approach..."*). This returning to a more hands on approach, reported to have occurred during the undertaking of LMD coaching. Kyle comments that Kyle's leadership development journey over the past 11 years has been:

"...by accident, by trial and error, by being there and making mistakes and I think some of it is by more formal, learning more formal interactions" – Kyle

Accepting that leadership education for Kyle has been a mixture of both accidental events and formalised learning; Kyle focuses on the notion of taking responsibility, what Kyle describes as *"self-management"*. Kyle presents as an optimist and describes a reluctance to take a negative attitude because of being *"...not made up that way"* – Kyle.351. Kyle correspondingly recognises the contentions and contradictions between holding a professional identity, the importance of self-reliance and occupying the role of a middle manager. Kyle summarises these demands as:

"I guess you'd kind of consider it middle management, but you're responsible for yourself. You're responsible for the people who work under you, but equally bad shit rolls downhill! You get hit from above as well!"

Kyle reported that a recent alteration in leadership style was largely informed by the coaching Kyle received through LMD training. Kyle conveyed to have benefited greatly from this coaching relationship and the leadership skills learned. Kyle reported to have proactively applied this to leadership practice in a hands-on type manner, while the coaching provided a scaffold for safe learning. Kyle described the coach as asking questions like *"...who's ultimately responsible for that in the Trust?"*. This questioning enhanced Kyle's leadership identity and style, by encouraging Kyle to look beyond Kyle's own sphere of responsibility. Kyle operationalises this approach by empowering others to challenge discursive arrangements within the workplace. Fairclough (2013) terms this *"discourse change"* (2013, p. 64), meaning a change in discursive events which uses *"innovation or creativity"* (2013, p. 64) to go against customs or expectations. For example:

"...we've got a person who, amongst our staff team, her thing is XXXXXXXX health care so who's ultimately responsible for that? So, she has the Director of XXXXXXXX as her sponsor. Now this is someone five or six grades higher than her who probably wouldn't even know that they existed otherwise, but she sees this very junior staff nurse monthly and that's fantastic" – Kyle

Kyle empowered another to grow and question arrangements beyond organisational position. Kyle recognised the multiple tensions of Kyle's middle management role and how effective self-management can help manage these pressures. Kyle concludes Kyle's leadership journey by returning to a *"...much more hands on approach and a doing approach..."*. This represented an appreciation that Kyle felt comfortable leading from the front line, rather than the office and regressing to what Kyle originally enjoyed about being a newly qualified nurse. Kyle subsequently operationalised an old identity to help deal with the restraints and demands of the senior management/managerialism discourse.

Within this second example, Reagan reflects on the proactive distribution of LMD learning (undertaken by Reagan) and the subsequent barriers which Reagan felt restricted the implementation of an LMD project. Reagan admits to being *"quite a strong person"* and declared that:

"During the training, I would come back after each session and usually I would book a team meeting for the day after and I would disseminate that learning to some degree"

Reagan would monitor the staff involved with this dissemination of LMD via *"...go out with them on occasions and observe what they were doing..."*. Like Kyle, Reagan wished to empower staff and subsequently challenge established ways of working. As they proceeded to implement an LMD project, Reagan reported significant resistance to the project. As described by Reagan, *"...it was just nobody was interested because they can't see the benefit"*). This was a reference to what was viewed as a symptom of a recent change in senior management. Reagan summarises:

"The management structure had changed... they're very different directors then the two that sent me on the course were very forward thinking, very much inclusive directors and they wanted their systems to work quicker. They wanted to know how things could work better whereas the changeover was very much, you'll do as I say. I don't care if it works, you'll do what I'm telling you, so it just lost its impetus and viability"

This change of leadership represented a leadership style which was contra to Reagan's style and understanding of leadership (reported to be inclusive and bold). Here Reagan failed to endorse the methods perceived to have been applied by the new directors, as they asserted their identities and agendas on to their new roles. Reagan concluded to not being *"use to dictatorial management"* and ultimately reporting *"it changed me from a very high positive and then it*

broke me on a very low negative". With the new directors reporting not to adhere to the LMD discourse as viewed as it should be by Reagan, this resorted in personal issues for Reagan.

The final example taken from the transcripts is related to Landry. Landry described feeling passionate regarding service improvement and how this interest empowered Landry to challenge ways of working. As said *"I've not got a lot of knowledge about it, but I've got a lot of passion..."* (Landry.495-496). Initially Landry identifies that a culture of change within the NHS is underway and recognises this through social media and events:

"I'm looking at people on Twitter, social media, in the news, at conferences, and to me there looks like a massive change..."

Landry does rationalise this *"...but actually am I just seeing the best practice?"*. Landry ponders that many staff who work on the frontline do not know enough about service improvement or are not motivated to become involved. Landry also suggests that when *"things are wrong with leadership"* this can distort and disempower staff to innovate. Landry believes that NHS staff groups are caught between the *"old ways"* and the *"new ways"*; the old ways representing a discourse of disempowerment, burn out and *"top-down"* management. The new ways, which for Landry means bottom-up, empowered frontline changes. The use of language shows a split, thus representing a challenge which service improvement faces within the NHS. Landry explains this further:

"...and they've got that insider knowledge; If we can just give them the tools and the techniques to do that and tell them, it is ok. You are allowed! Then they'd be more likely to do that. People think they need permission and they don't."

Like Kyle and Reagan, Landry identifies as an empowerer and wishes for others to feel empowered within their workplace. Using the language closely associated to the LMD discourse, Landry concludes that:

"To be a good leader in terms of supporting staff and working with them; not pushing them or leading them to do something but working with them"

Landry's split of 'the new ways' and 'the old ways' of working represent discourses additional to the senior management/managerialism and clinical-professional discourses. Reagan, Kyle and as exemplified in the previous section (7.4), Dale and Kai would argue that they represent 'the new ways' and are challenged by 'the old ways' of working within their NHS workplaces. These distinctions create two recognisable discourses of old and new, which represent further challenges for the LMD agenda and its influence. Landry's understanding may signify how the senior management/managerialism and clinical-professional and medical discourses can appropriate the LMD discourse to apply the new ways against the old ways. Thus, promoting the agendas and demonstrating the

power struggles of the dominant senior management/managerialism, the clinical-professional and medical discourses and its associated actors.

In summary, a selection of operationalised identities and styles of LMD participants have been analysed within this section. Kyle, Reagan and Landry present an understanding of leadership and how they have applied LMD within their NHS workplaces. Each one utilised their personalities, professional identity and style to challenge relationships and practices which also permitted them to empower others. Like the previous sections within this CDA, there was a notable tension between the discourses, impacting and challenging established organisational structures. To add, the old ways of working represented closure, permission seeking and authority, with power, martyrdom and resistance being central to this interplay. The LMD discourse within this chaotic scene appearing to be a tool of the senior management/managerialism and the clinical-professional and medical discourses. The LMD agenda is permitted to challenge 'the old ways' of working, by utilising the ideals of 'the new ways'. It can be argued that this challenging is permitted when done in line with the needs of the dominate discourses and its actors. Yet, this consideration leads to further unavoidable questions regarding the impartiality of the LMD being delivered.

To add, both Kyle and Landry felt comfortable with challenging and empowering others to contest the 'old ways' discourse. Reagan spoke of a change of management culture and having to alter personal styles of leadership from an empowering 'new ways', back to 'old ways'; which subsequently caused personal difficulties for Reagan's construction of leadership.

7.6 Conclusion

The purpose of this chapter has been to critically analyse a selection of discourses drawn from the interview transcripts of NHS LMD participants. This modified version of Fairclough's (2003; 2013) CDA endeavoured to associate the application of language to the notions of LMD and the influence of the associated discourses. The following analysis is not proposed to offer a decisive classification of the discourses. However, there is descriptive value to LMD participants and their relationship with their LMD training and workplace application.

Four areas of analysis were utilised by the researcher. The first of which recognised the genre of the semi-structured interview, which required that the transcripts be organised and created by the same method. Participants presented an assortment of work-related discourses and these began to be observable through the genre of the interview process. Two notable discourses emerged early, due to the acknowledgement of the organisational position, communicative practices and validation. The interdiscursivity of these discourses initially presented the LMD discourse as situated between the discourses of the clinical-professional and senior management/managerialism. The relationship

between the LMD and managerialism discourse appeared particularly difficult depending on the context. This was noted in the way both discourses, relied on each other to assert their agendas and the shared terms they use. The use of terminology and communication strategies was witnessed by the LMD participants as a tool used in the consolidation of organisational power. As well as faced with a contentious relationship with managerialism, the influence of the academy presented as problematic for the LMD discourse and how participants perceived its value. Not all, but some participants desired a formulised validation of their LMD from a university and/or understood definitions of leadership belonging to the domain of the academy. Nevertheless, when academic notions which participants associate to leadership were spoken, participants would counter this with more insightful workplace understandings of leadership.

The following section (7.3) of this analysis considered assumptions made by the participants and the hegemony of certain discourses. The discourses of the senior management/managerialism and the professional-clinical and medical continued to be recognised as dominant discourses (which battle for supremacy, depending on the agendas of the actors involved). Common assumptions which demonstrated a further understanding of these discourses were related to behaviours of actors when professional roles are challenged. There was also acknowledgement of a concealed intention of senior management and LMD facilitators and a leadership and management skill discrepancy in managers. The discourse of senior management represented a notable contradiction of holding many different functions of the supporter, antagonist and scapegoat. The GP was presented as the misunderstood medical professional when the GP lashed out at Ash, however Ash indicating that senior management were ultimately accountable for any misunderstandings between them.

As assumptions are acknowledged, emotions of anxiety and jealousy could be seen throughout the transcripts. It can be contended that many LMD participants may well be predisposed to want to progress or "*climb the ladder*" (Logan) into a senior and further management position or hybrid type roles. Observing current senior managers not undertaking their roles effectively or in-line with the LMD discourse must be challenging. Participants articulated critical, defensive, normalising and contradictory opinions of their senior management. An inconsistency exists; regardless of the capability of the LMD participant, a realisation that eventually LMD participants may require senior actors with positional power to progress them within the NHS; and the thought of eventual progression in to these highly complex roles, could be anxiety provoking. The subsequent behaviours of these actors involved in the organisational tensions, cause the LMD participant stress and confusion.

The representation and recontextualization of events illustrated another example where the clash of the discourses and agendas were textualized using emotive and physical language. The discourses clashing here were that of senior management/managerialism and the frontline staff, fighting to maintain their professional identities and an instinct of knowing what is best for their patients. Dale experienced this contention when taking over the line management of a

'difficult team' and Kai faced a similar resistance when implementing a modernisation project. The question posed from these two experiences, are both Dale and Kai (gifted with their LMD training) just empowered tools of the senior management/managerialism agenda? Logan represented the other side of this contention, representing a voice to the secluded teams and individuals, which Dale and Kai were faced with implementing change to and with. Logan's shock of dealing with "I AM" type people may help appreciate the tensions discussed here. Misunderstandings and anxieties are evident as the managerialism discourse challenges the established social practices of long-established teams. The LMD discourse appears caught between all these agendas vying for assertion and dominance.

The final section (7.5) considered the operationalisation of personality, styles and identities. Within this section a selection of operationalised approaches of LMD participants were analysed and presented here to assist in the building of a multi-discursive understanding. Kyle, Reagan and Landry presented a considered representation of leadership and how they applied LMD within their workplaces. It could be seen how personalities enabled relationships to grow through the empowerment of others. Friction between the established discourses was distinguishable throughout these examples. Two discourses became apparent within this section, allowing for a naming of these discourses roughly touched upon in section 7.4; neatly designated by Landry as being 'the new ways of working' and 'the old ways of working'. The challenging and application of these discourses inevitably ask searching questions regarding the impartiality of the LMD being utilised.

Figure 18. Orders of discourse with inter-discourse and interdiscursivity considerations



Black = Inter-discourse, Green = Interdiscursivity, the grey arrow = discourses are connected

Orange = Section of this CDA chapter, where these implicit / overt characteristics predominately feature

(Created: Author, 2018)

This chapter has laid a foundation for further reflections on the interactions between the different discourses identified by this modified CDA. There has been an overlap and a disfigured representation of the discourses presented throughout this analysis. This was primarily due to the interchangeable, heterogeneous and inconsistent nature of the discourses involved. Nevertheless, to support the summarising and depicting of the discourses drawn here, Fairclough (2013) suggests that establishing an '*orders of discourse*' (2013, p. 28) can assist in the defining and distinguishing of discourses from other discourses. Ascertaining an order of discourse will assist when applying some context to the conclusion of this thesis. Fairclough (2013) recognises the existence of the '*inter-discourse*' (2013, p. 58) which represents an implied or obvious relation between discourses. Interdiscursivity considerations present the features of these relations between discourses. Figure 18. identifies the dominant discourses drawn from this analysis and a potential order of discourse with consideration of their inter-discourse and interdiscursivity properties. This draws attention to the associations between the discourses and the recognition that the discourses are connected (the grey arrow in Figure 18.), but with varying degrees of importance and usefulness.

Determining how these discourses inter-discourse and order themselves is significant, as can be seen in Figure 18. With the LMD discourse placed central here, Figure 18. recognises the tension between the discourses, with some discourses co-habiting, appropriating and using each other to strengthen agendas. From this conceptualisation, the LMD discourse does seem particularly vulnerable to the whims and political agendas of the actors involved with the other discourses. This may account for the difficulties LMD participants face when applying their LMD training in to the complex ecosystem of their NHS workplace. It has also been asserted that some LMD facilitators are more in-line with senior managers or have an over-focus on their own investment in LMD as an agenda, rather than that of the LMD participant (section 7.3). This may fortify further feelings of vulnerability in LMD participants if they bear witness to this.

This analysis will assist in the triangulating of the IPA findings from chapter six; help answer the original research aims and questions developed throughout the previous chapters and consider what this research will add to the future of NHS LMD. This will be contemplated in the next chapter (eight), which will also draw a conclusion to this thesis.

Chapter Eight: Conclusion

8.1 Introduction

A conclusion to this thesis will now be presented, with recognition of how the research and findings offered here will inform the theory, practice and policy of LMD provision within the NHS. The significance and implications of these conclusions in relation to the research questions, LMD and knowledge will also be considered. This chapter will finish with a consideration of the drawbacks of this research, as well as future areas of study and subsequent recommendations.

8.2 The research journey

This research began by acknowledging the relatively ambiguous area of NHS LMD and its many associated topics. Consequently, chapter two initially focused on reviewing the general literature and the common understandings of leadership, management and the managerial discourses within the NHS. This progressed to critiquing the concepts of leadership, leader and manager learning, before refocusing on a more refined review of the literature in chapter three. Chapter three concentrated on more contemporary empirical and evaluative studies, related to the development of common theoretical threads of NHS LMD. From this review, five early themes for consideration were identified as influential factors associated to NHS LMD, these being:

- Change and the use of individual leadership skill development interventions.
- The influence of organisational culture.
- Stakeholder engagement.
- The competency framework debate.
- Participant desire to lead.

These themes drawn from the more refined and contemporary literature, presented a complex and dynamic understanding of NHS LMD. They cover deliberations of what is considered 'best NHS LMD practice', LMD participant willingness to lead and the influence of organisational culture. The limited and questionable quality and reliability of the data drawn from these articles was notable (Appendix 2.). Vague and inconclusive, these early themes nevertheless sparked a transition towards recognising areas requiring further exploration.

The purpose of chapters two and three was to develop a suitable theoretical framework to justify a sustainable research approach towards the study of NHS LMD. The concept of '*meta-theory*' (Mabey and Finch-Lees, 2008, p. 23) guided the eventual decision to apply a multi-analytic research design. This resulted in

the ensuing use of a qualitative, multi-method approach to address the issue of limited NHS LMD evidence (West *et al.*, 2015; Tull, 2018) and the neglected research approaches used in the research of LMD (Mabey, 2013). Burgoyne and Reynolds (1997), Day (2001) and Mabey (2013) all highlight that much LMD research has been undertaken from only the dominate positivist, performance focused functional/descriptive approaches. Day *et al.* (2014) and Day and Dragoni (2015) later suggest that more LMD research should be considered from a longitudinal perspective to address the developmental life span of a leader. They note the need for more context relevant leadership which requires addressing. Ultimately, the author chose to explore LMD from the lens of the interpretive, critical and dialogical discourses related to the provision of LMD (Mabey, 2013). Of note, it has been argued that the reluctance to use social process approaches which recognise these neglected discourses in organisational research do depict leadership as a somewhat intangible and an indefinable concept (Carroll and Lester, 2008; Karatas-Ozkan and Murphy, 2010). Hence, it can be reasoned why the application of these neglected approaches to LMD research have been minimal within the conventional literature.

Progressing to chapter five, the research design and method were outlined. Drawing from the previous chapters, the design was initially informed by the formulation of the following research aims:

- To explore how LMD participants experience their NHS LMD training.
- To examine barriers which impact upon the participant's LMD within the NHS workplace, during and after their NHS LMD training.

These aims were mapped onto four research questions, which informed the creation of the semi-structured interview schedule (Appendix 8.) being:

- How did the LMD participants feel about attending their NHS LMD training?
- How did the LMD participants' organisation respond to the LMD participant during and after their NHS LMD training?
- How does the participant feel the NHS LMD training influenced them?
- What, if anything, effected the participants engagement with the NHS LMD training and the NHS workplace?

Addressing the stipulated research aims and questions as above was only a part of this research journey, further consideration was given to '*methodological pluralism*' (Midgley *et al.*, 2017, p. 150) exhibited within this work. From the outset, Bhaskar's (2016) concept of critical realism provided a suitable basis to move past chapter six's interpretive account into chapter seven's critical analysis, while avoiding the creation or assertion of common social law. This

understanding worked well for the socially constructed notions of leadership being explored within the scope of this research; particularly with this research essentially being a case-based study, which utilised two types of analysis to explore situated experience and discursive practice. Kempster and Parry (2011) do promote the use of critical realism and a qualitative approach (such as grounded theory) as a useful theoretical foundation and approach in appreciating the contextualised and complex nature of leadership. Nevertheless, Kempster and Parry (2011) do acknowledge a restraint of critical realism being that its accounts do not suppose generalisation outside a study due to no two situations being identical. At most, critical realism proposes propensities concerning applicability in different circumstances.

To summarise, a triangulation of two qualitative research approaches has formed an appreciation of NHS LMD and its many intricacies. The author argues that each analysis presented as standalone findings would have lacked a more innate contextual depth of understanding. From the beginning there was an endeavour to explore the experiences of NHS LMD participants due to concerns regarding the use of limited NHS resources and LMD's limited evidence base. What has been created is a transitioning appreciation of LMD training issues, workplace factors, participant mind-sets and a presentation of discursive factors which influence the provision of LMD within the NHS.

In respect of the four research questions, the LMD participants reported to have accessed NHS LMD through either being sent, recommended or through their own interest and application. The LMD participants who were sent or felt "*press-ganged into a leadership development course*" (Kyle), still found LMD to be a motivating and useful experience.

LMD participants would often speak about their LMD training and their NHS workplace as being separate entities. Yet, a supportive line manager was emphasised by most participants as being significant here. Several LMD participants presented their workplace as being prevalent with over-controlling management and cultural toxicity. Resistance, with comments regarding "*jealously*" (Dale) from colleagues was also acknowledged when LMD participants applied LMD projects within their NHS workplace. To note Karter suggested that the role of LMD projects did not belong in the LMD training process due to the level of complexity these projects can bring.

Communication was noted to be a common issue of contention for the LMD participant within the workplace. Many participants spoke of how the role of effective communication sustained interpersonal relationships with colleagues. Lack of communication was frequently linked to project failure and was also a potent source of misunderstanding (sections 6.3 and 7.2). Additionally, informal and formal communication approaches were noted to be frequently used as tools to accuse, defend and contradict (sections 7.2 and 7.3). Fairhurst (2008) highlights the potency of communicative practice in leadership and how this understanding contrasts against the psychological approaches of leadership (as

represented in Table 1.) Often, LMD participants reported that LMD training allowed them to highlight the skills deficits of others. This was particularly focused on senior management who would frequently fulfil the role of being the supporter, the antagonist and scapegoat (section 7.3).

Limited time dedicated to LMD within the NHS workplace was additionally reported to have had a significant impact on the LMD participant experience. Some participants reported to have had more dedicated time to LMD than others, with most participants reporting a direct link between time given to the LMD training and their ability to consolidate learning. As Karter and Landry acknowledged, time poverty (section 6.3.4) impacted on their ability to promote innovation and change in their workplace (section 6.3.2). Logan concluded that the NHS has a culture of limited urgency in some areas, with limited time for LMD developmental activities and the development of more innovative practices (sections 6.3.2 and 6.3.4). Drawing on the CDA, it could be contended that time dedicated to LMD could be dependent on how the senior or line manager of the LMD participant values LMD. Overall, LMD participants expressed critical, defensive, normalising and contradictory opinions, which helped recognise some of the tensions which existed between the LMD participant and their NHS workplace and management (sections 7.3 and 7.4). The LMD participants also recognised active resistance by some senior managers who rebuff the LMD discourse. In section 7.4, it was surmised that the LMD discourse and the newer ways of working and flattening organisational structures could be a change too far for some senior managers. These managers may over identify with the more historic transactional and bureaucratic leadership approaches and reject other approaches to leadership. In section 7.3 it was noted in that regardless of the capability of the LMD participant, a realisation that eventually LMD participants may require these 'difficult' senior actors with positional power to progress them within the NHS. The author surmised that the thought of eventual progression in to highly complex NHS roles, could promote high anxiety for the LMD participants.

Interestingly, most LMD participants had a sense of what a leader is, and how these leaders demonstrate leader behaviours developed from their LMD trainings. Day *et al.* (2014) suggest that intrapersonal and interpersonal leadership development were visible with the way many participants spoke about their LMD journey. There was strong regard for the heroic, transformational, staff developmental focused leader (i.e. creating safe learning environments). There was a mixed appreciation for formalised NHS management positioning and hierarchy, which was frequently spoken about in negative connotations (section 6.4.1). Recurrent personal reflections of the LMD participants' leadership style and the importance of leaving a leadership legacy were identified (section 6.4.2). As a concluding remark, several LMD participants felt permitted to challenge old ways of working by using the methods of the new ways taught and encouraged by their NHS LMD training (sections 6.2.2, 6.3.2, 7.4 and 7.5).

8.3 Theoretical and conceptual contributions

In the known literature, this study is one of the first pieces of research to apply the Smith *et al.* (2009) IPA method to capture the lived experiences of LMD participants within the NHS. There are similar studies available which have utilised unspecified qualitative approaches or mixed methods to explore NHS LMD, however methods of research have generally been ill defined i.e. Stoll *et al.* (2011), Bagnall (2012), Grandy and Holton (2013) and so on. Much research in this area has attempted to descriptively assess leadership developmental needs (Grandy and Holton, 2013), define the 'best' LMD intervention or method to generate what would be perceived as 'effective' NHS LMD (Sutherland and Dodd, 2008). Much of this research supports the general notion that experiential learning such as LMD workplace projects, shadowing opportunities and one-to-one coaching type intervention are typically well regarded by NHS LMD participants (Edmonstone, 2011; Bagnall, 2012; Day *et al.*, 2014; West *et al.*, 2015). When not too elaborately applied (sections 6.2.2 and 7.2), the findings of this research do support the effectiveness of these type of developmental process focused experiential LMD interventions.

It is worth recognising, there have been studies which have acknowledged the social arrangements which can hinder effective NHS LMD training-workplace-participant synthesis (Bagnall, 2012; Yukl, 2013; Woods and West, 2014). While other studies and policy documents within the NHS leadership field have attempted to consider the value of certain leadership styles (West *et al.*, 2015). As acknowledged in chapter two, some leadership styles can be more conducive to the implementation of effective healthcare leadership than others (Jasper and Juma, 2005; Yukl, 2013; West, *et al.*, 2015) in the creation of compassionate workplace cultures (Ross, 2016; NHS Improvement, 2016; West, 2017; Hewison, 2018). From this understanding, Wong *et al.* (2010), Sanner-Stiehr and Kueny (2017) and Cummings *et al.* (2018) all highlight the value of socially and emotionally intelligent, authentic and transformational leadership styles within healthcare. The findings from this research do support the assertion that these leadership styles and behaviours, along with the notion of the 'heroic leader' are desirable attributes by the participants. The author suggests that this praise of the heroic leader requires further research. This is due to more recent NHS LMD trainings having a tendency not to over-promote the ideal of the heroic leader in favour of more collaborative approaches (The Kings fund, 2011; NHS Leadership Academy, 2013; The National Skills Academy, 2016).

Initially the focus of the IPA was to implement a hermeneutic interpretation of the experience of NHS LMD participants, it was not necessarily to assert or suggest an LMD intervention or leadership style over another. Nevertheless, participants (Dale and Reagan) reported to have mixed levels of appreciation towards action learning and experiential group learning. This was mostly

dependant on the skills and perceived experience of the facilitator. The appreciation and success of NHS LMD workplace projects was likewise reported to be dependent on the quality of line manager and workplace support and opportunity (section 6.3). The IPA findings recognised three dominant super-ordinate themes relating to the NHS LMD training experience; the experience of being an LMD participant within the NHS workplace and the role of personality, leadership and motivation from the LMD participants' context. Table 4. shows a reductive list of interventions drawn from the IPA (which created the super-ordinate themes), while also indicating where in the mixed NHS/LMD literature these interventions are supported.

As suggested here, it could be argued that future NHS LMD trainings and NHS workplaces which incorporate these LMD interventions presented in Table 4., may well find examples of successful LMD participant growth. This is in line with Sutherland and Dodd (2008), Yukl (2013) and Woods and West (2014) who also recommend the need for closer integration between the LMD training, the NHS workplace and the LMD participant as a catalyst for a positive LMD experience to occur (Figure 17.). As shown in Table 4., some LMD interventions presented as being helpful where more supported within the literature than others.

Table 4. NHS LMD interventions which can contribute towards effective NHS LMD with how they are supported within a selection of the literature

The NHS interventions which this research indicates as contributing towards a positive NHS LMD experience	Mixed examples of where they are supported within the NHS / LMD literature
	*Three sources found with any additional commentary searched for during July 2018.
Carefully managed application, interviews and post-LMD follow ups.	Nothing found which focuses on these arrangements for NHS LMD participants.
Diversity in learning methods, facilitators and peers.	Storey and Holti (2013), West <i>et al.</i> (2015) and Sonnino (2016).
NHS LMD commissioner attendance.	The Kings Fund (2011) and Edmonstone (2013a).
Clean and airy learning environments.	Nothing found which focuses precisely on the nuances of the LMD learning environments.
One-to-one coaching.	Enterkin <i>et al.</i> (2013), Mahoon <i>et al.</i> (2016) and Debebe (2017).
Carefully managed, focused learning activities.	Storey and Holti (2013), West <i>et al.</i> (2015) and Sonnino (2016) (with Harms <i>et al.</i> , 2011 and Arnulf <i>et al.</i> , 2016 recognising the need for care for general LMD training).
Skilled action learning set facilitators.	Pedler and Aboott (2013), Manley and Titchen (2016) and Bloodworth (2018).
Supportive line manager.	Hyrka <i>et al.</i> , (2005), Ahmed <i>et al.</i> (2015) and West <i>et al.</i> (2015).
Opportunities and time to implement projects and reflect on LMD learning.	Frankel (2011), Mahoon <i>et al.</i> (2016) and Beer <i>et al.</i> (2016b).
Opportunities to shadow senior NHS leaders.	Das (2014), Ahmed <i>et al.</i> (2015) and NHS Improvement (2017).
Less workplace cultures of control, toxicity and resistance.	British Psychological Society (2014), Braithwaite <i>et al.</i> (2017) and Nightingale (2018).
NHS LMD needs to promote healthy workplace communication strategies.	Vessey <i>et al.</i> (2009), West <i>et al.</i> (2015), Fitzpatrick (2018) and Wellings and Evens (2018).

LMD needs to acknowledge the complexity of innovation and co-production with end users.	The NHS Leadership Academy (2013) and Castle-Clarke <i>et al.</i> (2017). The evidence base for this type of intervention was not as prevalent as other NHS LMD considerations.
Adhere to the values and ideals of the NHS (such as those set out in the NHS constitution, 2015) / accept private sector reward mechanisms may motivate some staff more.	Storey and Holti (2013), Stephenson (2014) and Fitzpatrick (2018) / no evidence found regarding the private sector rewards considerations and LMD participants.
The cultivation of LMD in early career.	Ahmed <i>et al.</i> (2015), NHS Improvement (2017) and Lees (2018).
Managers need to consistently demonstrate LMD promoted behaviours and the creation of safe learning opportunities.	Tsai (2011), The Kings Fund (2012) and NHS Improvement (2016; 2017).

(Created: Author, 2018)

Recognising the CDA approach utilised within this study, this was the first occurrence in the available literature of a modified Fairclough (2003; 2013) CDA being applied in the analysis of qualitative interview NHS LMD participant transcripts. Ford (2005) did apply a CDA in the form of a feminist critique of the ways in which notions of leadership in NHS organisations fail to consider their potential for gender bias. Sambook (2008) also explored a range of discursive resources utilised by NHS senior managers, with a focus on the clinical/manager hybridity of some roles. In another similar CDA by O'Reilly and Reed (2010), this study of established NHS leaders highlighted three root metaphors (and related tensions) between professionalism, managerialism and leader-ism within the NHS. These root metaphors do share a resemblance to the orders of discourses identified from the CDA established within this research. Discursive arrangements presented here, presume that the LMD discourse is influenced by the operationalisation of these root metaphors. It was asserted during chapter seven, that LMD can be applied as a rhetorical tool to further the intentions of NHS actors to challenge or to reinforce differing centres of power and organisational arrangements (Figure 18.). As such this research suggests that NHS LMD should focus on pursuing an understanding of the LMD participants' needs and gaps in learning; in comparison to solely consolidating power requirements of actors and offering solutions to organisational problems or concerns.

NHS LMD is an unavoidably delicate, complicated endeavour which is dependent on the influence of the multiple specialists, agendas and approaches associated within this field. Consequently, it is suggested that rather than focusing on the

search to recognise one pure method of NHS LMD implementation and intervention, it is emphasised that commissioners, facilitators and organisations should promote an inclusive, co-productive relationship with the LMD participant. LMD commissioner involvement is acknowledged to be desirable by participant Reagan and something which Edmonstone's (2013a) study also endorses. A co-produced and integrated approach towards LMD training development, delivery and evaluation is desirable. This may present with the transparency and inclusiveness of a true collaborative approach, and a contra to the over-focused agendas of certain actors/professional tensions. Both Phillips and Byrne (2013) and Swenson and Gorringer (2016) demonstrate how LMD in a health care environment provides superior outcomes when co-produced with participants.

From a methodological perspective, the application of both an IPA and CDA research approach was a relatively novel one. This thesis has argued that these methodologies are positioned differently, yet they have valid and complementary modes of enquiries. Both Saukko (2005) and Hood (2016) show that through an integrated research design both IPA and CDA do have the capability to deliver an effective investigative double lens. This methodological pluralism has resulted in the co-investigation of the same qualitative data from both the lived experience and the discursive practice of NHS LMD participants.

This pluralist application of utilising both IPA and CDA methods has created a useful dynamic between the two analytic approaches. Applied together, the findings permitted NHS LMD to be understood as a phenomenon that was experienced as well as being structured in discourse. From an IPA approach, the LMD participant lived experienced highlighted the need for closer integration and the effective application of certain favoured LMD interventions. From a CDA viewpoint, the LMD participant experiences were linked to the use of sociolinguistic customs to comprehend their workplace experiences and the application of their acquired LMD skills.

As acknowledged in chapter four, critical and constructionist paradigms have been mostly considered to be discretionary paradigms in the organisational learning literature (Karatas-Ozkan and Murphy, 2010). Nonetheless, this research posed a pluralist method to explore the neglected interpretive, critical and dialogic LMD discourses (Maybe, 2013). By endorsing critical realism, this allowed for an acceptable connection between constructivist epistemology and realist ontological concerns to be considered. Advantages of this approach include the creation of a deeper, contextual understanding of NHS LMD as opposed to a deductive representation. Though issues regarding the simultaneous effort to both create knowledge and to produce a social change of some kind (or to uphold the status quo), can predispose this work to heightened levels of bias (MacCoun, 1998; Hammersley, 2007; 2009). Still, the interjection of hermeneutics towards the interview data has created findings which are highly contextualised, data rich and filled with valuable meaning.

In addition to the contributions this research offers to the NHS, its contribution towards the prevailing knowledge and practice of LMD (Enterkin *et al.*, 2013; Becker and Bish, 2017) through the augmentation of a deeper appreciation and recognition of the complexity associated to this area. The application of a phenomenological and critical research design has contributed to the fields of organisational and leadership research, by acknowledging these approaches as effective methods of research.

Acknowledging the research design, this research recruited participants from a range of differing health-related professions belonging to one regional NHS Trust. The method and design of NHS LMD training delivery which the participant received was not specified, thus allowing for a more representative sample of participants representing the diversity of NHS LMD trainings available (being a retrospective cohort case-based study with two years presenting as the average time from completion of LMD training to interview). The findings represented within this research, were restricted from presenting an over reliance of one professional grouping or one approach to NHS LMD delivery (see table 4. in section 5.5.2).

The concept of professional identity was frequently acknowledged in the earlier reviews of the literature (sections 2.4 and chapter three). Through this review, it was noted that identity has been previously explored within the NHS leadership and management literature, though this is mainly from the viewpoint of the medics (Bagnell, 2012; Spehar *et al.*, 2015; Powell, 2016) and nursing staff (Anderson, 2017). Within this research the use of certain professional NHS clinical-managerial language was noted to re-enforce certain agendas and discourses associated with the professional identity being spoken about by the LMD participants (sections 7.2 and 7.3).

Participants often spoke about examples of where senior managers, who have or have not partaken in LMD, chose not to promote the values and agenda associated with NHS LMD. Some LMD participants found this rejection of LMD difficult to accept (section 6.4.2) and held strong values and motivations of what it means to work within the NHS (but not its reward systems) to be important (section 6.4.3). This is linked to a core assertion that successful LMD occurs when there is interest or personal motivation from the LMD participant to promote effective leadership (sections 6.4.1, 6.4.3 and 7.5). This has been recognised within other NHS related research such as Enterkin *et al.* (2013) who link motivation to the undertaking of a leadership role to the participant holding their workplace in high esteem.

LMD participants such as Kyle and Ash, frequently viewed their LMD training as an opportunity to improve their overall practice (both clinical and managerial). Others recognised the varying degrees of ambiguity which can come with being a leader and leadership as an agenda (Charlie, Karter and Logan). The demanding and complex nature of identity change and the amalgamation of the leader development discourse (as recognised by Day, 2011 and Day *et al.*,

2014) were challenging and anxiety provoking for some participants. This was highlighted when participants (such as Dale and Kai, section 7.4) were empowered by their organisation to confront so called old ways of working, and were subsequently faced with change resistance cultures, unprofessionalism and associated organisational tensions. It could be argued that the junior medics in Bagnall's (2012) study experienced similar issues during the implementation their LMD learning.

The fears associated with the transition into NHS leadership and management roles have been well documented within the literature (Newman, 2012; Storey and Holti, 2013; Lai *et al.*, 2016). Within these studies, staff anxieties of moving into NHS management present as holding pessimistic opinions and apprehensions towards the responsibilities of management. Mahoon *et al.* (2016) recognise the historical negative connotations associated with NHS management and an essence of this is reported throughout chapters six and seven. Lai *et al.* (2016) reported that there is a concern that the impact of undertaking such leadership roles may undermine professional independence and credibility (as acknowledged in section 2.4.3). Relating to Haslam's *et al.* (2011) version of social identity theory (who contend that a leader's role is interconnected to the group they lead), LMD participants switching group allegiances from clinical to hybrid or pure management roles may suffer from this.

With the NHS LMD discourse presenting in a relatively fragile state, this does little to empower the participants who chose or are placed on to LMD to overcome fears surrounding the impact of hybridity. If NHS LMD had a greater range and variety of evidence concerning its effectiveness and a consensus on where and whom by LMD is best delivered; this could conceivably strengthen the discourse of LMD and empower its participants who are concerned about taking on combined clinical-managerial responsibilities. Additionally, participants acknowledged how they found diverse learning methods and external facilitators not directly related to the NHS particularly helpful. A more collective and congruent approach (with diverse interventions and clean learning environments, section 6.2.2) to NHS LMD training was also noted to contribute towards effective LMD. It was established that such a multifaceted approach to NHS LMD training can supplement an individual's skills and values, particularly in terms of curiosity and boundary spanning (Gilburt, 2016). These are skills which are currently wrapped up with the latest iteration of desirable NHS leadership approaches in the form of systems leadership.

From this research it can be contended that NHS workplaces should provide LMD participants with allocated time to develop and reflect on their leadership abilities. Conversely LMD participant growth into leadership will potentially be enhanced, if participants are provided with opportunities to apply their learning within their workplace. Hence, lack of dedicated time to LMD was reported to be a significant issue for the LMD participants (section 6.3.4). To note, LMD

attained prior to the attendance to a more 'formalised LMD training'; participants Kyle and Reagan expressed this as learning through mistakes approach to leadership development. Other participants (Dale, Kai and Logan) suggested that partaking in NHS LMD and the interaction with other participants had helped them with the confidence to apply a more focused approach when networking with colleagues.

The findings from this research additionally proposed that the end of the LMD training was not an end within its self. Pre and Post-LMD care were found to be particularly important (sections 6.2.1 and 6.2.3). In the Arnulf *et al.* (2016) study and alluded to in section 2.5.6 (which recognises the more troubling side of LMD), Arnulf *et al.* (2016) assert that a greater focus should be on ensuring that LMD participants are effectively supported throughout the LMD training journey. Drawn from this research, the author argues that if LMD participants are well supported pre-LMD and not abandoned post-LMD; the notions that the facilitators, senior managers and commissioners of LMD are motivated by other agendas other than the LMD development of participants could be dispelled slightly (section 6.2.3 and 7.3). The role of the NHS workplace support from line managers and organisational arrangements which inspire, or thwart innovation are also important factors to consider here from the context of the LMD participant (sections 6.3.1, 6.3.2, 7.4 and 7.5). As established, the importance of knowledge transfer of intellectual capital and a shared leadership identity can be reliant on an organisation, which permits LMD participants to build on the formalised LMD training approaches (a view shared by Phillips and Byrne, 2013). The organisational and senior management tolerance of LMD participants implementing NHS LMD based projects was indicative of an organisation willing to consolidate LMD participant learning (sections 6.2.2, 7.4 and 7.5).

Reagan found their workplace to be unsupportive and this resulted in LMD project failure. This suggests that a proactive organisational response towards LMD can strengthen the learning and training experienced by LMD participants. Implied within the analysis, LMD trainings require further implementation within the NHS workplace by senior management to support, mentor and coach LMD participants ready for future and progressive leadership roles. Thus, applying the concept of "*scaffolding*" used by Kyle, when reporting how the one-to-one coaching Kyle received supported Kyle's leadership development (section 6.2.2). Kyle also reported that NHS staff who have an interest in an area of practice, should also benefit from opportunities to shadow senior leaders within their field (section 7.5). This could provide opportunities for reverse mentoring to occur, where senior leaders can also learn from different aspects of their organisation and diverse staff groups (Chaudhuri and Ghosh, 2012; DeAngelis, 2013; D'Abate and Alpert, 2017).

To conclude this section, this research contributes to the greater literature by acknowledging the lived experience of the LMD participant and the discursive organisational tensions which surround them. As well as recognising the

responsibilities of the NHS workplace and the LMD commissioners and facilitators, it has emerged that the ability and innate desire to lead are also important considerations (section 6.4.1). Confusion regarding where LMD is best delivered, the various agendas of actors and limited integration between all those concerned with LMD; may result in an over reliance on the traits of the personality of the participants for real leader development to occur (as suggested by participants Charlie and Reagan). This does little to enhance the standing of LMD as a discourse and the importance of challenging the cynicism which accompanies this field (as well as developing its fledgling evidence base). Ultimately these issues must have an impact on the return of investment of the limited NHS funds used to subsidise these expensive trainings.

8.4 Implications for LMD theory and research

The complex field of LMD and its related models and methods explored to the context of the NHS have been discussed throughout this thesis. As represented within the traditional leadership models, these suggest that leadership can be something belonging innately within the leader or to the leader (as recognised in section 2.3.1). Drath *et al.* (2016) argues that within more recent theories of leadership, a mutual ontology occurs where leadership is characterised by actions of leaders applied to followers, through the medium of goal achievement. While this may apply to leadership relevant to certain contexts which require urgent decision making; this depiction does not necessarily work well within the more informal, multifaceted and co-operative type of organisational arrangements observed today. Acknowledgement goes to the ever-increasing occurrence of knowledge-based industries and marketplaces (Gustavs and Clegg, 2005; Hodgson, 2009; Thompson and Smith, 2010). This is combined with an expectation for organisations like the NHS to work in ever increasing partnerships, integration (Timmins, 2015; The Kings Fund, 2017; NHS England, 2014; 2017; 2018b) and to co-produce with end users (Barson, *et al.* 2017; Jabbal, 2017; Ross and Naylor, 2017). The requirement to advance theories of LMD and ways of conceptualising leadership to meet these ever more complex and contemporary demands are increasing.

Prevailing theories of leadership and LMD have predominately reflected on the social influences of the times in which they occur (Collins, 2000; Bolden, 2010b; Jarvis, 2013). However, it is suggested that most leadership development theories are grounded on inadequate and vague evidence (Alvesson and Willmott, 1996; Sundheim, 2014). As such they are particularly limited in accounting for the more diverse understandings and approaches to the concept of leader-ism becoming increasingly prevalent within organisations (O'Reilly and Reed, 2010). Forms of distributed, matrix and systems leadership are all promoted within this expansion of contemporary leader-ism (Storey and Holti, 2013; Fillingham and Weir, 2014; Timmins, 2015). Yet, the assumptions and

operationalised undertaking of the more historic heroic leader continues to be prevalent within the common discourses of leadership. This type of transformational leader was presented during the analysis of these findings (sections 6.4.2 and 7.5), with LMD participants appreciating the bold and heroic approaches. This leader is also required to hold the attributes of being attentive, developmentally focused and emotionally intelligent. This is much to ask of one person and as such the expectation of this perfect leader, may go some way to explain why some managers may reject aspects of the LMD mantra (section 7.4). With the existence of this research and other similar approaches to organisational studies; social process of leadership and LMD theories are now being increasingly pushed (Iles and Preece, 2006; Fisher, 2009; James, 2011; Martin *et al.*, 2014). Still there are disparities in how this is applied to LMD practice with many challenges existing when developing and empowering leaders to let go of historic reductive understandings (The King's Fund, 2012; Dickinson *et al.*, 2017; Day, 2017).

In examining and inferring the accounts of LMD participants, it was also possible to articulate what was of value and of influence on them. The author argues that the application of both the IPA and CDA approaches has worked relatively well here. The triangulation of these analyses has created an inquisitive and valuable assortment of insights, implied meanings, emotional responses, desires and reported physical reactions. Such responses have provided detailed accounts of inherent role contradictions with the CDA allowing for these discursive tensions to become visible.

The findings from this research have run slightly contra to the propensity to create generalised theories of leadership and LMD within the NHS. As alluded to within this section and chapter two, within this field there is a notable push to capture leadership behaviours, characteristics and practices and place them in to ontological domains (Carroll and Lester, 2008; Carroll *et al.*, 2008; Miner, 2015). This attempt of categorisation endeavours to attain a practical, deductive competency required of leaders within organisations. This research leans towards arguing in favour of Hewison and Morrell (2014) who suggest that such leadership competency approaches are insufficient in capturing the political and complex social environments leaders, lead in. An extensive Health Foundation evaluation report by Hardacre *et al.* (2011) also supports the idea that competency focused programmes are not capable of truly comprehending the complexities and nuances of NHS leadership. A further, tangible addition this thesis has contributed to the LMD evidence base, may not originate from the finding's chapters, but from its review of the literature and current debates linked to LMD. This was in the form of its consideration of the relevant discourses associated with work, the role of organisations, leadership and manager learning. A deliberation of the role and purposefulness of work was debated and linked to the role of organisations, LMD and the NHS within this.

With a nod to the CDA utilised within this research, the author asserts that a critical approach to LMD research is fitting and should be applied more frequently within this field. How this could be actioned requires much more consideration than can be considered within this work, however Flyvbjerg (2012) suggests the following when promoting social science research:

"If we want to empower and re-enchant social scientific research, we need to do three things. First, we must drop all pretence, however indirect, at emulating the success of the natural sciences in producing cumulative and predictive theory, for their approach simply does not work in any of the social sciences. Second, we must address problems that matter to groups in the local, national and global communities in which we live, and we must do it in ways that matter; we must focus on issues of context, values and power, as advocated by great social scientists from Aristotle and Machiavelli to Max Weber and Pierre Bourdieu. Finally, we must effectively and dialogically communicate the results of our research to our fellow citizens, the 'public', and carefully listen to their feedback. If we do this – focus on specific values and interests in the context of particular power relations – we may successfully transform social scientific research into an activity performed in public for publics, sometimes to clarify, sometimes to intervene, sometimes to generate new perspectives, and always to serve as eyes and ears in ongoing efforts to understand the present and to deliberate about the future. We may, in short, arrive at social research that matters." (2012, p. 370).

Both LMD and organisational research, can offer much towards modern society. Still, this author suggests that current evidence concerning leadership and LMD fails to be robust enough to effectively inform NHS leaders and policy makers. This thesis can offer NHS leaders, LMD participants and facilitators and students of leadership the opportunity to stimulate debate and empower them to ask inopportune questions. The criticality of these questions requires recognition; as such questions may break down barriers and organisational defences to promote a successful integration of the LMD participants, training providers and the NHS workplace. As a vulnerable discourse, frequently influenced by the agendas of various actors, asking such questions may well empower the LMD agenda to question the commissioning arrangements of NHS LMD trainings. The author argues that greater evidential diversity may mean LMD as a practice could become less susceptible to the functional/predetermined performance focused needs of those who commission and deliver NHS LMD training. This approach may well suggest that further leadership and development may not always be required, to solve an organisations problem (Mintzberg, 2009).

To continue to explore how this work will influence future leadership research, it first must be recognised that in most social science research, some social construction is required. Relating this to the more established quantitative

approaches to leadership research, this understanding is infrequently appreciated (Alvesson and Kärreman, 2000; Fairhurst and Grant, 2010; Mabey, 2013). Merely through identifying expectations and foreseeable biases, researchers may acquire a further realistic understanding for the relative benefits and limitations of a chosen approach to research. As Anderson *et al.* (2008) propose, only through an informed and honest account of ourselves, will we augment our appreciation of the fundamental apparatus of social occurrences. This recognises that we could pick from many different methods of research other than the ones which interest us, thus having the propensity to create degrees of random-creativity. If we choose to progress some approaches to research at the expense of others, research can only partly enlighten a phenomenon.

Furthering the above argument and as acknowledged throughout this thesis, most methods of LMD study are positioned within the positivist, performative functional or realist understanding (Mabey, 2013). This is predominately influenced by the attempt to provide descriptive guidance to managers and leaders. Though this approach is logical, particularly with concerns regarding the need to be able to demonstrate return on investments; this approach can impact on the prospect of LMD research to confront and challenge the way we think about LMD as a phenomenon. On a personal note from the author on this, there was no original intention to undertake a CDA for this research, only an IPA to begin with. Nevertheless, after further research it became clear that a CDA would be required regardless of the original intentions or preferences of the author. It is now felt that undertaking a CDA in addition to an IPA, has enlightened what would have remained hidden under the glare of just one analytic lens.

Further acknowledging the role of the CDA, consideration applies to Alvesson and Karreman (2000), who highlight the difference in how language is used, and how language is understood. This represents language as something which can be examined, as well as being something which can decipher pre-assigned meanings and static connotations. Viewed like this, language is applied through the medium of being a research method which can assist in developing (or disrupting) the denotations attached to texts. The CDA applied in this study is an example of where discourse has been studied to that effect. Reflection of language as ontology highlights how language can constitute social realities and patterns (Höpfl, 1997). What is different from language as epistemology, is that Cunliffe (2001) proposes that when *'language is metaphorical, language and meaning are an embodied practice, and language is indeterminate'* (2002, p. 359). From this perspective, researching-as-practice may not be a neutral data collecting exercise, but an inference of its own.

This research as an intervention of the act of exploring LMD and leadership within one regional NHS Trust may have impacted on the way in which an LMD participant or the associated NHS Trust functions. For example, the LMD

participant interviews frequently assisted participants in reflecting on their LMD training, the behaviour of colleagues and sometimes how this indirectly or directly influenced patient care. This reflection could well be processed further by the LMD participant and actions applied within the participants' workplace to (re)introduce aspects of LMD learning post-research interview. The interviews have influenced how the researcher/author as an LMD facilitator, delivers training. It can be argued that interviews (like the ones applied within this research) are significant and go beyond the purpose of just being a data collection exercise. These interviews may well begin a dialogue and contemplation which can have a significant effect on all those involved as Holmes *et al.* (2007) suggest, sometimes the research process can be a liberating process in its self.

Other implications of this research concern the assortment of perspectives generated by the authors' academic supervisors and colleagues who reviewed the authors' initial findings for theme saturation and compliance. These academics and colleagues supplemented this research process and improved this work, while placing caution to reduce the potential for bias within the research design, approach and the analysis of the qualitative data. Contributions from a variety of experienced supervisors to this research process, future LMD and leadership research could well benefit from this level of support.

To conclude, Alvesson and Deetz (2000) propose that both critical and interpretive research approaches necessitate a suitable '*interpretative repertoire*' (2000, p. 166) for organisational related research. This research has attempted to examine cases/LMD participants from a retrospective cohort, multi-discursive approach. Contributions to LMD theory via the application of a multi-method analysis have occurred, while acknowledging that the boundaries between these two approaches have been vague and porous at times. This view is acknowledged as consistent by Karatas-Ozkan and Murphy (2010), when applying these type of research approaches to organisational research.

8.5 Implications for LMD practice and policy

This research has maintained the idea that LMD is a process which can be more effective when closer levels of integration between those involved occurs. It is asserted from the findings that when certain types of LMD interventions are applied i.e. the use of skilled action learning set facilitators, shadowing of senior managers, adherence to the values of the NHS and so on; participant's experience of NHS LMD may well be enhanced. The findings (particularly the IPA findings) do mostly match some of the recommendations from similar studies, which have considered factors leading to successful healthcare LMD provision (Jasper and Juma, 2005; Yukl, 2013; West *et al.*, 2015). Yet, this research has

focused on the conduct of the NHS workplace and its discursive arrangements as well.

The findings here have suggested that LMD can occur in many different forms, in many diverse places. This variance (i.e. by who and where LMD is best delivered), could be considered a weakness associated to LMD. Though this research suggests that management learning is a varied and fluid concept, and so prescribing how LMD is best delivered is dependent on the needs and desires of each participant and their context. In acknowledgement of the CDA findings and the current literature (Woods and West, 2014; West *et al.*, 2015), it could be maintained that LMD's weakness is not by who or where LMD is to be best delivered, but its small and limited focused evidence base. Without strong evidential backing, it is suggested here that the practice of NHS LMD is at the mercy of the whims and desires of actors, agendas and the agents of those who commission and facilitate it.

Consequently, organisations and those who are thought to be accountable for leadership need to be encouraged not to over focus on their own perceptions of what LMD is and what they desire from it. It is proposed that they need to focus on promoting the conditions, in which the LMD participant can feel supported within their workplace. This may involve forging closer links with LMD facilitators and those LMD participants who have been involved in and would like to become future LMD participants. Considerations, of those leaders and managers that have done LMD and have chosen to reject their learning and the LMD mantra requires further explanation and understanding. Recognition and the promotion of diverse leadership styles and methods, which may not fit established styles of leadership and a prescribed competency profile, also require further investigation. Contemplation of how these diverse leadership formations balance, assist and limit each other is important too. This may contribute towards a deeper understanding of what in these findings was described as 'the old ways' and 'the new ways' of working discourses, their interdiscursive arrangements and the role of LMD within this.

This research has recognised that some LMD participants showed a deep respect for the hands-on type leader, who was bold yet extremely nurturing of their followers. As previously mentioned, the traits which the LMD participants are drawn towards and view as leader ideals sit well within the transformational leadership style, which has been (until more recently) frequently promoted (The NHS Leadership Academy, 2013; Timmins, 2015; Dougal *et al.*, 2018). Nevertheless, the demands of this style of leadership have been noted by Nielson and Daniels (2016) to heighten sickness rates, and instances of burnout and absenteeism in followers.

Undeniably, the findings from both the IPA and the CDA suggest that the concept of LMD can be applied in a rhetorical and dialogic way to augment obligation to managerial goals. Within the education literature, Hatcher (2005) names a similar phenomenon as a '*fundamental contradiction*' (Hatcher 2005, p.

253) between frontline experienced staff (in education) and the demands of performative managerialism. Hatcher (2005) highlights that these frontline staff often find themselves, frequently having to circumnavigate pressures and conflicts often linked to questions of professional identity and managerial function. These do mirror similar contentions presented within the NHS (Barker, 2001; Grint and Holt, 2011; Daly *et al.* 2014).

The findings of this research suggest leadership-as-practice for the LMD participants to be a discursive pursuit within which they can manipulate or be manipulated by the social processes and organisational settings they belong to. With social identity playing a significant part of a leaders' development (Haslam *et al.*, 2011; Bolden *et al.*, 2012). As such, this may advocate an approach to LMD called '*identity work*' (Sveningsson and Alvesson, 2003, p. 1163). Developing leaders (such as the LMD participants) may also be '*entrepreneurs of identity*' (Reicher and Haslam, 2007, p. 127), first acknowledged as an approach to leadership in section 2.3.5. This was exemplified by the developmental actions of participants Kyle and Reagan (section 7.5). Ladkin and Taylor (2010) offers that this understanding is fundamentally hermeneutic as it includes the interchange of sense and the creation of a shared approach, as previously acknowledged in section 8.4. This may well identify that the aptitudes needed of NHS LMD participants are those which are more in line with the concepts of the critical or reflective practitioner, as opposed to what is known as the management scientist or capable manager (Holman, 2000). The focus here was that such leaders and LMD participants can reflect as well as learn from encounter, as opposed to being able to employ a defined competency of leadership practice.

This critical approach towards leadership and LMD necessitates leaders who are willing to question and include others in resolutions, in contrast to the ability to deliver instant solutions or significant actions. It can be also suggested that 'the old ways' as highlighted as a prominent discourse to be historically associated with the latter interpretation of leadership. As previously expressed in chapter two, leadership and LMD can be an undertaking of social capital and interpersonal skill building along with person focused and intrapersonal development (Day, 2001). Consequently, this considers the developmental process to be contingent on leaders who can critically think as opposed to the application of procedural know-how and capability (Grint, 2007; Raelin, 2007a; 2007b). A common discussion within the LMD literature, critical reflection and thinking on leadership performance is thought to be an important developmental cornerstone (Jones-Devitt and Smith, 2007; Baldoni, 2010; Roberts, 2014). This reflective process has been demonstrated throughout the research interview process and has yielded much from exploring the lived experience of the LMD participant.

The application of one-to-one coaching is another important concern at this juncture, with the notion of the coaching relationship providing a "*scaffold*"

(Kyle) or a safe space for the participant. This research supports the increasing range of literature, which emphasises the worth of coaching and mentoring for leaders and managers within the NHS and beyond (Fowler and Gorman, 2004; Hamlin *et al.*, 2006; Fielden and Sutherland, 2009). It is contended in these studies that coaching assists the participants via the transference of knowledge, understanding and space for reflective dialogue. This research agrees with these studies and adds that the approach or background of the coach did not matter to the participant (section 6.2.2). Further research has established that there is also a prolonged effect of mentoring and coaching on obligation and devotion to the organisation (Bradford, 2017), with an appreciation of the coaching approach being an LMD aptitude of its own (Parker and Michael, 2004).

Experiential learning, even with its associated issues i.e. lack of a certain critical edge (Rigg and Trehan, 2004; Cooksey, 2004); LMD participants reported to have mostly benefited from these interventions, if they were not overly elaborate or deemed to be unnecessary (sections 6.2.2 and 7.2). However, diverse LMD learning opportunities such as shadowing others (as suggested by Kyle) can be helpful to the development of leader identity (Cohan *et al.*, 2007; Elash and Long, 2017). This may allow LMD participants to explore their pre-conceptions and entrenched beliefs associated with NHS leadership. Therefore, removing restrictive understandings of leadership and the trialling of new leadership approaches which are more in line with the individual leadership values of the participant (Bolden and Kirk, 2009). This research would even suggest that changing the reward and performance systems applied by the NHS to mirror more private sector reward approaches may incentivise some towards the leadership challenges of the NHS (section 6.4.3). Importantly this does not suggest the LMD participants want to see an erosion of NHS values and beliefs but would like to see a fairer and comparative reward and performance focused reward system of which they believe occurs within the private sector. This research proposes that LMD participants seek the demonstration of NHS values from their senior management colleagues, as opposed to witnessing frequent levels of unprofessionalism which have been commented on.

Further research could consider the appropriateness of LMD which does not consider the greater organisational arrangements within which leaders find themselves in. Reiterating the words of Steve Kerr (former Chief Learning Officer at GE), Raelin (2004) suggests '*you should never send a changed person back to an unchanged environment*' (2004, p. 131), an assertion that LMD and organisational strategy are fundamentally connected. Hewison and Griffiths (2004) additionally agree that when there is too much focus on leadership development (while neglecting the real organisational context), LMD risks being viewed as a fleeting management fad. Yet, as acknowledged within the findings, LMD can embolden, encourage and develop the abilities of leaders; LMD can also undertake a significant discursive purpose within organisations.

The process of participation and those who can attend and those who cannot, may imply the hegemony of certain professional groupings. In some instances, LMD has been applied as a remedial action (for example to address ward-based issue for participant Kyle). In contrast this does question how LMD is to be considered, is it to be an applied remuneration for senior management in acknowledgement of their organisational position? Is it a grooming process of certain chosen people to be compliant apprentice managers? Or is it a corrective mechanism for poor conduct and performance? Within this research, remuneration for senior management position was not directly demonstrated (however senior managers did play a role in LMD facilitation, which was viewed as problematic for Charlie and Karter). Burgoyne *et al.* (2004) and Bolden (2010b) both recognise that LMD is at its most effective when the focus is not so much on what interventions are applied, but how and who applies them. Findings here suggest that interventions which were favoured by participants were dependant on the skills of the facilitator involved. This research concludes that LMD has the potential to be an influential catalyst for leadership change and development. Nevertheless, and adding a seventh barrier to Lake's (2016) six barriers to effective NHS LMD implementation (acknowledged in section 1.2.1); without a critical analytic lens to moderate and to name bias of all those involved in NHS LMD, NHS LMD will remain infrequently poorly implemented and evaluated.

Relevant to contemporary policy regarding clinical leadership and LMD within the NHS, chapter two noted that a discourse of leader-ism and managerialism within the paradigm of NPM and governance are present within the NHS (O'Reilly and Reed, 2010; West, 2015). As recognised there has been a focus on hybrid clinical leaders who can promote change and engage others beyond traditional healthcare boundaries (Dickinson and Ham, 2008; Swanwick and McKimm, 2011). This endeavour has continued through the promotion of systems leadership approaches and behaviours, with integration and collaboration intending to reduce costly duplication of services and waste (Fillingham and Weir, 2014; Timmins, 2015). This research has showed that staff who partake in LMD and wish to proceed in leadership, appear to wrestle with the demands of promoting causes such as innovation and transformation (the 'new ways' of working) also establishing a sense of identity as a leader. Throughout these torsions, the historic reputation of poor and inadequate NHS management plays heavy on the mind of LMD participants, new managers and established staff groups (The Kings Fund, 2012; Ahmed, 2015; Mahoon *et al.*, 2015).

This research has frequently promoted the importance of supportive opportunities for LMD participants to develop and practice their leadership learning. Being provided with time dedicated to their LMD training and the provision of shadowing opportunities are important considerations. Furthermore, these opportunities may allow LMD participants to develop a further understanding of the organisation's strategic objectives and complexities. It was noted that, multi-professional LMD trainings with diverse facilitators and multi-

professional participants were highly appreciated by LMD participants as well (section 6.2.2).

Consolidating this, LMD trainings can be conducive to effective leadership identity construction. However, maintainable benefits of a strong leadership identity and positive outcomes require organisational backing to be in place i.e. encouraging learning cultures, and cross-organisational growth which entrenches a shared perspective. It was significant for LMD participants such as Reagan, to have some developmental freedom to implement their LMD within their workplace.

8.6 Research limitations

As recognised in chapters four and five, this research is subject to several limits and restrictions. Chapter four commented on the limitations of organisational discourses, while chapter five considered methodological limits. Readdressing these and other concerns further, there are additional limitations which have placed restrictions on the data produced from this research.

Firstly, the non-probability judgement sample of nine LMD participants (Balnaves and Caputi, 2001), significantly reduced any level of generalisability attached to these findings. Because of the methodology taken, it was acknowledged early on within this thesis that generalisability was not the intention of this research. The purpose of the research aims, and questions was an attempt to retrieve the accounts of NHS LMD participants and to explore their experiences related to both their LMD training and subsequent NHS workplace experience. To gain a level of meaning required to explore the life experiences of the LMD participant, a limited sample size was applied with a focus on depth rather than breadth. In addition, relatively small sample sizes are common in IPA research (Brocki, and Wearden, 2006; Smith *et al.*, 2013), with a mean sample of between nine and twelve participants being used regularly (Cassidy *et al.*, 2011), with some samples being just one participant (Glasscoe and Smith, 2008). Conversely, what this study did show is that LMD is a multifaceted and continuing process founded on a complex array of political, relational and personal factors which contribute to the maintenance of organisational life. These findings are consistent with other comparable research with higher participant numbers (Sutherland and Dodd, 2008; Yukl, 2013; Woods and West, 2014), therefore the use of nine participants would suggest this has not overly reduced the integrity of the research approach and findings.

Secondly, while an assortment of NHS LMD participants was utilised, a potential restriction was not interviewing the other actors involved in NHS LMD. The perspectives of NHS directors, medical consultants, human resources, commissioners and facilitators were not accounted for. As such this study may lack a fuller appreciation of their part in the design and shaping of NHS LMD

strategy. Yet interviewing these other actors could have provided too much authority to the senior actors and facilitators, while undermining the focus of understanding of the lived experience of the NHS LMD participant. Correspondingly, critical management theorists might also argue that obtaining these accounts would neglect the social and ideological influences which underpin leadership and identity processes of developing leaders (Alvesson and Spicer, 2012). Though, it can be countered that seeking these further accounts would have enhanced the CDA understandings, in relation to the orders of discourse, the use of power towards LMD participants and inter-discourse arrangements.

Thirdly, the interviews applied within this research were performed over a short time frame, as such they are only a cross sectional, retrospective longitudinal glimpse of the LMD participants' experiences. Still, this research has offered an understanding of the role of NHS LMD training as an intervention of growth; hence, the NHS workplace representing a place of LMD participant development, in addition to a destructive and challenging context. This research could have appreciated a greater longitudinal, lifelong effect of NHS LMD trainings on participants, which it did not due to time and cost restraints. Day *et al.* (2014) and Day and Dragoni (2015) do recommend the need for larger scale longitudinal studies as a way forward to study the effectiveness of leadership and approaches to LMD over longer time periods.

Fourthly, from the outset this research has been self-funded and as a result has not been predisposed by any policy agenda, other than the researchers desire to understand the experience of NHS LMD participants and their workplace context. Though it cannot be denied (and acknowledged within chapter one) the themes developed from this research may relate to an agenda of a more efficient and effective use of NHS resources. This is an opinion of the author who from the outset questioned the agendas of those involved in NHS LMD and the perceived disparity between LMD training and the authors' workplace. This push for more transparency regarding the application of NHS LMD may not be shared with others and has also invariably influenced the literature reviews, supervisions and qualitative theme development within this thesis. As an NHS professional and LMD facilitator, the author is aware of the vested interest of this work and the influence of bias which the writer holds. This is a noted criticism associated with qualitative research (Noble and Smith, 2015; Galdas, 2017) and when taking a critical realist stance according to Hammersley (2009; 2014).

8.7 Some future directions for research

This research has provided a unique combined research approach in the investigation of NHS LMD and leadership within organisations. Further areas of exploration may incorporate considerations of those LMD participants who after

attending NHS LMD training, have chosen not to lead. Contemplations of how recent LMD participants (who are or become hybrid clinical-managerial professionals) continue to shape their identities over a prolonged period could require further exploration too. This research primarily recommends that regardless of future areas of LMD interest, there should be further consideration of the neglected LMD discourses as prominent research approaches (Mabey, 2013). Accordingly, contributing to the greater knowledge base of LMD beyond that of the pre-defined performance focused functionalist LMD agenda and its associated bias. It could be argued that this would help strengthen the evidence base for LMD as a discourse and subsequently resist the mixed agendas of the more dominant actors involved within the NHS.

Historically, the NHS tends to address service problems by either concentrating on a few key people or by restructuring, rarely contemplating the drivers which join and empower people towards a collective endeavour (Rose, 2015; Buchan, Seccombe and Charlesworth, 2016; Care Quality Commission, 2017); though there are current attempts to remedy this in the form of the promotion of systems leadership and integrated care systems and organisations (Fillingham and Weir, 2014; NHS England, 2014; 2017; 2018a) and so on. How these systems-based approaches are placed within future NHS LMD training curriculum and operationalised into NHS workplaces is difficult to answer here. Supplementary research considerations may consider the emotional shifts within leaders (as explored by Maddocks, 2014) and how they are affected by the implementation of these new system leadership understandings within hierarchical organisational structures. Something tentatively explored by Fiedler (1986), DeRue *et al.* (2011) advise that additional emphasis should be placed on the cognitive shifts and sense making processes of leaders.

Further discursive approaches towards organisational research, may consider similar approaches to that taken by Forester (2003), who applied comprehensive transcript analysis of business meetings. Through this analysis of discourse, Forester (2003) demonstrated the different way language was employed to communicate meaning, validity, distinctiveness, position and power. Within this study, the participants principally used language to strengthen and to continue to make sense of existing arrangements and relationships. In relation to this research, LMD participants found it difficult to understand why some senior managers and clinicians rejected collaboration and mutual respect, in favour of unprofessionalism and disunity (section's 6.3.2 and 7.3). It can be argued that the discursive approach applied within this research has further potential regarding the practice of leadership, leadership identity and LMD. This approach may well disentangle some of the embedded and interrelating relationships between leadership practice and LMD interventions i.e. exploring the dynamics of action learning sets linked to workplace dynamics and so forth.

Relevant to any future research endeavour, both Alvesson and Deetz (2000) and Bryman and Bell (2015) suggest that there could be possible power disparities

between the researcher and the manager, which favour the manager. Bryman and Bell (2015) additionally acknowledge that there can be difficulties associated with the maintenance of confidentiality. After the undertaking of this research, the writer agrees with these as possible concerns which require extra attention during the application of further leadership research. An additional consideration could be the exploration of those responsible for the national NHS LMD strategy. Providing these senior figures with a voice may open policy formulation processes and address some of the discursive concerns highlighted within this work. This line of inquiry may help shift further accountability for LMD learning to the NHS workplace and, even proactively challenge those managers and clinicians who chose to ignore the LMD agenda (Becker and Bish, 2017).

8.8 Summary

This chapter has principally involved examining the research findings and relating them to NHS LMD theory, research and practice. As a summary, the author suggests that there should be greater NHS LMD research due to the quality, amount and diversity available being relatively limited (in comparisons to other areas of organisational study).

Future NHS LMD research must further acknowledge the existence of the other (less common) LMD discourses, beyond that of the functional/performative discourses. Much can be determined from the under applied interpretative, critical and dialogic discourses explored throughout this work (Karatas-Ozkan and Murphy, 2010; Mabey, 2013). Through the application of an '*interpretive repoitare*' (Alvesson and Deetz, 2000, p. 166) applied within this research; it was apparent that LMD as a field of study with its limited evidence base (Mabey, 2013), can be easily influenced by unhelpful structural forces and poor implementation; this ultimately questioning the effectiveness of expensive formalised LMD trainings as an approach to leader development.

In terms of the exploration of the research aims and questions; this thesis suggests that for a more positive LMD experience to occur there should be greater integration between the LMD participant, LMD training and the NHS workplace (Figure 17.). Certain indicators (or sub-themes) from the IPA did highlight what LMD interventions were deemed to be more helpful in the creation of a 'positive LMD experience'. Some of these interventions were established within the LMD and NHS LMD literature, others require further exploration (Table 4.).

The discursive elements attracted concern by the way LMD was applied as a tool to challenge 'old ways' of working and how LMD participants were influenced by other greater discourses within the NHS. This subsequently leaves NHS LMD training to be a vulnerable endeavour which is not helped by the greater conflict of where LMD is best delivered. This recognises the academy as a place of

knowledge creation, the workplace as a place of leadership development, however important to note that both reinforce management hierarchies.

In terms of NHS LMD specific interventions, these findings suggest that reflective and experiential methods empower LMD participants to learn and grow while valuing their own professional context. Applied with caution, novel and diverse methods of learning and one-to-one coaching seemed particularly popular. To summarise, this thesis adds to knowledge in three distinct ways:

Firstly, a contribution is made to the field of LMD in the analysis and theorising of a topic which has received minimal consideration, in comparison to other areas of organisational research (De Vries *et al.*, 2010; Hartly and Bennington, 2011; West *et al.*, 2015).

Secondly, in embarking on this research and exploration of NHS LMD, a contemporary recognition of how NHS LMD is comprehended and implemented has been captured; this acknowledging its limitations, tensions and problems, but also its potential and value to NHS staff.

Thirdly, both IPA and CDA findings acknowledge the array of actors involved in NHS LMD and how they utilise LMD in a variety of ways which make it assessable to them and a tool to forward agendas. This outcome has highlighted how leaders as learners are subjected to the same influences of organisational power and culture, as all other staff within the NHS.

8.9 Recommendations

This thesis makes the following assertions and recommendations:

- i. Increased integration and closer working relationships between the NHS LMD training providers, the NHS LMD participant and the NHS workplace may enhance the LMD experience for all involved.
- ii. Utilise a co-productive and collaborative approach towards the creation of the NHS LMD training. This can play an important part of an LMD integration agenda and support the various abilities and personality traits of LMD participants.
- iii. The findings from this thesis suggest that the following interventions are appreciated by NHS LMD participants and these interventions are relatively supported within the NHS/LMD literature:
 - a. Diversity in learning methods, facilitators and peers.
 - b. NHS LMD commissioner attendance.
 - c. One-to-one coaching.

- d. Carefully managed, focused learning activities.
 - e. The use of skilled and experienced action learning set facilitators.
 - f. Opportunities and time to implement projects and reflect on LMD learning within the NHS workplace.
 - g. Less NHS workplace cultures of control, toxicity and resistance.
 - h. NHS LMD needs to promote healthy workplace communication strategies.
 - i. Adhere to the values and ideals of the NHS (such as those set out in the NHS Constitution, 2015).
 - j. The cultivation of LMD in early NHS career.
 - k. NHS staff should consistently demonstrate LMD promoted behaviours and create safe learning opportunities for each other.
- iv. The findings from this thesis suggest that the following interventions are appreciated by the LMD participants; however, these interventions are not so well supported within the NHS/LMD literature. These LMD interventions may require further research:
- l. Related to the NHS LMD training process; carefully managed application, assessment interviews and post-LMD follow ups should be implemented.
 - m. The need for clean and airy learning environments.
 - n. NHS LMD needs to acknowledge the complexity of innovation and co-production and how these impact on established NHS staff.
 - o. Acceptance of private sector reward mechanisms, which may motivate some staff further.
- v. This thesis supports Hardacre *et al.* (2011) notion that competency focused LMD trainings are not capable of truly comprehending the complexities and nuances of NHS leadership.
- vi. More diversity and increased quality of both general LMD and NHS LMD research and evidence, which moves beyond the functional, performative and descriptive approaches is required. This could consider the neglected LMD research discourses of the interpretive, critical and dialogic domains used within this research.
- vii. Greater awareness of LMD as a discourse is overly vulnerable to the agendas and hegemony of senior professions, groups and actors involved within it, who may not necessarily have the learning needs of the LMD participant principally in mind.
- viii. The confusion regarding where and who is best to deliver LMD, is not as important as focusing on the context and needs of the NHS LMD participant.

- ix. Accepting methodological pluralism, both IPA and CDA are compatible and useful approaches in organisational and leadership research.
- x. LMD should continue within the NHS as participants reported that their NHS LMD training experience to be a stratifying and a rewarding experience.

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Appendix 1. Literature review search strategy of NHS LMD

Literature review search					
Database and date of search.	Reason for choosing database / Filter settings.	Search terms.	Number of results.	Comments.	
NU Central 04/01/17	Primo A wide ranging and well-resourced sourced literature drawn from multiple databases (within the past ten years).	"Leadership Development" (S1)	377,433	Too large and too varied returns.	
SHU library search 04/01/17	As above (peer reviewed and within the past ten years).	"Leadership Development" (S2)	435,357	Too large and too varied returns.	
NU Central 04/04/17	Primo Peer reviewed and works within the past ten years.	"Leadership AND Development AND Health" (S3)	3,757	More focused returns.	
SHU library search 04/01/17	Peer reviewed and works over the past ten years.	"Leadership AND Development AND Health" (S4)	4,231	More focused returns.	
Manual search between the search returns. 04/01/17 to 27/04/17	Peer reviewed and within the past ten years (NHS England and Scotland plus general relevance).	Results from S3 and S4 search combined and compared.	37	After an intensive process of hand sorting 7,988 results (the reading of introductions, abstracts and summaries / conclusions, as well as removal of duplications) 37 pieces of literature were deemed appropriate.	

Total number of results: 10

After further review, 10 pieces of literature were ultimately selected for further critique.

Appendix 2. Summary of studies reviewed.

Author/s, year published and journal or funding organisation	Topic	Type of study, No. of participants or evaluations / documents reviewed, data gathering and methods	Main themes / Findings	Identified implications and limitations of the study
(Study No. 1) Sutherland and Dodd (2008) <i>International Journal of Health Care Quality Assurance</i>	NHS Lanarkshire's leadership development programme's impact on clinical practice	Qualitative study of 44 senior clinical managers interviewed at various stages of their leadership programme. Thematic analysis used, and exemplars of text provided within the article to demonstrate theme development.	The programme under review reported to be effective in changing participants' attitude, behaviour and performance, during and post their NHS LMD. Exemplar quotes from participants throughout the paper are applied to demonstrate this change. The authors highlight the power of action learning and role plays as being the most memorable and influential change techniques.	Time constraints merited two different cohorts being examined simultaneously during the various stages of the LMD. A longitudinal study is reported to be underway encompassing the evaluations of these different cohorts. No acknowledgment of workplace difficulties and barriers faced by participants; poor training experiences were not recognised.
(Study No. 2) Stoll, Swanwick, Foster-Turner and	Leadership development for junior doctors: What can we	Both qualitative and quantitative data was iteratively applied to evaluate the learning from this fellowship programme.	The foremost findings indicated that the Fellows demonstrated clarity of purpose and the need for a supportive workplace was	The extent to which results are generalisable needs to be considered within the constraints of this programme

Moss (2011) <i>International Journal of Leadership in Public Services</i>	learn from Darzi Fellowships in clinical leadership?	Not clear on the number of participants used though data collection methods ranged from interviews to questionnaires.	critical to the ultimate realisation of benefits from the Fellowship programme to be realised.	evaluation. This is important in relation to the expense of running these programmes and one's similar.
(Study No. 3) Hardacre, Cragg, Shapiro, Spurgeon and Flanagan (2011) <i>The Health Foundation</i>	What's Leadership got to do with it?	A mixed quantitative and qualitative design. 44 doctors participated from six NHS Health Foundation backed LMD trainings. Semi-structured interviews, paper-based surveys and organisational based blind counterfactual interviews were used for data collection.	This intensive evaluation concluded that coaching, informal networking, academic input and action learning were the most relevant interventions which contributed towards quality improvement. This evaluation also established that engagement and interpersonal competencies alone are not enough to influence the complexity of healthcare quality improvement.	This study recognises that while the sample comprised of a range of clinical and managerial leaders from different professional backgrounds, it arguably does not represent a typical range of leaders within the NHS. It also noted to be a relatively small sample, compared with the number of clinicians and managers affecting improvement in the NHS. The study concludes that the need for a supportive organisational culture is important to embed learning, though this was not covered within this study.

(Study No. 4) Bagnall (2012) <i>The Kings Fund</i>	Facilitators and barriers to leadership and quality improvement	Qualitative study of 27 junior doctors from six NHS LMD trainings, interviewed face-to-face or over the phone. Thematic analysis used.	The influence of organisational culture and politics stood out as well as one-to-one coaching and action learning interventions being the most influential interventions within the LMD trainings. Informal networking additionally acknowledged as helpful.	Assumed that all junior doctors want to become leaders after clinical practice or after attending LMD training. The study indicates that it was subjected to significant time restraints and that findings are limited to the number of participants used.
(Study No. 5) Edmonstone (2013a) <i>Leadership in Health Services</i>	Healthcare leadership: Learning from evaluation	Evaluations of eight NHS LMD training evaluations conducted over a 13-year period. Covering 1,653 people from first-line clinical management to executive director positions. The studies were evaluated in terms of the staff groups, numbers involved in the programme, duration, programme elements, evaluation approach adopted and key learning points.	This wide ranging evaluation of evaluations highlighted the key learning points to be issues of the lack of work place support, conceptual fuzziness and difficulties related to stakeholder engagement.	The framework developed from the review may be useful to those commissioning, designing, delivering and evaluating NHS LMD trainings. There was also a limited understanding of the journey and organisational contexts which either hindered or assisted the embedding of LMD learning within the NHS workplace.
(Study No. 6)		A purposive sampling survey method was applied	Primary measures reported on the creation, facilitation and	Multiple factors recognised the impact LMD will have on

Enterkin, Robb and McLaren (2013) <i>Journal of Nursing Management</i>	Clinical leadership for high-quality care: Developing future ward leaders	to scrutinise the effectiveness of NHS LMD trainings. 36 out of 60 participants who finished the LMD training completed an evaluation. The study was described as a feature of an academic accreditation programme. Data was prepared into subdivisions and then organised into greater themes using a thematic analysis method (Braun and Clarke, 2006).	evaluation of an NHS LMD for ambitious ward leaders of an English NHS trust. Organised role development and supervision was supported to enhance the desirability of management roles in nursing. The requirement of an understanding / mature networks in line the greater context was reported to have been increased by participating in LMD. Positive feelings regarding the organisation and participants role was also linked to greater retention.	the future of the nursing workforce internationally, was acknowledged. This comprising of projected workforce deficit and LMDs influence on capability and succession planning. Main drawback of this paper being that only those who completed the questionnaire were involved and consequences for future research are that longer term follow-up is required.
(Study No. 7) Phillips and Byrne (2013) <i>Journal of Clinical Nursing</i>	Enhancing frontline clinical leadership in an acute hospital trust	A qualitative study to evaluate an NHS LMD which used 22 participants who had finished their NHS LMD training. Participants completed a semi-structured questionnaire at each transition stage. Action learning was assessed for effectiveness via a multi-structured questionnaire. The sampling strategy was purposive due to the NHS LMD training being focused towards a subsection of staff	Primary measures applied by the researchers accounted for a cohort for NHS ward managers focused on enhancing their involvement towards achieving important organisational objectives. Outcomes proposed that challenges occurred during the development of leadership abilities, particularly growing new nurse leaders. Consequences for NHS LMD is that it should not be developed in isolation. Organisational	It is suggested here that learning organisations are required to maintain the distribution of best leadership practice via communities of practice. There is an assertion that internal trainings are cost-effective, (in comparison to LMD external trainings), though it could be beneficial for LMD trainings to be multi-disciplinary. Individuals that partake in LMD should demonstrate obligation to the

		belonging to the NHS organisation sampled.	backing is important for participants to generate their own personal and professional development as well.	process and the organisation by the achievement and respect of the training and its associated interventions.
(Study No. 8) Hewison and Morrell (2014) <i>International Journal of Nursing Studies</i>	Leadership development in the English National Health Service: A counter narrative to inform policy	A policy review informed by the concept of episteme. Relevant data policy and related literature was utilised in the development of a counter narrative against the current trend of competency-based NHS LMD trainings.	This paper argues that leadership can take many forms and varies hugely according to the task and context. Acknowledging that this form of counter narrative offers a contribution to more constructive policy development in the NHS and more widely. This paper contends that a more nuanced debate about LMD and the need for greater diversity is required.	Within this review there was a lack of data and literature noted to be in favour of competency framework-based LMD or positive examples of experimental professionalism. Arguments for the use of such frameworks may well be related to demonstrating to commissioners what providers are 'going to do' for their money, quality and so on.
(Study No. 9) Mahoon, Bartlett, Dickinson and Glanville (2015)	Literature review of the clinicians as improvement leaders	A literature review which consisted of the review of the evidence and data extraction from 8422 records from eleven	This review of the literature concluded that the most useful aspects of the interventions were noted to be the use of real-world change projects, coaching and mentoring and learning linked to achieving	This review recognises that several studies were originally evaluated poorly, and questions arose regarding the vested interests of the evaluators of these studies. This is a clinician LMD training

<i>The University of York</i>	following training in improvement and large-scale change	bibliographic databases. 136 full documents relating to the NHS LMD of clinicians were obtained.	individual aims. This review also recognised barriers such as the desire to lead and ultimately surmises that there is an apparent culture within the NHS which dissuades future leaders.	focused only review, consequently misses out on the opportunity to evaluate the valued LMD experiences of none clinical staff within the NHS.
(Study No. 10) West, Armit, Loewenthal, Eckert, West and Lee (2015) <i>The Kings Fund</i>	Leadership and leadership development in health care: The evidence base	For this review it was reported that a literature search was conducted across multiple databases. The search terms were described to be limited to NHS related articles published in the last 10 years, and peer-reviewed. A separate review was also reported to have been conducted which looked at the grey literature and trade press.	Overall, this review suggests that there is little robust evidence for the effectiveness of specific NHS LMD trainings. Some trainings were reported to work for some people, some of the time, but evaluating effectiveness and impact on patient care was reported to be challenging. Much of the available evidence reported from this review highlighted the importance of collective leadership and advocated an equilibrium between individual skill enhancement and organisational capacity building.	Applied research was based on very small sample sizes or specific settings. Hence, the knowledge gathered from this review and in general on NHS LMD is restrictive and this review reflected this. This review also suggests, it is highly pertinent for health care to draw from generic LMD literature, to help improve understanding of NHS LMD.

Appendix 3. DPM Project Planner – September 2015 to September 2018

Project Planner

Period Highlight: 1

Plan

Actual

% Complete

Actual (beyond plan)

% Complete (beyond plan)

ACTIVITY	PLAN	PLAN	ACTUAL	ACTUAL	PERCENT	PERIODS																																								
	START	DURATION	START	DURATION	COMPLETE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	8th September 2018	29	30	31	32	33	34	35	36	37				
Firm up proposal	1	3	1	0	0%																																									
Start NHS ethical approval process	1	3	1	0	0%																																									
Begin compiling chapter one	1	3	1	0	0%																																									
Make contacts with EMLA etc...	4	4	0	0	0%																																									
Finish chapters one and two	4	4	0	0	0%																																									
Gain ethical approvals	1	7	0	0	0%																																									
Secure research resources	8	2	0	0	0%																																									
Perfecting interview design	8	2	0	0	0%																																									
Recruiting/Sampling	8	8	0	0	0%																																									
Pilot interview	8	4	0	0	0%																																									
Compilation of chapter three	8	4	0	0	0%																																									
Participant interviews	8	8	0	0	0%																																									
Re-drafting of chapters one & two	12	4	0	0	0%																																									
Transcription of audio material	12	4	0	0	0%																																									
Theme analysis	16	5	0	0	0%																																									
Compile chapter four	17	4	0	0	0%																																									
Participant conformation	21	4	0	0	0%																																									
Compile chapter five	21	4	0	0	0%																																									
Link to/draft chapter six	23	2	0	0	0%																																									
Review chapter two	25	1	0	0	0%																																									
Write up chapter six	25	2	0	0	0%																																									
Write up chapter seven	26	2	0	0	0%																																									
Drafting, re-drafting & citation checking	26	3	0	0	0%																																									
Abstract, dedications and contents	28	1	0	0	0%																																									
Activity 25	0	0	0	0	0%																																									
Activity 26	0	0	0	0	0%																																									

Appendix 4. Copy of the university research indemnity insurance

HENDERSON
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Capitol Park
Leeds
LS27 0TS

26th July 2017

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Fax 0113 393 6363

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Our Ref: 5701854

Dear Sirs,

EVIDENCE OF INSURANCE – The University of Nottingham &/or Subsidiary Companies

We are writing to confirm that we act as Insurance Brokers to the above client and that we have arranged liability insurance on their behalf as detailed below:

EMPLOYERS LIABILITY

Cover in respect of indemnity for claims made for death, injury or disease to any person arising out of and in the course of their employment.

INSURER	:	QBE Insurance (Europe) Ltd
POLICY NUMBER	:	Y078413QBE0116A
PERIOD OF INSURANCE	:	1 st August 2017 to 31 st July 2018
LIMIT OF INDEMNITY	:	£25,000,000 each occurrence including costs and expenses

PUBLIC/PRODUCTS LIABILITY

Indemnity in respect of claims made for death, injury or disease to persons (other than employees) or loss or damage to third party property arising out of and in the course of the business.

INSURER	:	QBE Insurance (Europe) Ltd
POLICY NUMBER	:	Y078413QBE0116A
PERIOD OF INSURANCE	:	1 st August 2017 to 31 st July 2018
LIMIT OF INDEMNITY	:	£35,000,000 each occurrence (and in the aggregate in respect of Products Liability)

PROFESSIONAL INDEMNITY

Indemnity in respect of the Legal Liability to Third Parties for breach of professional duty due to negligent act, error or omission in connection with your business.

INSURER	:	Royal & Sun Alliance
POLICY NUMBER	:	RKK792185
PERIOD OF INSURANCE	:	1 st August 2017 to 31 st July 2018
LIMIT OF INDEMNITY	:	£10,000,000 each occurrence and in the aggregate

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Appendix 5. Copies of all relevant approval and permission letters from the required bodies to undertake this research

9/1/2018

17RS002 IRAS 216563 Confirmation of Capacity and Capa... - Mark Gallagher-Read

17RS002 IRAS 216563 Confirmation of Capacity and Capability at Nottingham University Hospitals NHS Trust

Hobbs Jo (Research & Innovation) <Jo.Hobbs@nuh.nhs.uk>

Fri 1/19/2018 3:28 PM

To: Mark Gallagher-Read <lqxmjre@exmail.nottingham.ac.uk>;

2 attachments (346 KB)

Conditions of Confirmation of Capacity April 2016.pdf; IRAS ID 216563 HRA statement-of-activities.docx;

Dear Mark

RE: IRAS 216563 Confirmation of Capacity and Capability at Nottingham University Hospitals NHS Trust

R&I Ref: 17RS002

Full Study Title: Exploring the experiences of NHS leadership development graduates

Sponsoring Organisation: University of Nottingham

This email confirms that **Nottingham University Hospitals NHS Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on **19 January 2018**.

Please be aware this confirmation of capacity is provided on the understanding and provision that you will follow the conditions set out in the attached document (NUH R&I of Confirmation of Capacity and Capability Conditions, v1).

The following documents were reviewed:

- The final document set assessed and approved by HRA Approval is listed below.
 - Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) 26 July 2017
 - IRAS Application Form [IRAS_Form_19102017]
 - Letter from sponsor 29 September 2017
 - Participant consent form [Consent Form & PIS] 1.0 15 October 2017
 - Participant information sheet 1.0 15 October 2017
 - Research protocol or project proposal 1.0 15 October 2017
 - HRA Schedule of Events 23 October 2017
 - HRA Statement of Activities 23 October 2017
 - Interview schedules or topic guides for participants 1.0 15 October 2017

If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Dr Maria Koufali

Deputy Director Research and Innovation

Please note that the R&I department maintains a database containing study related information, and personal information about individual investigators e.g. name, address, contact details etc. This information will be managed according to the principles established in the Data Protection Act.

<https://outlook.office.com/owa/nottingham.ac.uk/lqxmjre@UniofNottm.mail.onmicrosoft.com/?viewmodel=ReadMessageItem&ItemID=AAMkADY0...> 1/2

DPM Thesis: Leadership and management development within the NHS: A phenomenological and critical account

9/1/2018

17RS002 IRAS 216563 Confirmation of Capacity and Capa... - Mark Gallagher-Read

Kind regards

Jo Hobbs

Research Facilitator
Divisions of CAS and Clinical Support
Research and Innovation
Nottingham Health Science Partners, Nottingham University Hospitals NHS Trust
C Floor, South Block, QMC Campus, Derby Road
Nottingham NG7 2UH
T: 0115 9249924 ext 70679

E: jo.hobbs@nuh.nhs.uk
w. <http://www.nihr.ac.uk/nihr-in-your-area/east-midlands/>

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Nottingham University Hospitals NHS Trust

City Hospital campus | Hucknall Road | Nottingham | NG5 1PB | Tel: 0115 969 1169
QMC campus | Derby Road | Nottingham | NG7 2UH | Tel: 0115 924 9924

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DPM Thesis: Leadership and management development within the NHS: A phenomenological and critical account



**University of
Nottingham**
UK | CHINA | MALAYSIA

**Faculty of Social Sciences
School of Sociology & Social
Policy**
University of Nottingham
University Park
Nottingham
NG7 2RD

29/11/2017

Reference: HRA approved November 2017

Dear Mark,

Your application for ethical approval from the School of Sociology and Social Policy

On behalf of the Research Ethics Sub-Committee, I am pleased to confirm that your project "*A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees*" has been reviewed and approved and you are now welcome to begin your data collection.

If you propose to make any amendments to the approved project or supporting documentation, you must first send details of the amendment along with any supporting documents to the Research Ethics generic email address, LQ-ResearchethicSSP@exmail.nottingham.ac.uk for approval. Please do not use any unapproved or amended documents or procedures before these have been reviewed and approved by the Ethics Sub-Committee.

If you have any queries during your project, please contact either the Research Ethics administration team or your academic supervisor(s).

Good luck with your project!

Kind regards

**Dr Alison Mohr
Research Ethics Sub-Committee Officer**

+44 (0)115 951 4860
LQ-researchethicSSP@exmail.nottingham.ac.uk
nottingham.ac.uk/sociology

Mr Mark Read
Post Graduate Researcher/Doctorate Student
The University of Nottingham
School of Sociology and Social Policy, Law and Social
Sciences Building
University Park
Nottingham
NG7 2RD

Email: hra.approval@nhs.net

23 October 2017

Dear Mr Read

Letter of HRA Approval

Study title: A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees.
IRAS project ID: 216563
Protocol number: 1
Sponsor The University of Nottingham

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Page 1 of 9

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *“After HRA Approval – guidance for sponsors and investigators”* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

IRAS project ID	216563
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We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **216563**. Please quote this on all correspondence.

Yours sincerely

Miss Lauren Allen
Assessor

Email: hra.approval@nhs.net

*Copy to: Ms Angela Shone,
Lauren Blackburn, Nottingham University Hospitals NHS Trust*

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Covering letter on headed paper [Covering letter]	1	15 October 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		26 July 2017
HRA Schedule of Events	1.1	23 October 2017
HRA Statement of Activities	1.1	23 October 2017
Interview schedules or topic guides for participants [Participant interview schedule]	1	15 October 2017
IRAS Application Form [IRAS_Form_19102017]		19 October 2017
Letter from sponsor		29 September 2017
Participant consent form [Participant consent form]	1	15 October 2017
Participant information sheet (PIS) [PIS]	1	15 October 2017
Referee's report or other scientific critique report [Referee's declaration of scientific relevance]	1	15 October 2017
Research protocol or project proposal [Project protocol]	1	15 October 2017
Summary CV for Chief Investigator (CI) [Summary CV of CI]	1	15 October 2017
Summary CV for student [Summary CV of student]	1	15 October 2017
Summary CV for supervisor (student research) [Summary CV of supervisor]	1	15 October 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Summary_Flow Chart v.1]	1	15 October 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Mr Mark Read
 Tel: 07462392867
 Email: markread2002@hotmail.com

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities and Schedule of Events will act as the agreement between the sponsor and site. Although formal confirmation of capacity and capability is not expected of all or some organisations participating in this study (see

Page 5 of 9

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			<i>Confirmation of Capacity and Capability</i> section for full details), and such organisations would therefore be assumed to have confirmed their capacity and capability should they not respond to the contrary, we would ask that these organisations pro-actively engage with the sponsor in order to confirm at as early a date as possible. Confirmation in such cases should be by email to the CI and Sponsor confirming participation based on the relevant Statement of Activities and information within this Appendix B.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No funding will be provided to the site.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No identifiable data will be stored on home or personal computers. The applicant has outlined arrangements for transferring data securely from the site to the University.
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments

Section	HRA Assessment Criteria	Compliant with Standards	Comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one site type. The Research and Development team at the Trust will be asked to assist with sending the study information to staff participants. Consent and interviews with staff may be conducted in non-patient care areas of the site or at the University.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

The HRA has determined that participating NHS organisations in England **are not expected to formally confirm their capacity and capability to host this research**, because all study activity will be conducted by the external research team other than sending an invitation email which will be sent to all staff by the sites Research and Development Team. Up to 12 staff members will take part in an hour long interview which can be undertaken in non-working hours.

- The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary.

- Following issue of the HRA Approval letter, and subject to the two conditions below, it is expected that these organisations will become participating NHS organisations 35 days after issue of this Letter of HRA Approval (no later than **27th November 2017**):
 - You may not include the NHS organisation if they provide justification to the sponsor and the HRA as to why the organisation cannot participate
 - You may not include the NHS organisation if they request additional time to confirm, until they notify you that the considerations have been satisfactorily completed..
- You may include NHS organisations in this study in advance of the deadline above where the organisation confirms by email to the CI and sponsor that the research may proceed.
- The document "Collaborative working between sponsors and NHS organisations in England for HRA Approval studies, where no formal confirmation of capacity and capability is expected" provides further information for the sponsor and NHS organisations on working with NHS organisations in England where no formal confirmation of capacity and capability is expected, and the processes involved in adding new organisations. Further study specific details are provided the *Participating NHS Organisations and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections of this Appendix.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A key contact should be identified at the site to assist with sending the study information to staff participants.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

No access arrangements are expected as interviews will involve NHS staff only and will not be conducted in patient care areas of the site.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

- The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

IRAS project ID	216563
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Appendix 6. Copy of participant information sheet



Participant Information Sheet (Final Version 1.0: 15/10/2017) IRAS Project ID: 216563

Title of Study: **A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees.**

Name of Researcher: Mark Read **Chief Researcher:** Prof Ian Shaw

I would like to invite you to take part in our research study. Before you decide I would like you to understand why this research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The aim of this study is to explore the experiences of participants who attended a NHS leadership and management development training. Understanding these experiences may help improve the long-term outcomes of similar trainings as well as improving the learning experience for future participants.

Why have I been invited?

The inspiration for this project originates from the Mid Staffs NHS Trust Public Inquiry by Robert Francis QC (2013), which highlighted the need for a new culture of person centred care and the need for 'strong patient centred healthcare leadership'. The Government's response to the Francis Inquiry was to significantly increase funding to NHS Leadership Academies to develop and provide high calibre leadership trainings.

With NHS leadership and management development trainings becoming increasingly available to NHS staff, this study endeavours to understand the individual experiences of those who attend these trainings, as well as the impact attendance has had on the career aspirations of participants since 2006. Using the qualitative methodology of interpretive phenomenology, feedback from the participant interviews will attempt to uncover themes and values which will enable the understanding of participant experiences and the impact these trainings have had on the career aspirations of previous attendees. This research is looking for nine to 12 participants to generate enough information to ensure themes can be developed and in-depth understandings attained.

I am seeking participants who have attended NHS delivered or commissioned leadership and management development trainings since 2006 and are also over the age of 18.

Do I have to take part?

It is up to you to decide whether to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

Page 1 of 3

A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees Participant Information Sheet Final v1.0 15/10/2017

DPM Thesis: Leadership and management development within the NHS: A phenomenological and critical account

What will happen to me if I take part?

Your participation will involve a face to face, sound recorded interview by me, Mark Read (Researcher) and it will last around 60 minutes with a 5-minute debrief afterwards. The interview can be undertaken within your workplace, outside a patient area or in a pre-booked room at The University of Nottingham, Law and Social Sciences Building. A recorded telephone interview can also potentially be arranged if there are problems with arranging a suitable day/venue for the interview to take place in person. A translator can additionally be sort if this is appropriate. Details will be discussed and confirmed during the telephone selection interview/email discussion, though I am contactable during office hours if required.

Expenses and payments

Participants are not paid to participate in the study.

What are the possible disadvantages and risks of taking part?

Taking part in the interview may bring about difficult feelings related to the situations you were involved in during your training/development. Details of the local occupational health department will be available to you. Please be reassured that confidentiality will be maintained at all times.

What are the possible benefits of taking part?

Material from this interview will contribute towards a deeper understanding of experiences related to your NHS leadership and management development training. It may be a cathartic process for you. Potentially this research may improve the experiences of future participants and improve the longer-term outcomes of future NHS leadership and management development training. This will be done by getting to the heart of what really matters and what makes a difference to the performance of managers and leaders within the NHS.

What happens when the research study stops?

If the research must conclude before completion of thesis, all data and recordings will be destroyed.

What if there is a problem?

If you have a concern about any aspects of this study, you should ask to speak to myself who will do his best to answer your questions. My contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Prof Ian Shaw at The University of Nottingham, School of Sociology and Social Policy who is the Head of the School and Chief Investigator linked to this research.

Will my taking part in the study be kept confidential?

I will follow ethical and legal practice and all information about you will be handled in confidence. All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database within The University of Nottingham.

Your personal data (name, relevant addresses and contact telephone number) will be kept for up to 12 months from the date of your interview, so I am able to contact you about the findings of the study (unless you advise me that you do not wish to be contacted). This personal data will be stored on The University of Nottingham secure server for 12 months then deleted. Only myself (Mark Read) and Prof Ian Shaw will have access to this personal information. After 12 months,

Page 2 of 3

A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees Participant Information Sheet Final v1.0 15/10/2017

anonymous research data (with no personal identifiers) will be kept securely for a further 25 years. This will be within the secure thesis cupboard/room based within The University of Nottingham, Law and Social Sciences Building, University Park (room B23). After this time, your data will be disposed of securely. During this time, all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team (Prof Ian Shaw and Mark Read) and the designated admin manager who maintains the cupboard will have access to your data.

To add although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

This research will be of a publishable standard as it is part of a doctorate degree course awarded by The University of Nottingham.

Who is organising and funding the research?

This research is being organised by The University of Nottingham and is being funded by myself.

Who has reviewed the study?

- Health Research Authority (HRA)
- Nottingham University Hospitals NHS Trust Research Department
- The University of Nottingham School of Sociology and Social Policy Ethics Committee
- Two senior academics/research staff based at The University of Nottingham

Further information and contact details

Mark Read
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A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees Participant Information Sheet Final v1.0 15/10/2017

Appendix 7. Copy of participant consent form



CONSENT FORM (Final Version 1.0: 15.10.17)

Title of Study: A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees.

IRAS Project ID: 216563

Name of Researcher: Mark Read

Chief Investigator: Prof Ian Shaw

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1 dated 15th October 2017 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far can be erased if I wish it to be. ☐
3. I give permission for Mark Read and Prof Ian Shaw to have access to the recordings and to collect, store, analyse and publish information obtained from my participation in this study. ☐
4. I understand that the interview will be recorded and that anonymous direct quotes from the interview and if appropriate my generic profession/job role may be commented on within the thesis, but no names or locations will be mentioned. ☐
5. I understand that identifiable and personal information will be securely held and maintained by The University of Nottingham for no more than 12 months, none identifiable information no longer than 25 years post-interview. ☐
6. I understand that my personal details will be kept confidential, though Mark or Ian may confidentially contact you if required to do so for as long as we have your personal contact details (12 months after recording). ☐
7. It is ok to be potentially contacted by phone call, by the researcher post interview (within the next 12 months) in the assistance of clarifying information drawn from the interview. ☐
8. I would like a completed copy of the thesis related to this research once it is complete. ☐
9. I agree to take part in the above study. ☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

2 copies: 1 for participant and 1 for the Instigator file

Appendix 8. Copy of the definitive semi-structured interview schedule of questions

Semi-Structured Interview Schedule

(Final Version v 1.0: 15.10.17)

Title of Study: A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees.

IRAS Project ID: 216563

Name of Researcher: Mark Read

Begins: Thank you for agreeing to be interviewed about your experiences of NHS Leadership and Management Development programme or training and how these experiences has influenced your career aspirations. Please answer as openly as you can, but do not feel obliged to answer any question you would rather not.

Part One

Main Question

- Can you tell me about your leadership training please?

Sub-Questions (if not touched upon during the main question answer)

- How did you get onto the training?
- Where and when was it?
- How many sessions of the training did you attend?
- What was the training environment like?
- How long was the training for?
- Tell me about the main features of the training?
- How many people do you think were on the training with you?
- Where were the other people from?
- How did you find the facilitators? (if appropriate)

Example Clarifying Questions/Probes (if required)

- Can you expand a little on this?
- Can you tell me anything else?
- Can you give me some examples?

Part Two

Main Question

- How did you find the training?

Sub Questions (if not touched upon during the main question answer)

- Can you tell me about your expectations of the training?
- Did the training meet your expectations?
- Do you feel the training met your learning needs?

1

A qualitative research study: NHS leadership and management development training and understanding the experiences of attendees Interview Schedule Draft v1.0 15/10/2017

- What did you find to be the most interesting parts? *(if appropriate)*
- Can you tell me about any disappointments related to the training?
- Would you change anything about the training? *(if appropriate)*

Example Clarifying Questions/Probes (if required)

- Can you expand a little on this?
- Can you tell me anything else?
- Can you give me some examples?

Part Three

Main Question

- How did your organisation respond to you during and after your leadership training?

Sub-Questions (if not touched upon during the main question answer)

- How did you find people around you, when you applied what you had learned to practice?
- How was your line manager with you?
- How did you find other professionals from different disciplines? *(if appropriate)*

Example Clarifying Questions/Probes (if appropriate) (if required)

- Can you expand a little on this?
- Can you tell me anything else?
- Can you give me some examples?

Part Four

Main Question

- How do you think the training influenced you?

Sub-Questions (if not touched upon during the main question answer)

- Did the training change affect you professionally? *(if required)*
- Did the training change you on a personal level? *(if required)*
- Do you still practice or develop any of the skills from the training?
- Are you still in touch with anybody from the training, professionally or socially or both?

Clarifying Questions (for the sub-questions, if required)

- Can you expand a little on this?
- Can you tell me anything else?
- Can you give me some examples?

Part Five

Main Question

- In relation to the training, can you tell me if the experience has altered your future career aspirations in anyway?

Sub-Questions (if not touched upon during the main question answer)

- Are you in a new role since the training? (If yes, do you feel the training helped you in anyway?)
- Are you looking for a new role? (If yes, is this related to your training experience?)
- How do you see your future career?
- If a further management role is not for you, why? (If the answer is yes, is this related to the training in anyway?)

Clarifying Questions (for the sub-questions, if required)

- Can you expand a little on this?
- Can you tell me anything else?
- Can you give me some examples?

Final Question

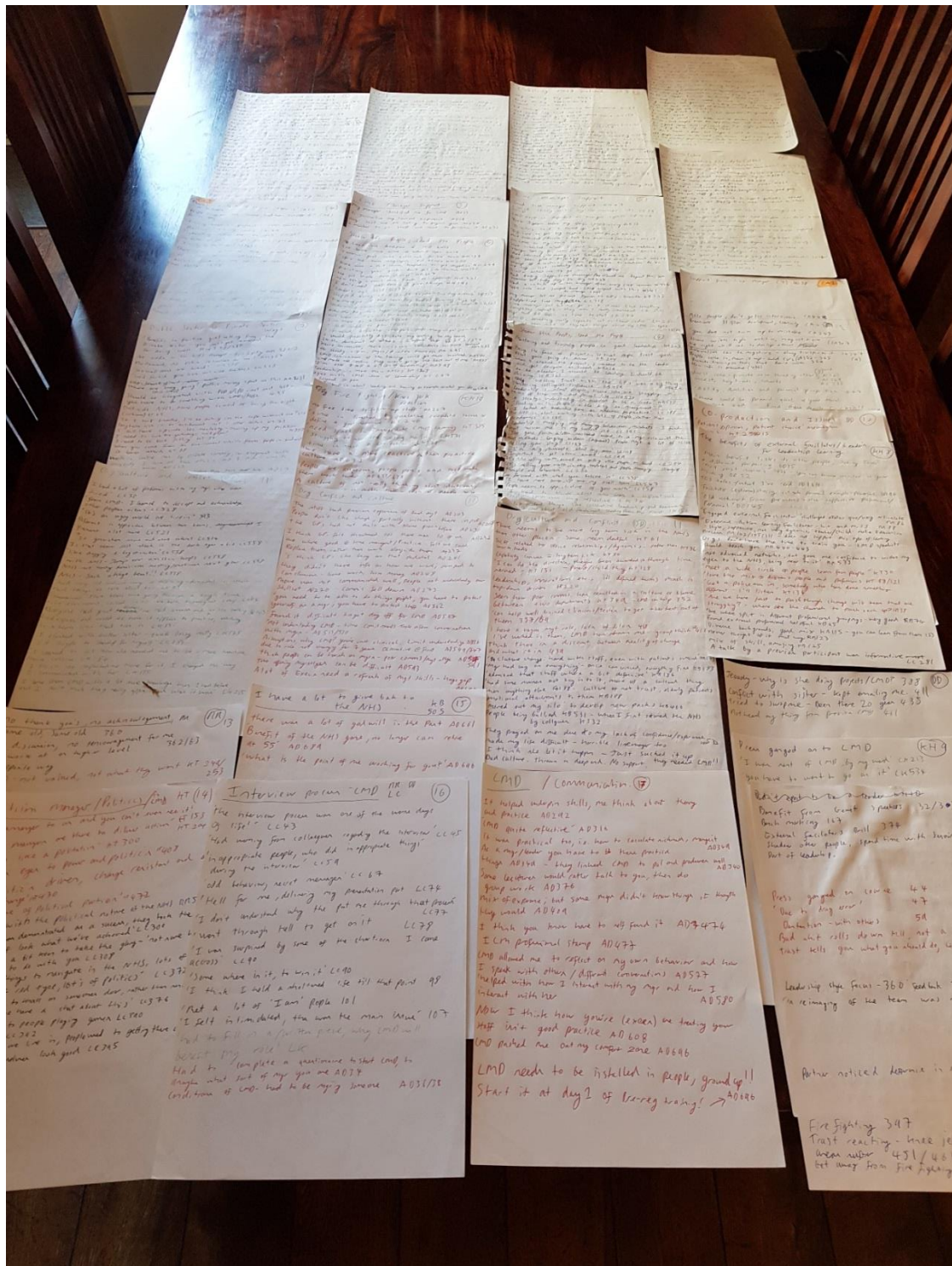
- Is there anything that we haven't covered that you feel is important concerning your experiences of NHS leadership and management development training?

Ends: Thank you very much for your time and effort. It is very much appreciated.

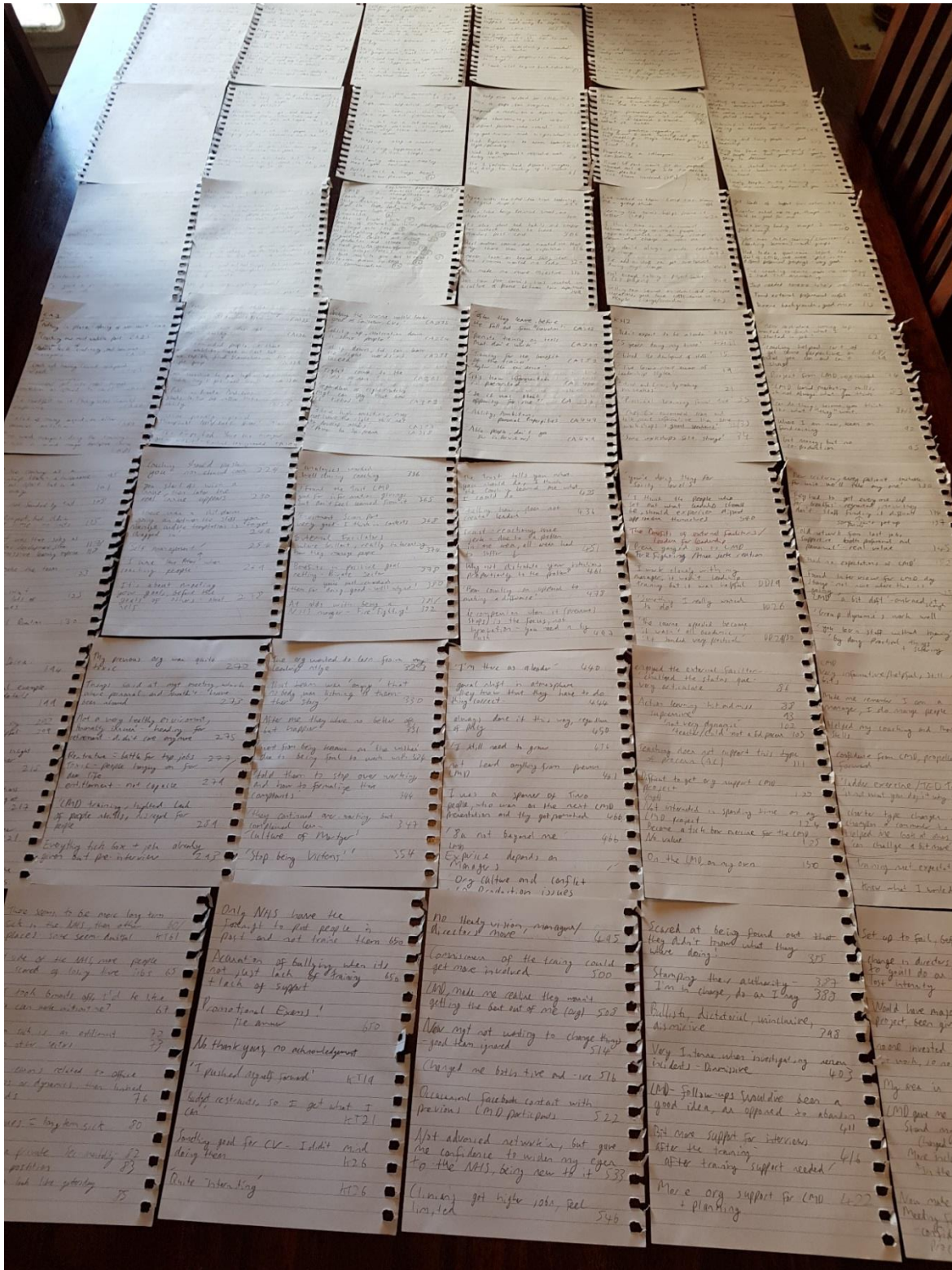
Appendix 9. Sample of an interview transcript

KT1	Thank you for volunteering to do this XXXXX. It's much appreciated.	
KT2		
KT3	As I said, thank you for agreeing to be interviewed about your experiences of NHS Leadership and Management Development programme or training and	
KT4	how these experiences have influenced your career aspirations and also your	
KT5	practice as a professional. So please answer as openly as you can but do not	
KT6	feel obliged to answer questions that you'd rather not. What will be said will	
KT7	also be in confidence and this will be destroyed once transcribed.	
KT8	So, first question is; can you tell me about your leadership training please?	
KT9		
KT10	I have done the Invest To Lead training about four years ago. I've done the	} multiple CMP
KT11	Strategic Management Masters Degree. I have done the East Midlands	
KT12	Academy Leadership Transition, something like that, which again was a longer	
KT13	course over several days. I've done the Mary Seacole Programme and I'm	
KT14	currently doing the Vision 21 Middle Management Programme.	
KT15	Wow! That's quite a lot! So just to reiterate, I'm looking mainly at the last 10	
KT16	years in NHS Leadership training provided relevant to your NHS role. So, how	
KT17	did you get on to the training, or is there any particular training you want	
KT18	to talk about?	
KT19	I just pushed myself forward. There was very little prompting. The emails	- volunteered for CMP Academy (MP) ①
KT20	went out and I tended to chase them up and that's generally been the case. If	
KT21	there's training going, and I'm always conscious that there's going to be	
KT22	budget restraints, so it might not be around for ever so you need to get it	
KT23	while it's there.	
KT24	When you say you "pushed for it", was that of your own volition?	
KT25	Yes, of my own volition and it was, primarily I suppose, thinking ahead that	- something good for CV Academy (MP) ① ↓ Workplace (MP)
KT26	this would be something good for your CV but on the other side I thought,	
KT27	after doing one, actually I didn't mind doing them. It was quite interesting. It	
KT28	was a change from quite a monotonous role so I don't perhaps get to meet a	
KT29	wide circle of people. It gave me a chance to get out and meet other people	
KT30	and talk to other people in different sorts of jobs and also, I liked the sort of	
KT31	self-reflection aspect of them. I thought that they would be much drier than	
KT32	they turned out to be. They were very different in tone from say the Masters	- 'seen by others'?
KT33	which was overwhelmingly academic. This was much more in general about	
KT34	how you manage yourself and how you're seen by others, that sort of thing.	
KT35	So it does have a general interest for me.	
KT36	So where and when was your training, or if you want to pick a particular one?	
KT37	Where?	
KT38	Yes, where would you go normally? What type of environment were they	
KT39	delivered in?	
KT40	They're very similar, in as much that I'm talking about the NHS management	
KT41	ones, in as much as they tended to have formal days involving wider groups of	
KT42	people and they'd have a number of smaller days where you'd be split into	

Appendix 10. Picture of the IPA workings



Appendix 11. Picture of the CDA workings



Appendix 12. Overarching IPA super-ordinate themes acknowledged, with their connected sub and emergent themes

Super-Ordinate Themes	Sub-Themes	Emergent-Themes
6.2 The NHS Leadership and Management Development (LMD) training experience	6.2.1 Access to NHS LMD	• <i>"It was a blanket, there's an error on your ward, go on a leadership course. That's how it felt" – Kyle</i> • <i>"The interview process was one of the worse days of my life!" – Logan</i> • <i>"Something good for the CV, I didn't mind doing them" – Karter</i> • <i>"We had to be managing somebody at that time" – Ash</i>
	6.2.2 During the NHS LMD training: Coaching, diversity, interaction and the learning environment	• <i>"Coaching learned, me what I could do" – Kyle</i> • <i>"Challenged the status quo, very articulate" – Reagan</i> • <i>"Get me someone like a policeman or something who's done something different, I think I'll listen!" – Karter</i> • <i>"I think the beauty of having this course was because you had people from diverse backgrounds" – Kai</i> • <i>"How they taught it wasn't necessarily the best way. Some of them would talk at you rather than doing lots and lots of group work" – Ash</i> • <i>"I thought the environment they had was quite conducive to the learning because it was light; it was airy; the sound carried well; we were able to see each other... It was a comfortable</i>

		<i>learning environment” – Ash</i>
	6.2.3 Post-NHS LMD	• <i>“I was demonstrated as a success, they took the responsibility of look what we’ve achieved” – Logan</i> • <i>“Follow-ups could have been better, and I think just to abandon people, to put them out the door, tick box exercise. I would change that bit, we’ve done our bit, you now do yours!” – Reagan</i> • <i>“It did meet my expectations. I think I benefitted a lot more than I thought I would do from it” – Dale</i>
	6.3.1 Line manager support	• <i>“Fab! No issues, no bother. No, you can’t have the time, none of that. Very supportive, yes” – Logan</i> • <i>“As far as they were concerned, it was just another course that I was doing, and I think that they treated it in that way” – Karter</i> • <i>“Not from the training point of view but depending on what your managers are like, will depend on what sort of experience that you have” – Dale</i> • <i>“I had a line manager who was really horrible, who was a bit of a bully as well. XXXX manager, XXXX didn’t really know what was happening each day, even if XXXXX did, I think XXXX just allowed XXXX line manager do XXXXX own</i>

6.3 The experience of being a NHS LMD participant in the workplace		<i>stuff"</i>
	6.3.2 Organisational culture: Conflict, groups and innovation	• <i>"We have a more reactive then proactive culture"</i> • <i>"Wards can be very hierarchical, clicks and groups form" – Landry</i> • <i>"Stamping their authority was just one of the tactics that they used, I am in charge! Do as I say! This is how I do it! Not a very good leadership skill!" – Reagan</i> • <i>"Patient opinion, patient choice, meaningless terms" – Karter</i> • <i>"That's what defines their success is their ability to hit those targets which is fine, but I don't necessarily think that innovation, new ways of doing it, is necessarily a huge part of their roles" – Karter</i>
	6.3.3 Communication	• <i>"Listening to people more, so communication skills and things like that. Thinking about playing to people's strengths in a team and how best to utilise the team that you've got" – Landry</i> • <i>"So, I think a big part of it was down to the communication possibly from the management team to the rest of the staff which it seemed didn't happen" – Ash</i> • <i>"I wouldn't have necessarily paid so much attention to otherwise, but you realise, as I say,</i>

		<i>how much of it is down to communication" - Karter</i>
	6.3.4 Time poverty	• <i>"You did things, in your own time outside of work, there were a lot of writing to do but actually in work" – Landry</i> • <i>"I wasn't able to do a lot of the programming side of it, so it required time from other people that I just couldn't get" – Reagan8</i> • <i>"They don't have it, they don't have the time, the resource, the expertise and so we generally tend to fall back on what are easily measurable indicators" – Karter</i>
6.4 The role of personality, leadership and motivation within the LMD participants context	6.4.1 Ability, ambition and politics	• <i>"They don't necessarily have the skills and its driven sometimes more by ambition rather than ability" – Charlie</i> • <i>"I think often it is the case that there is the presumption of competence by having reached that level. It is a presumption" – Karter</i> • <i>"It was very incestuous and if you weren't within that department, nobody from the outside was going to come in and get promoted unless someone got sacked and made a role for you" – Charlie</i> • <i>"After the course, I realised how much I was hungry for it. I was hungry to progress and to take on what I'd learned somewhere else and help other teams develop as well" – Kai</i>

	6.4.2 Leadership: Show the people, lead the people	• <i>"Highlights what's a good manager and you are surrounded by not good managers, shall we say!" – Reagan</i> • <i>"You show the people, you lead the people" – Charlie</i> • <i>"I quite liked the development of staff sort of seeing how they do and obviously those kinds of things fall under the umbrella of leadership" – Kyle</i> • <i>"There were two team leaders that I sponsored that were Band X's but then went onto be Band X's, so that's really good. Good on them!" – Dale</i> • <i>"I think it's added to my clinical practice as well because it's not just about managing staff, it's about patients" – Ash</i>
	6.4.3 Values and motivations	• <i>"You just get rewarded for doing well" – Kyle</i> • <i>"I have a lot to give back to the NHS" – Kai</i> • <i>"You get to a point where you've done all you can as an individual and there was no well done after it. There was no acknowledgement that you'd done it. It was just the same old, same old!" – Reagan</i>